STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	205004		C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIBBARD SKILLED NURSING & REHABILITATION CENTER	1037 WEST MAIN STREET DOVER FOXCROFT, ME 04426

(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		
	From 6/2/25 through 6/5/25, on-site visits were conducted at Hibbard Skilled Nursing and Rehabilitation Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate facility reported incidents #ME00051756, #ME00051684, and #ME00051352. It was determined that Hibbard Skilled Nursing and Rehabilitation Center is not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.			
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		
	§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility's interdisciplinary team (IDT) failed to determine if it was clinically appropriate for a resident to keep medications at bedside and self-administer medications for 2 of 29 Residents reviewed during a medication pass (Residents #1 [R1] and R9).			
	Findings:			
	Review of facility policy, "Self-Administration of Medications," revised 3/2025 states, "...the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident...If it is deemed safe and appropriate for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/20/25

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 554	Continued From page 1 a resident to self-administer medications, this is documented in the medical record and the care plan...For self-administering residents, the nursing staff determine who is responsible (the resident or the nursing staff) for documenting that medications are taken... Self-administered medications are stored in a safe and secure place, which is not accessible by other residents...Nursing staff reviews the self-administered record for each nursing shift, and transfers pertinent information to the medication administration record (MAR)...noting that the doses were self-administered." During a medication pass observation for Resident (R)9 on 6/3/25 at 7:28 a.m., Certified Nursing Assistant/ Medication Technician (CNA/MT) was observed to retrieve 1 tablet of Medication "Bayer back and body oral 500-32.5 [milligram (mg)]" and placed it in a medication cup. At this time CNA/MT stated, "Just to let you know [he/she] has an order for self-administration of the Bayer, but I don't think its care planned, but there is an order to self-administer." CNA/MT was then observed walking into R9's room and placed medication cup on R9's over the bed table and left the room. Review of R9 clinical record revealed an order with start date 5/7/25 that states "Bayer Back & Body Oral Tablet 500-32.5 mg (Aspirin-Caffeine) Give 1 tablet by mouth one time a day related to other chronic pain. Administration time per resident request..." Further review of R9s medication orders lacked evidence of an order to self-administer this medication. Review of R9's electronic and paper chart lacked evidence that a "Self-Administration" Assessment	F 554	F554 Assessment for self-administering of medications was completed for residents #1 and #9. Care plans were updated. No other residents are self administering medications at this time. Education for licensed nursing and med techs on medication self administration policy and procedures Staff will complete education by completion date or prior to next worked shift. A weekly Audit of residents that self administer medications for care planning, physician orders, charting of administration records, and record of self administration assessment will be complete by DON or designee. Results of weekly audits will be reviewed with QAPI group for 3 months to determine frequency of any future audits or adjustments.	7/11/25

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F 554	Continued From page 2 was completed. Review of R9's care plan updated 5/13/25 lacked evidence of self-administration goals and interventions. During a review of R9's clinical record with Long Term Care Unit Manager (LTCUM) on 6/3/25 at approximately 9:08 a.m., LTCUM stated residents should have an order to self-administrator medications, they should have an assessment completed as well as an established care plan. At this time LTCUM confirmed the above findings. 2.On 6/2/25 at 11:21 a.m. and 6/3/25 at 9:00 a.m., during observations of Resident #1's room, a box containing a 15 milliliter (mL) bottle of Muro 128 eye drops was observed in a basket on Resident #1's over-the-bed table. A review of Resident #1's clinical record revealed an active order with start date of 5/6/25 for "Muro 128 Ophthalmic Solution 5% (Sodium Chloride Hypertonic) ... Instill 2 drops in both eyes every 4 hours as needed for corneal edema." Review of Resident #1's May 2025 and June 2025 Medication Administration Record (MAR) lacked evidence of administration of the eye drops. Further review of Resident #1's clinical record lacked evidence of an IDT assessment for self-administering medications, a physician order to self-administer the eye drops, or documentation on the care plan. On 6/3/25 at 11:21 a.m., during an interview, Resident #1 stated he/she is supposed to	F 554		

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F 554	Continued From page 3 administer the eye drops to himself/herself, 3 to 4 hours after the nurses administer his/her other eye drops. On 6/3/25 at 10:03 a.m. during an interview, Licensed Practical Nurse (LPN) #1 stated for a resident to self-administer medications, there needs to be a physician order to self-administer medications, an order to store the medication at bedside, and a self-administration assessment. At this time, LPN #1 reviewed Resident #1's entire electronic record and paper chart and confirmed it lacked evidence of an order to self-administer medications and lacked evidence of a self-administration assessment. On 6/3/25 at 10:15 a.m., the above finding was discussed with the Operations Consultant.	F 554		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		

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F 578	Continued From page 4 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interview, the facility failed to ensure that the resident and/or resident representative received assistance/follow up assistance to complete the written information provided concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, or appoint a surrogate, for 5 of 7 residents reviewed for advanced directives. (Resident #21 [R21], R24, R42 R72, R75). Findings: Review of facility policy "Advanced Directives" dated 3/25, Page 3 of 5, Section: If the Resident	F 578		

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F 578	Continued From page 5 Does not have an Advanced Directive states " if the resident or representative indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. Nursing staff will document in the medical records the offer to assist and the residents decision to accept or decline assistance. 1. On 6/3/25, a review of R21's electronic medical record indicated that on 7/20/2023, R21 documented that they did not have an advanced directive and a family member would look into one. The medical record lacked evidence that the facility followed up with the resident and/or resident representative concerning the right to accept or refuse medical or surgical treatment and to ensure the completion of the resident's advanced directive wishes. 2. On 6/2/25, a review of R24's electronic medical record indicated that on 3/6/2019, documentation indicated that R24 did not have an advanced directive and declined to have one. Documentation in the clinical record indicated that R24 is diagnosed with Alzheimer's disease and is cognitively impaired and has a family member listed in the clinical record as the resident representative. The medical record lacked evidence that the facility followed up with the resident representative concerning the right to accept or refuse medical or surgical treatment and to ensure the completion of the resident's advanced directive wishes. 3. On 6/3/25, a review of R42's electronic medical record indicated that on 1/2/2024, documentation indicated that R42 did not have an advanced directive and would look into it. The medical	F 578		

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F 578	Continued From page 6 record lacked evidence that the facility followed up with the resident/resident representative concerning the right to accept or refuse medical or surgical treatment and to ensure the completion of the resident's advanced directive wishes. On 6/3/25 at 11:25 a.m., in an interview with the surveyor, the Licensed Social Worker, confirmed that she was unable to find a documented note regarding the resident's/representative's advanced directive wishes and outcomes. 4. On 6/3/25, a review of Resident #71's "Acknowledgement of Important Infomation and Policies," dated 12/3/24, indicates Resident #71 has an Advance Directive and states, "will provide to us." On 6/3/25 at 11:35 a.m., during an interview, the Social Services Director stated Resident #71's spouse was looking for documents. At this time, the Social Services Director confirmed the clinical record lacks evidence that the facility followed up with Resident #71's representative concerning the right to formulate an Advance Directive. 5. On 6/3/25, a review of Resident #75's "Acknowledgement of Important Infomation and Policies," dated 5/8/25, indicates Resident #75 does not have an Advance Directive and states, "working on one." On 6/3/25 at 11:42 a.m., during an interview in the presence of 4 surveyors, the Social Services Director stated Resident #75 does not have an Advance Directive but that it was discussed in the Interdisciplinary Team (IDT) meeting dated 5/13/25, and Resident #75's family are working on one. A Review of the IDT meeting notes, dated	F 578	F578 Advanced Directives for resident #71 and resident #42 have been updated and documented. Education to Social Services on advanced directives policy and procedures Audit of all residents for documentation of advanced directive record, or appropriate declination. Audit to be performed by Social Services Director or designee and reported to Administrator. Weekly audit of new residents and a selection of current residents to ensure Advanced Directives are consistent with their wishes will be completed by SS Director or designee. Results of weekly audits will be reviewed with QAPI group for 3 months to determine frequency of any future audits or adjustments.	7/11/25

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F 578	Continued From page 7 5/13/25, lacks evidence that Advance Directives were discussed.	F 578		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy, the facility failed to thoroughly investigate an allegation injury of unknown origin for 2 of 3 facility incident reports reviewed [Resident #4 (R4) and R61]. Findings: Review of facility "Abuse & Neglect - Clinical Protocol" dated 10/22 states :"Abuse" is defined at 483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or	F 610	F610 Incidents involving listed residents have been investigated Audit of incidents and accidents of previous 30 days to ensure follow-up and completeness Education to clinical staff for abuse/neglect reporting policy and procedures Education to clinical management team and Administrator on policy and procedures for investigations relating to resident injuries of unknown origin. Staff will complete education by completion date or prior to next worked shift. A weekly audit of incidents and accidents will be completed by DON or designee to ensure all incidents are investigated and reported appropriately. Results of weekly audits will be reviewed with QAPI group for 3 months to determine frequency of any future audits or adjustments.	7/11/25

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F 610	Continued From page 8 mental anguish ...It includes verbal abuse, sexual abuse, physical abuse, and mental abuse ..The nurse will assess the individual and document related findings: Assessment data will include: injury assessment (bleeding, bruising deformity, swelling etc); pain assessment; current behavior; patients age and sex.; all current medications, especially anticoagulants, NSAIDS, salicylate; other plate inhibitors; vital signs; behavior over last 24 hours (bruise could be related to movement disorder or aggressive behavior); history of any tendency toward bruising, any related labs ....The staff, with the physician's input (as needed) will investigate alleged occurrences of abuse and neglect to clarify what happened and identify possible causes ..." Review of facility policy titled "Resident Rights", and dignity dated 10/2022 states " ... The staff, with the physician's input (as needed), will investigate all alleged occurrences of abuse and neglect to clarify what happened and identify possible causes ..." 1. On 5/27/25, the Department of Licensing received a Facility Reported Incident indicating that on 5/24/25, Resident #4 sustained an "injury of unknown origin" after he/she returned from an acute care hospital on 5/23/25, a nurse noted Resident #4's left knee to be swollen and warm to the touch. X-ray results revealed Resident #4 had sustained a femoral fracture. Review of H&P dated 5/28/25 states "During transfer, patient had a seizure and was consequently transferred to eastern Maine medical center and subsequently admitted. After returning from the hospital on May 22, 2025, patient complained of left knee pain and x-ray	F 610		

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F 610	Continued From page 9 discovered a left femoral supracondylar fracture. [He/she] was then sent to the emergency department ... where [he/she] received a CT of [his/her] knee which showed a fracture of the distal epiphysis of the femur. Patient then complained of left wrist pain and an x-ray was obtained 2 days later which showed an acute angulated right distal radial fracture. [He/she] was then transferred to the emergency room and was given a splint for [his/her] wrist. Review of Facility 5-day Investigation Follow-up dated 5/27/25" states "[RN] spoke with residents [family member] who reported to her that [Resident #4] complained of L [left] knee pain while hospitalized last week.." further review of the 5-day investigation named 3 staff members, Resident #4 and a family member were interviewed, but facility was unable to show any written documentation these interviews took place. Further review of Resident #4's clinical record lacked evidence that this injury was noted in the emergency department. During an interview on 6/2/25 at 10:03 a.m., Long Term Care Unit Manager (LTCUM) stated that the facility was not sure if the injuries happened at the facility or while in the hospital. 2. On 5/19/25 the Department of Licensing received a facility reported incident stating that on 5/18/25 Resident #61 sustained an "Injury of Unknown Origin." Report states "No known history of a fall ... What interventions were in place at the time of the incident? Please describe in full below: Resident has rails next to toilet to assist with independent toileting, to prevent falls... Were there any adverse effects to the	F 610		

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F 610	Continued From page 10 resident/patient (physical or mental)? Yes: Resident has a large hematoma near L [left] eye." Review of facility 5-day follow up dated 5/20/25 states "Description of incident: bruise of unknown origin. Resident did have an unwitnessed fall on 5/18/25 prior to noticing bruise over left eye. Bruise was not noticed at time of assessment following fall. Resident has also had increasing confusion and unsteady gate ..." Further review of facility follow-up lacked evidence that this injury of unknown origin was thoroughly investigated. During a review of above 5-day follow ups on 6/2/25 at 12:31 p.m., Long Term Care Unit Manger (LTCUM) stated that all injuries of unknown injury should be investigated as possible abuse, she is now responsible for the investigations in Long Term Care and is new to this role and was unsure of how to complete the follow up investigations. At this time LTCUM confirmed thorough investigations of the above incidents were not conducted, and in the future, she will ensure she has all the necessary information in the investigation.	F 610		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		

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F 644	Continued From page 11 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required, or incorporate the recommendations from a PASRR level II determination into a resident's assessment and care planning for 2 of 5 sampled residents reviewed for PASRR [Resident #30 (R30), R52]. Findings: 1. On 6/3/25, R30's clinical record was reviewed. R30's PASRR level II, completed on 4/22/20, indicated the following: "Specialized Services: [R30] will need to be provided the following specialized services": -"Individual therapy by licensed behavioral health professional (may include mobile therapy): You we're receptive to having a counselor to come meet with you at [another facility]. You were able to have a few visits prior to the COVID-19 Pandemic. You may benefit from having this service start again once the quarantine protocols are lifted."	F 644	F644 The services recommended in R #30's PASRR Level 2 have been offered, and documented appropriately as declined. Education provided to SS Director and SS Assistant on PASRR policy and procedures Audit of all residents for appropriate PASRR level 2 and follow through of offered services, or appropriate denial documented A weekly audit of PASRR assessments and follow through will be complete by SS Director or designee to ensure compliance. Results of weekly audits will be reviewed with QAPI group for 3 months to determine frequency of any future audits or adjustments.	7/11/25

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F 644	Continued From page 12 -"Neuropsychiatric evaluation by neurological and behavioral health professional: Recommending a psychiatric and/or neurological evaluation to determine if symptoms are related to mental health for Parkinson's disease and to assess possible treatment options. Possibly looking into some holistic options that therapist could work on: breathing exercises and ways to communicate needs without being aggressive with care team." "Rehabilitative services: [R30] will need to be provided the following services and/or supports:" -"Occupational Therapy Evaluation" -"Physical Therapy Evaluation" -"Speech/language therapy" -"Neurological Examination" -"Family Involvement in the Individual's Care" -"Supportive Counseling from [Nursing Facility (NF)] Staff" -"Obtain Archive Psychiatric Records to Clarify History" The clinical record lacked evidence that these services were offered, provided, and/or refused, addressed in resident assessments or during care planning. On 6/4/25 at 1:06 p.m., during an interview with a surveyor, the Scheduler stated there are no appointments or referrals for R30 for specialized services. On 6/4/25 at 1:09 p.m., during an interview with the Long Term Care Manager and a surveyor, R30's clinical record was reviewed. At this time the surveyor confirmed that there was no evidence specialized services were offered, provided, and/or refused, or addressed in the care plan. 2. On 6/2/25 at 3:24 p.m., during an interview with	F 644		

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F 644	Continued From page 13 a surveyor, R52 stated they wanted their call bell back, that the facility took it away after a suicide attempt. R52 stated he/she wanted therapy for Post Traumatic Stress Disorder (PTSD). On 6/3/25, review of R52's clinical record indicated the following: -Review of R52's PASRR, completed on 4/1/24, indicated R52's history of suicidal talk and behaviors occurred greater than 5 years ago. The PASRR level I result indicated: "A PASRR Level II evaluation is not required at this time for the following reason: No status change has occurred and the current PASRR evaluation remains valid. If a status change occurs, then an updated level I must be submitted by the NF to report that change." -Review of the current PASRR evaluation indicated "The following services must be provided to [R52]." 1. Initial psychiatric evaluation to determine diagnosis and develop plan of care, to manage psychotropic medicines, and assess need for changes if needed. 2. Individual therapy by a licensed behavioral health professional (may include mobile therapy) to address self-injurious behaviors and PTSD. -Review of the medical diagnosis list indicated that on 4/29/25, R52 had a new diagnosis of Schizophrenia (See F842). -The provider's note, signed 12/2/24 at 7:23 p.m., stated "During [R52's] hospital stay, [R52] made statements about wanting to kill [himself/herself] and [R52] was seen by behavioral health team with medication adjustment." This note indicates R52 had suicidal talk / behaviors within the past 5 years prior to admission to the facility. -Review of nursing notes indicated that R52 had several incidents involving suicide talk/behaviors	F 644		

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F 644	Continued From page 14 since their date of admission. The clinical record lacked evidence that R52 was referred to the State mental health authority for a new PASRR level II determination after new incidents of suicidal talk / behaviors, or after a new qualifying diagnosis. On 6/4/25 at 9:18 a.m., during an interview with the Licensed Social Worker and a Surveyor, R52's clinical record was reviewed. At this time, the surveyor confirmed the PASRR assessment was not accurate to the R52's condition on admission and was not resubmitted for a new level II determination after new incidents of suicidal talk / behaviors, or after a new qualifying diagnosis.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		

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F 655	Continued From page 15 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on obervation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to care for 1 of 5 residents reviewed for baseline care plans (Resident #333). Finding: 1. Review of Facility policy, "Care Plans-Baseline," revised 3/2025, states, "A baseline plan of care to meet the resident's	F 655	F655 Care Plans for residents listed were updated for comprehensiveness. Comprehensive care plan audit for completeness, appropriateness and reflection of current status performed by DON or designee Education to clinical staff for policies and procedures relating to care plans Care plans have been updated for all residents. Weekly audit of care plans to be completed by DON or designee. Results reported to the QAPI committee for a period of three months to establish timing of future audits.	7/11/25

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F 655	Continued From page 16 immediate health and safety needs is developed for each resident within forty-eight [48] hours of admission...and must include the minimum healthcare information necessary to properly care for the resident, including, but not limited to the following: Initial goals, based on admission orders and discussion with the resident/representative ...physician orders...Dietary orders...Therapy services...Social services...PASSAR recommendation, if applicable..." Resident #333 was recently admitted with diagnoses to include Coronary artery disease; Chest pain with exertion; Chronic Obstructive Pulmonary Disease (COPD); Type 2 Diabetes Mellitus (DM); Neuropathy (nerve pain); acute and chronic pain; peripheral artery disease, status post recent lower extremity bypass surgery and stenting, with surgical incisions of the right arm, left groin, and left leg; Left great toe arterial wound; and Stage 2 pressure ulcers of the sacrum and left heel. On 6/2/25 at 11:18 a.m., during an observation, Resident #333 had a gauze dressing on his/her left lower extremity, extending over his/her foot, and blood was observed coming through the dressing on the bottom of the foot. At this time, Resident #333 stated the nurse just changed his/her left leg dressing and had to come back in to change his/her wrist dressing because of bleeding and then stated he/she has been on 2 anticoagulants (blood thinner) since his/her surgery. A review of Resident #333's clinical record revealed the following active physician orders: -An order for "Pregabalin Oral Capsule 75 MG ...Give 75 mg by mouth three times a day for	F 655		

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F 655	Continued From page 17 Pain" -An order for "ProAir HFA Inhalation Aerosol Solution ...2 puff inhale every 4 hours as needed for COPD" -An order for "Nitrostat Sublingual Tablet ...as needed for Chest pain ...Notify MD [medical doctor] immediately" -An order for "Apixaban Oral Tablet 5 MG ...Give 5 mg by mouth two times a day for DVT [Deep Vein Thrombosis]" -An order for "Clopidogrel Bisulfate Oral Tablet 75 MG ...Give 75 mg by mouth one time a day for DVT " -An order for "Acetaminophen Oral Tablet 500 MG ...Give 2 tablet by mouth every 6 hours as needed for chronic foot pain ..." -An order for "Blood Glucose Monitoring before meals and HS [hour of sleep] four times a day for DM" -An order for "Apply dry dressing to the groin incision daily ...for wound care" -An order for "Apply Mepilex to sacrum every 3 days or as needed ...for wound care" Review of Resident #333's baseline care plan lacked evidence that goals and interventions were put into place for the cardiac diagnoses, chest pain, anticoagulant use, COPD, Diabetes, acute and chronic pain, care of the surgical and pressure wounds, nutrition, or therapy services. On 6/4/25 at 2:02 p.m., the above concerns were discussed with the Director of Nursing.	F 655		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 18 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 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 observation, record reviews, and interview, the facility failed to obtain physician orders for the treatment of a surgical wound and pressure ulcer for 1 of 1 Resident sampled for wound care (Resident #333). Finding: Resident #333 was recently admitted with diagnoses to include status post recent lower extremity bypass surgery and stenting, with surgical incisions of the right arm, left groin, and left leg; Left great toe arterial wound; and Stage 2 pressure ulcers of the sacrum and left heel. A review of Resident #333's clinical record lacked treatment orders for the right arm surgical incision and the left heel pressure ulcer. On 6/4/25 between 9:59 a.m. and 11:15 a.m., during an observation of Resident #333's dressing changes, Registered Nurse (RN) #1 removed the existing bordered gauze dressing from Resident #333's right arm surgical wound, cleansed the wound with normal saline solution (NSS), and applied a new bordered gauze dressing. RN #1 then removed the existing silicone dressing from Resident #333's left heel, cleansed the wound with NSS, and applied a new silicone dressing.	F 684	F684 Treatment orders for resident #333 were updated for comprehensive care Audit of current treatment orders and TAR for completeness. Audit to be performed by DON or designee with results reported to the Administrator. Education to nursing staff for policies and procedures for treatment orders Weekly audit of wound orders will be completed by DON or designee Wound reporting as standing agenda item for QAPI group.	7/11/25

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F 684	Continued From page 19	F 684		
	Following the wound treatments, a surveyor reviewed Resident #333's current Treatment Administration Record (TAR) with RN #1 and discussed the above concerns. At this time, RN #1 confirmed the clinical record lacked evidence of orders for the right arm surgical wound care and left heel arterial wound care and stated she thought she had a general order for dry dressings daily but that it could have been for another resident because she does not see that in the active orders. On 6/4/25 at 2:02 p.m., the above concerns were discussed with the Director of Nursing.			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on Smoking Policy review, record review and interviews, the facility failed to complete a Safe Smoking Evaluation for 1 of 1 sampled resident that actively smokes cigarettes (Resident #383 [R383]). Finding: On 6/5/25, a review of the facility's Smoking Policy indicated under Number 6-Resident	F 689		

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F 689	Continued From page 20 smoking status is evaluated upon admission. If a smoker, the evaluation includes: 6d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). On 6/5/25, a review of R383's clinical record was completed. In a Provider assessment note dated 5/21/25, the resident declines smoking cessation given his/her diagnosis of Amyotrophic Lateral Sclerosis (ALS) and being on Hospice for palliative care. There was no evidence that a Safe Smoker Evaluation had been completed. On 6/5/25 at 10:30 a.m., in an interview with the surveyor, the resident stated they are currently smoking when able. On 6/5/25 at 11:25 a.m., in an interview with the surveyor, the Skilled Nursing Manager confirmed that a Safe Smoker Evaluation was not completed.	F 689	F689 Safe smoking evaluation completed and charted for R383. No other residents have indicated a wish to smoke at this time Audit of safe smoking evaluation for all residents in accordance with smoking data obtained upon admission. Audit to be performed by DON or designee with results reported to Administrator. Education to licensed nursing staff on safe smoking evaluation, policy and procedures Results of monthly audits will be reviewed with QAPI group for 3 months to determine frequency of any future audits or adjustments.	7/11/25
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		

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F 690	Continued From page 21 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to notify the physician of a suspected Urinary Tract Infection (UTI) for 1 of 4 Residents (Resident #71) reviewed for indwelling urinary catheters. Resident #71 was admitted in December 2024 with diagnoses to include Benign Prostatic Hyperplasia (enlarged prostate), retention of urine, obstructive uropathy (a blockage in the urinary tract that causes difficulty urinating), and indwelling urinary catheter (Foley catheter). Review of Resident #71's clinical record revealed a nursing progress note dated 6/1/25 states, "Flushed resident's foley with acetic acid solution, replaced bag and tubing as it was full of sediment and smelled badly. Resident may have a UTI,	F 690	F690 Urinalysis obtained for resident #71 and charted appropriately with physician notified. Education for licensed nursing staff of UTI policy and procedures Audit of UTI's and UA's for previous 30 days for completeness by DON or designee and reported to Administrator. Results to determine timing of future audits. Weekly audit of physician ordered UA's completed by DON or designee. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25

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F 690	Continued From page 22 recommend a UA [urinalysis] to r/o [rule out]." Further review of Resident #71's clinical record lacked evidence that the physician was notified of the above urinary concerns and that a urinalysis was done. On 6/2/25 at 12:13 p.m., during an interview, Resident #71's representative stated over the weekend, the staff told him/her they were going to check for a UTI because of a change in Resident #71's mental status, but he/she hasn't heard back. On 6/5/25 at 9:40 a.m., the above finding was discussed with the Administrator.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement, monitor and/or revise as necessary interventions to prevent or manage a resident's pain for 2 of 4 residents reviewed for pain (Resident #52 (R52) and R333) Findings: 1. On 6/3/25, review of R52's clinical record revealed the following:	F 697		

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F 697	Continued From page 23 -R52's Care Plan identifies "Potential for Acute Pain / Chronic Pain", "[R52] is on pain/OPIOD medication therapy [related to (r/t)] chronic pain", and "[R52] has chronic pain r/t end stage liver failure with ascites". - On 4/7/25 at 10:45 a.m., the provider note indicated R52 had an existing order for 5 milligrams (mg) oxycodone for pain, and a new order for buprenorphine 5 micrograms (MCG) / hour (HR) transdermal (application of medicine through the skin) patch to be applied weekly. At 1:35 p.m., Order notes indicated, "The order you have entered Buprenorphine Transdermal Patch Weekly 5 MCG/HR (Buprenorphine) *Controlled Drug* Apply 1 patch transdermally one time a day every [Tuesday (Tue)] for pain and remove per schedule Has triggered the following drug protocol alerts/ warning(s): Drug to Drug Interaction The system has identified a possible drug interaction with the following orders: oxycodone [Hydrochloride (Hcl)] Oral Tablet 5 mg ... Severity: Severe Interaction: Buprenorphine, ... may diminish the analgesic effect of opioid agonists and precipitate withdrawal symptoms in patients chronically maintained on full agonist opioids ([example (eg)], oxycodone Hcl Oral Tablet 5 MG). The opiate receptor antagonist effects of buprenorphine are expected at higher doses." The record lacks evidence that the severe interaction warning was discussed with the provider. - On 4/10/25 at 9:01 a.m., a nursing note indicated R52 stated he had exhibited suicidal behaviors because "I am in pain". At 2:11 p.m., a nurse note indicated R52's family member expressed concern that "[R52] is in constant pain ...every time that I talk with [R52] [he/she]	F 697		

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F 697	Continued From page 24 [complains of (c/o)] pain". -On 4/11/25 at 12:30 p.m., a provider note indicated R52 was seen by the provider. R52 stated he/she had stopped taking their medications because they were in pain. The provider ordered as needed medications would be scheduled as R52's cognition may prevent the resident from asking for pain medicine. At 4:04 p.m., an order note indicated a new order for oxycodone 5mg "Give 1 tablet by mouth [immediately (STAT)] for pain stat dose for increased pain", triggered a severe drug to drug interaction warning. At 4:06 p.m., an order note indicated a severe drug to drug interaction between scheduled oxycodone 5 mg to be given by mouth twice a day and buprenorphine transdermal 5MCG/HR patch weekly. At 4:21 p.m., an order note indicated a severe drug to drug interaction between scheduled oxycodone 5 mg to be given by mouth twice a day and buprenorphine transdermal 5MCG/HR patch weekly. There is no evidence that the severe drug interaction warning was reviewed with the provider. On 6/3/25 at 11:22 a.m., during an interview with the surveyor and the Long Term Care Unit Manager (LTCUM) R52's medical record was reviewed. LTCUM stated there is no evidence that the drug interaction was addressed or reviewed with the provider. At this time the surveyor confirmed the resident had increased reports of pain after the introduction of the pain patch and the facility did not monitor and revise as necessary to treat R52's pain.	F 697		

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F 697	Continued From page 25 On 6/4/25 at 10:23 a.m., during an interview with a surveyor, the Physician Assistant (PA) stated nursing did not make her aware of the medication conflict, and stated if she had known she would have used an alternative option. 2. Resident #333 was recently admitted with diagnoses to include Acute and chronic pain; status post recent lower extremity bypass surgery and stenting, with surgical incisions of the right arm, left groin, and left leg; Left great toe arterial wound; and Stage 2 pressure ulcers of the sacrum and left heel. A review of Resident #333's clinical record revealed the following physician orders: - An active order for "Pain Monitoring - Assess for pain every shift for pain" - An active order for "oxycodone HCl Oral Tablet 5 MG ...Give 2 tablet by mouth three times a day for pain for 30 Days" -An active order for "oxycodone HCl Oral Capsule 5 MG ...Give 1 tablet by mouth every 4 hours as needed [PRN] for pain control for 29 Days" On 6/3/25 at 12:45 p.m., a surveyor attempted to observe Resident #333's dressing changes with Licensed Practical Nurse (LPN) #2 and asked Resident #333 permission to observe the dressing change. Resident #333 became tearful, stating his/her pain medications are messed up and that he/she had spoken to the doctor and thought he/she would be receiving a PRN dose of oxycodone so he/she could have medication prior to the dressing change. Resident #333 then stated that he/she cannot tolerate a dressing change now because it will be too painful. Resident #333 proceeded to state he/she went 12 hours last night (6/2/25) without pain medication	F 697		

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F 697	Continued From page 26 because the facility did not have the medication in stock. At this time, LPN #2 stated there is a call out to the physician to clarify the pain medication orders. On 6/4/25 at 8:40 a.m., during a follow-up interview, Resident #333, stated the nurse came in before supper last night and said he/she had orders for scheduled and PRN oxycodone but when he/she asked for a PRN dose at 1:30 a.m., he/she was told there was no oxycodone available, so he/she went 10 hours without pain medication. Review of Resident #333's June 2025 Treatment Administration Record (TAR) revealed Resident #333 received a PRN dose of Oxycodone at 12:45 p.m. on 6/2/25 and did not receive any additional doses of oxycodone until the 2:00 p.m. scheduled dose on 6/3/25. The TAR indicated Resident #333's pain level was 5/10 on the night shift on 6/3/25. Further review of the TAR revealed that on 6/3/25, Resident #333 received a scheduled dose of oxycodone at 10:00 p.m. and did not receive any additional doses of oxycodone until the 6:00 a.m. scheduled dose on 6/4/25. The TAR indicated Resident #333's pain level was 8/10 on the morning of 6/4/25. On 6/4/25 at 9:15 a.m., during an interview, LPN #1 stated new orders are entered in the electronic medical record (EMR) and go directly to the pharmacy, and the Cubex [medication storage cabinet] in the medication room has house stock available while awaiting the delivery from the pharmacy. In the presence of a surveyor, LPN #1 checked the medication cart and stated Resident #333 has 172 tablets of oxycodone 5mg on hand and that 6 have been given so far. At 9:17 a.m.,	F 697	F697 Pain medication orders clarified with provider for resident #333 and medications obtained as appropriate and ordered. Education to licensed nurses for pain management policy and procedures Education to licensed nursing for drug interaction protocol, policy and procedures. Audit of residents with pain medication orders for comprehensiveness of orders and charting in the TAR. Audit to be performed weekly by DON or designee with results reported to Administrator. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25

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F 697	Continued From page 27 in the presence of a surveyor, LPN #1 signed into the Cubex and confirmed there was no oxycodone 5mg in stock and stated she knows she used the last 6 tablets on the night of 6/2/25 and is not sure if it has been refilled since then. On 6/4/25 at 2:02 p.m., during an interview, the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated that Resident #333 probably did get his/her pain medication and is telling everyone he/she is not getting it.	F 697		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to address the needs of residents diagnosed with Post Traumatic Stress Disorder (PTSD) in order to eliminate or mitigate triggers that may cause re-traumatization for 2 of 4 residents reviewed with PTSD [Resident #52 (R52) and R57]. Findings: 1. A review of the facility's policy, "Trauma Informed Care and Culturally Competent Care," revised 3/2025, states, "Purpose...To address the	F 699		

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F 699	Continued From page 28 needs of trauma survivors by minimizing triggers and/or re-traumatization...Resident Assessment...Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers...Resident Care Planning...Identify and decrease exposure to triggers that may re-traumatize the resident... Resident #57 was admitted in November 2022 and has diagnoses to include PTSD. Review of Resident #57's Quarterly Minimum Data Set (MDS), dated 5/1/25, Section I, 16100. Post Traumatic Stress Disorder, indicated Resident #57 has an active diagnosis of PTSD. Review of Resident #57's care plan, updated 5/31/25, includes, "Focus: The resident has potential for psychosocial well-being problem r/t [related to] PTSD ..." but lacked evidence that a trauma informed care plan was established to include Resident #57's trigger(s) for PTSD. Review of Resident #57's clinical record revealed, "Trauma Informed Care Assessment-PTSD 5," dated 4/29/25 and states, "Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic ....Have you ever experienced this kind of event?" The assessment response indicates, "No." On 6/3/25 at 11:54 a.m., during an interview in the presence of 4 surveyors, the Social Services Director stated it is her understanding that she should be completing the above screening based only on changes in the past 90 days and confirmed she did not complete the assessment based on Resident #57's current PTSD	F 699		

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F 699	Continued From page 29 diagnosis. At this time, the Social Services Director confirmed Resident #57's care plan does not address his/her trigger(s) for PTSD. On 6/3/25 at 3:59 p.m., during a follow-up Interview, the Social Services Director stated she does not have an initial trauma screen for Resident #57 and stated she does not know if an initial trauma screen was ever done for Resident #57. 2. On 6/3/25, review of R52's clinical notes indicated the following: On 12/2/24 at 7:23 p.m., a provider note stated "During [R52's] hospital stay, [R52] made statements about wanting to kill [himself/herself] and [R52] was seen by behavioral health team with medication adjustment." There is no evidence that a referral was made for follow-up services at that time. On 12/4/24 at 3:22 a.m., a provider note indicated "[complaint of (c/o)] hallucinations. [He/She] is seeing 'corpses in the room with [him/her] ... Actively having visual hallucinations. [Differential diagnosis (Ddx)] includes hepatic encephalopathy, infection, medication." There was no evidence that R52's active diagnosis of PTSD was addressed. On 12/4/24 at 6:37 a.m., a nurse note stated "[R52] stated "There is a dead body's on the wall and decomposing body's with maggots coming out of their mouths." A provider was notified and gave an order for "Hydroxyzine 25mg x1 with positive effect." Additional orders for urine culture, and bloodwork were submitted at that time. There is no documentation to indicate PTSD was addressed at that time.	F 699		

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F 699	Continued From page 30 On 12/4/24 at 11:52 a.m., The provider's admission note identified an active diagnosis of "Suicidal ideation ... Multiple episodes" and "will check to see if [he/she] is to continue following with Acadia", and "Continue to follow up with Acadia". There is no evidence that Acadia was contacted for follow-up care at that time. On 12/11/24 at 6:50 a.m., a nurse note indicated R52 expressed suicidal ideation by throwing self on floor to break his/her skull, wanting a gun to shoot self, and use of johnny pants to strangle self. At 2:37 p.m., a social service note indicated, "[Crisis Worker] reports that he believes that R52's suicidality can be managed in the facility. His reported listed the following recommendations for R52 to try when escalated: ... 6. Participate in mental health counseling [Social Service Director (SSD)] will submit a referral for Counseling and will continue to check in with nursing as needed." There is no evidence that a referral was submitted for counseling at that time. On 12/16/24 at 10:23 a.m., a provider note indicated R52 had suicidal ideation with severe PTSD and anxiety. R52 was referred to Mayo Hospital Emergency Department (ED) for suicidal ideation and self-harm behavior. "[R52] needs a psychiatric provider. [He/she] does go to the [Veteran Affairs (VA)] and maybe able to refer [him/her] to VA for telemedicine. Will check to see what maybe available for when [he/she] comes back from the hospital." There is no evidence that a referral was made to the VA. On 6/3/25, review of the current Pre-Admission Screening and Resident Review (PASRR)	F 699	F699 Trauma informed care assessment complete for affected residents. Education to all staff for Trauma Informed Care policy and procedures Education to Social Services on trauma assessment policy, procedures and criteria. Comprehensive audit of residents with trauma related diagnosis for appropriate care planning and services provided, or resident declination. Weekly audit of residents with PTSD diagnosis to be performed by SS Director or designee. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25

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F 699	Continued From page 31 evaluation indicated Individual therapy by a licensed behavioral health professional must be provided to R52 to address self-injurious behaviors and PTSD (See F644). There is no evidence that a referral was made by the facility for behavioral health services prior to 4/11/25. On 6/3/25 at 12:45 p.m., During an interview with a surveyor, the Scheduler stated R52 is on a waiting list for Acadia, they say it would be a year out before an in-person appointment. Nursing called Acadia on 4/11/25, but they were unable to connect due to an issue with the equipment (computer), follow-up calls were made on 4/28/25 and 5/1/25. R52 had their telepsych visit on 5/2/25. R52 tried telepsych, but said it wasn't working for him/her, R52 had an in-person appointment with Acadia on 5/28/25 and is now on their waiting list. On 6/3/25 at 3:38 p.m., during an interview with a surveyor, the Licensed Social Worker (LSW) stated she had not completed an initial trauma assessment on R52. On 6/4/25 at 9:18 a.m., during an interview with a surveyor, the LSW stated the referral for counseling services referenced in her note on 12/11/24, was the call made to Acadia on 4/11/25. At this time the surveyor confirmed that referrals were not made by the facility for counseling services, to Acadia, or to the VA for R52's active diagnosis of PTSD and / or incidents of suicidal speech / behaviors, to eliminate or mitigate re-traumatization, from admission through 4/11/25. The surveyor also confirmed at the time of the interview that no referrals had been made to the VA for services.	F 699		

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F 761	Continued From page 32	F 761	F761	7/11/25
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure expired medications were removed from the available for use supply, for 1of 3 Medication storage Carts reviewed (Treatment Cart). Finding: On 6/3/25 at 7:33 a.m., during review of the	F 761	Comprehensive audit of all medication storage areas for outdated, unlabeled or improperly stored medications to be completed by DON or designee and reported to Administrator Education to nursing and med techs for medication storage policy and procedures Weekly medication check by DON or designee for outdated, unlabeled or improperly stored medication in medication carts. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	

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F 761	Continued From page 33 treatment cart a surveyor observed and confirmed the following were on the cart and available for use with the Licensed Practice Nurse (LPN2): -1 used bottle (less than half full of fluid) 100 milliliters (ml) Normal Saline irrigation fluid, open, unlabeled, and undated. -1 Tube of Hydrophilic Wound Dressing (Triad) open, unlabeled, with an expiration date of 3/31/25. -1 sealed multi-use vial containing 10ml of Insulin glargine 100units (u)/10ml, labeled with a yellow sticker stating "refrigerate". LPN2 stated it should be in the refrigerator until it is opened. LPN2 was unable to determine how long the vial had been out of the refrigerator. -1 sealed multi-use vial containing 10ml of Insulin Lispro 100u /10ml, labeled with a yellow sticker stating "refrigerate". LPN2 stated it should be in the refrigerator until it is opened. LPN2 was unable to determine how long the vial had been out of the refrigerator. -1 3-ounce tube of GoodSense Arthritis Relief with an expiration date of 1/2025. -1 tube of Triamcinolone Acetonide 0.1%, the pharmacy label indicated "Discard After 11/28/24" -1 opened package of Lidocaine Hydrochloride Jelly USP 2% (package is a sterile kit when sealed, used to numb genitalia prior to foley catheter insertion), resting in an unsealed zip lock bag dated 4/4/25.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		

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F 812	Continued From page 34 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility policy the facility failed to ensure temperatures were monitored in the walk-in refrigerator and freezer in order to prevent food borne illness for 2 of 3 months reviewed (January and February 2025). Findings: Review of facility "Food Storage" policy "undated states "...Refrigerated Food Storage: Foods must be maintained at or below 41 degrees. ...Thermometers should be checked twice per day and recorded on a temperature log... Frozen Food Storage: Frozen foods must be maintained at a temperature to keep the food frozen solid. At best that should be 0 degrees F or below. The freezer thermometers shall be checked twice per day and recorded on a temperature log...." Review of "Jan [January] Year: 2025" Walk in Refrigerator Temperatures lacked evidence that	F 812	F812 Kitchen temperature logs currently up to date. Education to kitchen staff on temperature log policy and procedures Dietary Manager to audit temperature logs weekly for compliance and completeness. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25

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

(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 812	Continued From page 35 temperatures were taken on 1/1/25 and 1/2/25 at 6 a.m., or 6 p.m. Review of "Feb [February] Year 2025" lacked evidence temperatures were taken on 2/23/25 at 6 a.m. or 6 p.m., and 2/4/25, 2/18/25, and 2/29/35 at 6 p.m. Review of "Jan [January] Year: 2025" Walk in Freezer Temperatures lacked evidence that temperatures were taken on 1/1/25 and 1/2/25 at 6 a.m., or 6 p.m. Review of "Feb [February] Year 2025 " lacked evidence temperatures were taken on 2/23/25 at 6 a.m., or 6 p.m., and 2/18/25 and 2/29/25 at 6 p.m. During a review of temperature logs with the Dietary Manager (DM) on 6/2/25 at 10:55 a.m., DM stated temperatures are supposed to be obtained and logged 3 times a day, and she had a hard time getting the cook at that time to ensure temperatures were being logged. At this time the DM confirmed the above findings. During an interview on 6/3/25 at 10:03 a.m. the above was discussed with the Administrator.	F 812		
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.	F 842		

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F 842	Continued From page 36 §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; (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	F 842		

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F 842	Continued From page 37 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: Based on record reviews, interviews, and policy review, the facility failed to ensure that clinical records were complete and contained accurate information for 5 of 26 sampled residents reviewed. (Resident #46 [R46], R7, R52, R71, R333). Findings: Review of facility "Abuse & Neglect - Clinical Protocol" dated 10/22 states :"Abuse" is defined at 483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish ...It includes verbal abuse, sexual abuse, physical abuse, and mental abuse ..The nurse will assess the individual and document related findings> Assessment data will include: injury assessment (bleeding, bruising deformity, swelling etc.); pain assessment; current behavior; patients age and sex.; all current medications, especially anticoagulants, NSAIDS, salicylate; other plate inhibitors; vital signs; behavior over	F 842		

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F 842	Continued From page 38 last 24 hours 9 bruise could be related to movement disorder or aggressive behavior); history of any tendency toward bruising, any related labs ....The staff, with the physician's input (as needed) will investigate alleged occurrences of abuse and neglect to clarify what happened and identify possible causes ..." On 4/19/25 the Department of Licensing received a facility reported incident indicating on 4/19/25 R#7 stated Resident #46 had threatened to shoot [him/her] earlier today. RN heard them arguing and heard Resident #46 say "Ow." RN assessed R#46 and noted redness and slight swelling on R#46's left side of face. The residents were separated, and in-house provider will assess R#46. 1. R#46 was admitted 5/22/23 and has diagnoses to include vascular dementia with psychotic disturbance, and major depressive disorder. Review of Nursing note dated 4/19/25 at 16:21 states "[R#46] was in [his/her] wheelchair in the hallway. [R#7] was going the same way and went beside [R#46]. [He/she] stated [R#46] had threatened to shoot [him/her] earlier today. This RN heard them arguing and heard [R#46] say "OW" I heard them as I was at the computer at the nurse's station, I did not see [him/her] hit [him/her]. Redness noted on left side of [R#46's] face with slight swelling. Residents were separated. Provider is in the building and was notified, she will assess [R#46]. Ice pack applied to [R#46's] face. Family to be notified. DON was notified. Review of R7's clinical record lacked evidence that the provider assessed this resident. Review of provider note dated 4/19/25 states	F 842		

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F 842	Continued From page 39 "[R#46] is a long-term resident I am asked to see on account of increasing episode of behaviors with agitation and outburst towards other residents. Today, there was an incident where [he/she] was telling another resident that [he/she] would kill them. ultimately, this resulted in the resident striking [R#46] in the face. There is no significant injury from this, however staff note that the episodes seem to be increasing in frequency greatly lately. ...[His/Her] BIMS score was 3 of 3, indicating severe cognitive impairment ...has a history of vascular dementia with psychotic features, type 2 diabetes mellitus, and right above-knee amputation. .. bupropion was increased from 150 mg back to 300 mg daily." Review of progress note dated 5/1/25 at 15:05 states "Behavior note: Argumentative with peer in front of the nurses station. Asked resident to please not engage with other resident as the other party will not end confrontation very easily. Separated residents and both seemed to be calmer and more agreeable. A short time later, this resident continued the verbal confrontation, Redirected." Progress note dated 5/1/25 at 16:09 states "Behavior note: confrontation with peer again. Removed residents from situation. SS aware Music therapy initiated with positive effect." Review of Resident (R)46 care plan most recently updated 5/21/25 lacked evidence that it was updated to reflect goals/interventions for verbal and physical behaviors. Observation of Resident #46 on 6/2/25 at 11:39 a.m., resident in hall in wheelchair, self-propelling, dressed for time and season. stating: 'stinking pig, stinking pig..."	F 842		

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During an interview on 6/2/25 at 11:42 a.m., Licensed Practical Nurse (LPN)1 stated R#46 does have verbal and physical behaviors and can get vocal and has been in verbal altercation with previous roommate.

2. R7 has a diagnosis to include anxiety.

Review of R#7's progress note dated 5/19/25 at 16:21 states "[R#46] was in [his/her] wheelchair in the hallway. [R#7] was going the same way and went beside [R#46]. [He/she] stated [R#36] had threatened to shoot [him/her] earlier today. This RN heard them arguing and heard [R#46] say "OW" I heard them as I was at the computer at the nurse's station, I did not see [him/her] hit [him/her]. Redness noted on left side of [Resident #46's] face with slight swelling. Residents were separated. Provider is in the building and was notified, she will assess [R#46]. Ice pack applied to [R#46's] face. Family to be notified. DON was notified. Review of R7's clinical record lacked evidence that the provider assessed this resident.

Review of R#7 care plan updated 5/30/25 lacked evidence that goals and interventions were put into place for R#7's physical behaviors.

During an interview on 6/4/25 at 3:10 p.m. R#7 stated he/she was angry because R#46 comes into his/her room all the time, every day, and tells me to get of my own room. He/she yells all the time. "Yes, I hit [him/her], and I don't feel bad about it either."

During a review of R#7's clinical record with Long Term Care Unit Manager (LTUM) on 6/4/25 at 2:30 p.m., LTCUM confirmed R#7's progress note

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F 842	Continued From page 41	F 842		

was a copy and paste directly from R#46's progress note, and there is no evidence that R#7 was assessed by the in house provider.

During an interview LTCUM and Skilled Nursing Manager (SNM) on 6/4/25 at 3:15 p.m., SNM stated care plans are updated during the weekdays they are done in real time and if it happens over the weekend they are updated on Monday. At this time SNM reviewed R7's care plan and confirmed it was not updated for physical behaviors, and R#46 did not have a care plan for verbal and physical behaviors.

During an interview on 6/4/25 at 4:02 p.m. the above was discussed with the Administrator.

3. On 6/3/25, review of R52's clinical record indicated the following:
On 12/4/24 at 11:52 a.m., the provider note indicated the R52 was prescribed Risperidal 0.5 milligrams (mg) to be taken by mouth twice a day for anxiety. There was no mention of a diagnosis of Schizophrenia at that time.
On 12/10/24 at 4:28 p.m., a new order for Risperidal 1mg to be taken by mouth twice a day for schizophrenia was entered by nursing staff. The clinical record lacks evidence that the resident was evaluated to confirm a new diagnosis of schizophrenia.
On 12/16/24 at 10:23 a.m., the provider note did not address a new diagnosis of schizophrenia. The medications listed at the end of the provider note indicated Risperidal 1mg to be taken by mouth twice a day for schizophrenia.
On 4/29/25, schizophrenia was added to R52's list of active diagnosis. The clinical record lacks evidence that the resident was evaluated to confirm a new diagnosis of schizophrenia.

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F 842	Continued From page 42 On 6/4/25 at 10:23 a.m., during an interview with a surveyor and the Physician Assistant (PA), R52's record was reviewed. The PA stated she knows R52 has psychosis but cannot state where the diagnosis of schizophrenia came from. The PA stated there is no order to change the diagnosis on the risperidone. The PA also confirmed the diagnosis heading found above nurse and provider notes, as well as the medications listed at the bottom of a provider note automatically flow over from Point Click Care (the electronic record) and are not documented by the provider. At this time the surveyor confirmed R52's record contained inaccurate / incomplete documentation regarding the new diagnosis of schizophrenia. 4. On 6/4/25 at 9:18 a.m., during an interview with a surveyor and the Licensed Social Worker (LSW) , R52's Social Services Quarterly Note and Pre-Admission Screening and Resident Review (PASRR) were reviewed. The LSW confirmed R52 is on a psychotropic medication, but the Social Services Quarterly Note indicated R52 is not receiving psychotropic medications. At this time the surveyor confirmed the Social Services Quarterly Note had inaccurate documentation regarding the use of psychotropic medications, and the PASRR contained inaccurate information regarding R52's medical condition (See F644). 5. Resident #71 was admitted with diagnoses to include Benign Prostatic Hyperplasia (enlarged prostate), retention of urine, obstructive uropathy (a blockage in the urinary tract that causes difficulty urinating), and indwelling urinary catheter (Foley catheter).	F 842	F842 Residents seen by provider for change in behavior and/or condition. Audit complete to ensure any other residents with change in behavior and/or condition are seen by provider appropriately with documentation of care. Education to licensed nursing staff for treatment policies and procedures Weekly audit complete by DON or designee to ensure residents with change of behavior and/or condition are seen and treated appropriately with correct documentation. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25

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F 842	Continued From page 43 Review of Resident #71's clinical record revealed the following active physician orders: -An order for "Measure I & O [intake and output] every shift for foley" -An order for "Weigh weekly in the morning every Wed [Wednesday] for weight monitoring" Review of Resident #71's May and June 2025 Treatment Administration Records (TAR) lacked evidence that I &O was recorded for the following shifts on the following dates: -Day shift: -5/8/25 -Evening shift: -5/20/25 -6/2/25 -6/3/25 -Night shift: -5/2/25 -5/4/25 -5/16/25 -5/19/25 -5/28/25 -5/30/25 -5/31/25 -6/2/25 Further review of the May TAR lacked documentation of the weekly weight on 5/14/25 and 5/21/25. On 6/5/25 at 9:18 a.m., during an interview, Registered Nurse (RN) #2 stated I & O is documented by nurses and certified nursing assistants (CNAs), but nurses review the CNA documentation at the end of the shift and total the I & O recorded by the CNA and the nurse, and	F 842		

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	document that amount on the TAR because the physician reviews the TAR. 6. Resident #333 was recently admitted with diagnoses to include left great toe arterial wound and Stage 2 pressure ulcer of the sacrum. A review of Resident #333's clinical record revealed the following physician orders: -An active order for "Apply mepilex [a type of foam dressing] to sacrum every 3 days or as needed for soiled dressing ..." -An order for "Iodosorb External Gel 0.9%...Apply to L [left] great toe topically every day shift for wound" -An active order for "Blood Glucose Monitoring before meals and HS [bedtime]" -An order for "Insulin Lispro Injection Solution 100 UNIT/ML ...Inject as per sliding scale ...before meals for dm2 [Type 2 Diabetes Mellitus]" Review of Resident #333's June 2025 TAR lacked evidence that the above Mepilex dressing and Iodosorb treatment was applied on 6/3/25, or that the resident refused treatment(s). Further review of the TAR revealed the Insulin Lispro was scheduled for 6:00 a.m., 11:00 a.m., and 4:00 p.m. daily and lacked evidence that the Insulin Lispro was administered, held, or refused for the 6:00 a.m. doses on 6/1/25, 6/2/25, and 6/3/25. On 6/5/25 at 9:40 a.m., the above findings were discussed with the Administrator.			
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	F 880		

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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:
(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

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F 880	Continued From page 46 (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: Based on observations and interviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to a dressing change and the processing of linens for 1 of 2 observations during the survey. Findings: 1. On 6/4/25 at 9:59 a.m., a surveyor entered Resident #333's room with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 to observe Resident #333's wound dressing	F 880		

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F 880	Continued From page 47 change. Upon entering the room, a surveyor observed an unbagged, soiled gown and an open, clear plastic trash bag containing soiled linen lying on the floor under the sink. RN #1 walked from Resident #333's bed to the sink and stepped on the soiled gown as she washed her hands. RN #1 then returned to Resident #333's bedside and began the dressing change. Resident #333 requested help supporting his/her left leg during the dressing change, and RN #1 proceeded to remove a pillow from the top of the bed and placed it under Resident #333's left knee. A surveyor observed dried blood on the pillowcase and asked Resident #333 if he/she uses this pillow, and he/she stated he/she uses it to sleep. RN #1 then began removing the existing left leg dressing. At this time (10:25 a.m.) a surveyor intervened and voiced concern regarding performing a wound dressing change on a soiled pillowcase. LPN #1 then changed the pillowcase and obtained a clean, disposable under pad to place over the pillow before completing the dressing change. RN #1 then stated Resident #333 was previously able to hold his/her leg up for the dressing change, so RN #1 did not come prepared with supplies. After the dressing change observation, a surveyor discussed the above concern regarding the soiled linens under the sink with RN #1, and that multiple staff entered and exited the room throughout the observation and failed to remove the soiled linens. On 6/4/25 at 1:20 p.m., during an interview, the above findings were discussed with the Infection Preventionist (IP).	F 880	F880 Soiled clothing and floor was cleaned at time of survey Education to all staff for infection control and prevention policies and procedures Weekly audit of resident rooms to be performed by Infection Preventionist or designee. Results to be reported to Administrator. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25
F 883 SS=D	Influenza and Pneumococcal Immunizations	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	205004		C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIBBARD SKILLED NURSING & REHABILITATION CENTER	1037 WEST MAIN STREET DOVER FOXCROFT, ME 04426

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F 883	Continued From page 48 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 49 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the updated Pneumococcal Conjugate Vaccination (PCV) 20 to 2 of 5 residents (Resident #47 [R47] and R72). Findings: 1. The facility's policy, "Pneumococcal Vaccine", revised "06/2022", indicated prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal Vaccine series and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Assessments of Pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission.	F 883		

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F 883	Continued From page 50 Administration of the Pneumococcal vaccines are made in accordance with current CDC recommendations at the time of the vaccination. 1. The documentation in R72's clinical record indicated that R72 received the PCV13 in 2016, and Pneumococcal Polysaccharide Vaccine (PPSV) 23 in 2018. The CDC recommendation was based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. The clinical record lacked evidence that the PCV20 was offered, provided, or refused by R72. 2. The documentation in R47's clinical record indicated that R47 received the PCV13 in 2018 but refused the PPSV23 in 2022. The CDC recommendation was to give one dose of PCV20 or PCV21 at least 1 year after PCV13. The clinical record lacks evidence that the PCV20 was offered, provided, or refused by R47. On 6/5/25 at 10:30 a.m., during an interview with a surveyor, the Administrative Coordinator stated she did not offer PCV20 to R47 or R72 because she believed they were up to date on the vaccine, that if a resident had the PCV13 they would not need the PCV20. The Administrative Coordinator and surveyor reviewed the policy. At this time the surveyor confirmed the PCV20 was not offered to R47 or R72 as recommended by CDC guidelines, or as directed by the facility's policy.	F 883	F883 Residents identified have been offered pneumococcal vaccination in accordance with the most up to date CDC guidance and either provided with the vaccination or declination documented Education to Administrative Coordinator and Infection Preventionist of CDC guidance for pneumoccocal vaccination frequency and dose. Audit of current residents for compliance of pneumoccocal vaccination schedule or documented resident declination. Results to be reported to DON and Administrator. Weekly audit to ensure CDC recommended pneumococcal vaccination scheduled is being offered to residents, to be completed by DON or designee. Results of audit to be reviewed with QAPI for 3 months to determine timing of future audits	7/11/25