

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2025
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 C 12/23/2024	
NAME OF PROVIDER OR SUPPLIER HIGH VIEW REHABILITATION AND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 517 RIVERVIEW ST MADAWASKA, ME 04756			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 580 SS=D	On 12/23/24 an on-site visit was conducted at High View Rehabilitation and Living Center for the purpose of completing an investigation for facility reported incident #ME00049935. It was determined that High View Rehabilitation and Living Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and was in past non-compliance for §483.25 - F684. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.			F 580			

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

TITLE

(X6) DATE

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.

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F 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: 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	F 580			

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F 580	Continued From page 2 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 staff member 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.	F 580			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684			

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F 684	Continued From page 3 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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	F 684	Past noncompliance: no plan of correction required.		

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F 684	Continued From page 4 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. - RN1 worked on 12/9/24 (incident date) and next scheduled day to work was 12/13/24. RN1 was	F 684			

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F 684	Continued From page 5 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.	F 684			