STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205004	A. BUILDING _____ B. WING _____	C 08/27/2024

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HIBBARD SKILLED NURSING & REHABILITATION CENTER	1037 WEST MAIN STREET DOVER FOXCROFT, ME 04426

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F 000	INITIAL COMMENTS On 8/26/24 through 8/27/24, unannounced visits were conducted at Hibbard Skilled Nursing and Rehabilitation Center for the purpose of completing an investigation for complaint #ME00048400. It was determined that Hibbard Skilled Nursing and Rehabilitation Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842	One resident was affected by this practice All residents with a new skin change of condition had the potential to be affected by this practice. RN1 had originally assessed the resident, started treatment for the resident, notified family, completed SBAR to MD and written in Nurse passdown. RN1 completed a late entry for the incident report at the time of survey. A complete audit of all new skin treatments or changes of condition was complete to ensure accidents and incidents investigation was complete as appropriate. All licensed staff will be educated on FAH policy "Accidents and Incidents-Investigation and reporting" Weekly audit will be complete by DON or designee of all new skin treatments or changes of condition to ensure investigations were complete and documented as appropriate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admn | (X6) DATE 9/13/24

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 842	Continued From page 1 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842	Results of this audit will be shared with Corporate Compliance QAPI committee for three months to determine frequency of future audits Completion date: 9/20/24	

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F 842	Continued From page 2 Based on record review, facility policies review, and interviews, the facility failed to ensure a clinical record contained complete and accurate information for 1 of 1 residents reviewed for a skin tear incident (Resident #1 [R1]). Finding: The facility's policy, "Accidents & Incidents - Investigation and Reporting," revised 2/2022, indicated that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/ Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident Form: - the date and time the accident or incident took place; - the nature of the injury/illness (bruise, fall, nausea, etc.); - the circumstances surrounding the accident or incident; - where the accident or incident took place; - the name(s) of witnesses and their accounts of the accident or incident; - the injured person's account of the accident or incident; - the time the injured persons attending physician was notified, as well as the time the physician responded and his or her instructions; - the condition of the injured person including his/her vital signs; - the disposition of the injured (transfer to	F 842		

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F 842	Continued From page 3 hospital, put to , sent home, returned to work, etc.) - any corrective action taken; - follow up information; - other pertinent data as necessary or required; what's going on now and - the signature and title of the person completing the report. The Nurse Supervisor/Charge Nurse and or the department director or supervisor shall complete a report of Incident/Accident form and submit the original to the Director of Nursing services within 24 hours of the accident or incident. The Director of Nursing shall ensure that the administrator receives a copy of the report of Incident/Accident form for each occurrence. Incident/Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities The facility's policy, "Wound Care", last reviewed on 2/2022, stated that the following information should be recorded in the resident's medical record to include: The type of wound care given, the date and time the wound care was given, All assessment data (wound bed color,size, drainage, etc.) obtained when inspecting the wound. On 8/26/24, R1's clinical record was reviewed and included a nurses note completed by Registered Nurse #1 (RN1) that indicated on 8/2/24 at 7:48 a.m., R1's Resident Representative was notified of a skin tear. The	F 842		

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F 842	Continued From page 4 clinical record lacked evidence of an Accident/Incident report being completed. There was also a fax sent to the provider on 8/1/24 at 8:48 p.m., letting the provider know, "Skin tear to right lower leg. Got caught on leg rest while transferring to bed with Certified Nursing Assistant (CNA1)" and that a dressing was applied per standing order. On 8/26/24 at 12:45 p.m., during an interview with a surveyor, the Long Term Care (LTC) Unit Manager stated that the nurse would have wrote something in the computer under incidents and that information would transfer to the Incident Report; LTC Unit Manager was unable to find any documentation of the incident in the computer or information that described the skin tear wound. The surveyor confirmed there is no documentation of an Incident Report or wound that a dressing was applied to, at the time the incident occurred. On 8/26/24 at 1:05 p.m., during an interview with a surveyor, LTC Unit Manager stated she believed that a foot rest was on (the wheelchair) when the skin tear occurred and R1 tried to get up before staff could remove it. On 8/27/24 at 10:15 a.m., R1's clinical record was reviewed and included a (late) entry incident charting, dated 8/26/24 at 8:57 p.m., completed by RN1, regarding the skin tear incident that occurred on 8/2/24. On 8/27/24 at 9:23 p.m., during a telephone interview with a surveyor, RN1 stated that she documented last night how she thought the incident occurred. CNA1 was present during this telephone conversation and demonstrated for	F 842		

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F 842	Continued From page 5 RN1 how the incident occurred. CNA1 stated that R1 attempted to stand up from the wheelchair and grabbed onto the bed rail and when he/she did, R1 hit his/her leg on the wheelchair frame which caused the skin tear; there was not a leg/foot rest on that side. The surveyor confirmed at this time with RN1 that the Incident/Accident was not documented timely or correctly when it was finally documented.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880	At time of survey, all fans were removed from both covid positive rooms were they had been in use. In the room with the AC in use, the roommate volunteered to move and we helped her move to a private room. In addition to the rooms identified during survey, a complete audit of all covid positive rooms was complete by Admin and all fans were removed at that time. Education was provided to all C.N.A's and licensed staff on FAH policy "Guidance on fans and A/C R/t covid" Weekly audits will be complete by I/P or designee to ensure fans and AC --- if being utilized --- are being utilized appropriately. Results of these audits will be shared with Corporate compliance QAPI group monthly for three months to determine frequency of future audits. correction date: 9/20/24	

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F 880	Continued From page 6 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 7 Based on observations and interviews, the facility failed to maintain a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections in 3 of 16 residents diagnosed with Coronavirus (COVID-19). Findings: According to the Centers for Disease Control (CDC) website, "About COVID-19 | COVID-19 | CDC", revised June 13, 2024, Coronavirus (COVID 19) spreads when an infected person breathes out droplets and very small particles that contain the virus. Other people can breathe in these droplets and particles, or these droplets and particles can land on others' eyes, nose, or mouth. In some circumstances, these droplets may contaminate the surfaces they touch. On 8/26/24 at 10:50 a.m., a list was provided to a surveyor by the Administrator that identified resident's that currently tested positive for COVID-19. Further review indicated that R2 tested positive on 8/25/24, R3 tested positive on 8/23/24, R4 tested positive on 8/21/24 and 8/25/24. On 8/26/24 between 2:40 p.m. - 2:50 p.m., a tour of the facility was completed with the Administrator with the following observed and confirmed: 1. R2's room door was closed but there was an air conditioner in the window on R2's side of the room, blowing towards the roommate who was currently negative for COVID-19;	F 880		

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F 880	Continued From page 8 2. R3's room door was closed but there was a fan in the room on R3's side of the room, blowing towards the roommate who was currently negative for COVID-19; and 3. R4's room door was closed but there was a fan in the room on R4's side of the room and one in the center of room oscillating from side to side , blowing towards the roommate who was currently negative for COVID-19. During these observations/interviews, the Administrator spoke with staff present who were able to identify that the doors should be closed and that the fans should not be blowing towards the hallway, but did not think about the fan location in the room and the direction it was blowing towards.	F 880		