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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. BUILDING _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTELLO MANOR	540 COLLEGE ST LEWISTON, ME 04240

(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		

(Census 36 Capacity 37 beds)

Recertification Survey
Federal Complaints: 44946 & 45720
Onsite Survey Dates: 11/28/2023 through 12/1/2023; 12/6/2023 through 12/8/2023; and 12/12/2023
Offsite Survey Dates: 12/11/23

The Division of Licensing and Certification conducted the annual Long Term Care Survey Process and two (2) complaint investigations at Montello Manor to evaluate compliance with 42 Code of Federal Regulation (CFR) Part 483, Subpart B, Requirements for Long Term Care Facilities. These reviews determined Montello Manor was not in compliance with requirements within 42 Code of Federal Regulation (CFR) Part 483, Subpart B, Requirements for Long Term Care Facilities.

Non-compliance with 42 Part 483, Subpart §483.25 (d)(1)(2) - F689 Free of Accident Hazards/Supervision/Devices was determined to constitute an immediate jeopardy situation beginning on 12/1/2023 and ending on 12/12/2023. The facility failed to supervise a resident, who was dependent on staff for eating safely. This failure resulted in the death of Resident #11 and created an immediate jeopardy situation for 1 of 12 residents diagnosed with dysphagia and placed the remaining 11 residents at risk if the non-compliance continued. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance

This plan of correction constitutes my written allegation of compliance for deficiencies cited during the recent survey on 11-28-2023. However, submission of this plan of correction is not an admission that a deficiency exists or that was cited correctly. This plan of correction is submitted to meet the requirement established by State and Federal Law.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Luddy	Administrator	1/5/24

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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with one or more health and safety requirements. See §483.25(d)(1)(2), also known as F689, for details.

On 12/07/23 at 2:32 p.m., the Administrator, Director of Nursing (DON), & Healthcare Operations Manager were provided written notification (IJ template) and a removal plan was requested.

On 12/08/23, the facility submitted a removal plan. The removal plan was reviewed and approved by the State Agency on 12/08/23 at 3:30 p.m. This removal plan indicated the following:
-all residents' diet plans were assessed for accuracy and appropriateness;
-diet plans were immediately modified if needed; changes were made as needed;
-staff were reeducated on residents' plan of care as it related to the residents' safety risks and level of assistance with meals. This education was to be completed by the DON to each staff as they come on duty;
a review of processes related to dietary management of therapeutic diets and management of staff supervision would be completed and adjustments made as needed;
-the Dietician would review current menus and processes with the Dietary Manager;
-huddles would be initiated at the start of every shift to review residents' kardexes and plans of care with safety risks identified;
-staff were to be reeducated on steps to deal with residents with signs of choking during meal assistance;
-staff were being assessed for current basic life support (BLS) certification;
-plans would be made to certify, all direct care

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F 000	Continued From page 2 personnel, who were identified as lacking BLS certification; and audit tools were be developed to assess compliance and safety with meal assistance for the six residents requiring extensive to total assistance with meals. On 12/12/23 at 11:15 a.m., a surveyor conducted an onsite visit and verified that the facility's plan to remove the IJ was implemented and effective. The surveyor determined the IJ was removed through interviews, reviews of residents' plan of care, and reviews of staff in-service sign in sheets.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584	• No resident was directly affected by these findings. • All residents have the potential to be affected by these findings. • North unit shower room cleaned and cove bases replaced. • Resident care items and dusty surfaces were cleaned and items repaired to assure all areas are safe and clean at this time and surfaces are cleanable. • All identified equipment and railings have been repaired and or painted at this time. • All units audited for any repairs needed. • All staff responsible for cleaning and maintenance of items educated on policy and procedures to assure all areas of concern were addressed and compliance can be maintained and sustained moving forward. 1-3-24 and ongoing • Kitchen door frame sanded and painted. • Baseboard in hallway by room 61 was repaired • Hand Rails were resurfaced on both units. • Ceiling tile at end of the wing by exit door was replaced.	

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and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 2 of 2 Units (North and East) and common areas for 2 of 2 environmental tours (11/28/23 and 11/30/23)

Findings:

1. On 11/28/23 at 9:55 AM., a surveyor observed the North Unit shower room which had a code lock, but was unlocked. The cove base around the shower was peeling away and had a brown and black substance and debris caked between the molding and tile. Clothing items were crumpled on the floor in the corner immediately to the left upon entering room. The room had a musty odor. The wall cabinet to the left of the

- Rooms 44,46,22,49,53,54,62,63,65,67 were repaired and were all cleaned and all broken, chipped or dented areas were repaired.
- Noted floor tiles identified as broken have been replaced.
- Environmental Service Director to complete weekly audits for 4 weeks to assure areas of concern remain corrected and resident care areas are clean and comfortable.
- Audits to be completed by Environmental Service Director /designee will to be reviewed in monthly QAPI until 100 percent compliance is achieved for 3 consecutive months. Frequencies of audits will be revaluated and revised by QAPI committee as appropriate.

Correction date 1-3-2024

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door had peeling vinyl type and the molding had a dark dried substance visible between the molding and the cabinet surface. A spray bottle of Hyperfact 256 one step disinfecting cleaner was sitting on top of the wall cabinet.

On 11/28/23 at 10:00 AM., in an interview, the Director of Nursing confirmed the findings and the disinfectant was removed.

2. On 11/30/23 from 9:20 AM to 10:20 AM, a surveyor conduced an Environment Tour with Environmental Services Director in which the following findings were observed:

Common Areas:
> There were ten (10) cracked/broken floor tiles in the hallway outside the Rehab room.
> The wall fan behind nurses station was dusty/dirty
> The hallway baseboard heater next to the nurse's station was bent/dented and was broken and falling apart.
> The kitchen door frame had chipped/missing paint creating an uncleanable surface.
> There were three (3) cracked/broken floor tiles in front of storage door next to medical director's office. The storage door frame had chipped/missing paint and the kick plate was scuffed and missing portions of the surface creating uncleanable surfaces.

North Unit:
> The Sit-to-Stand patient lift had chipped/missing paint and was rusty on the base legs.
> The hallway wooden hand railings were missing surface treatment exposing bare wood creating uncleanable surfaces.

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> The hallway baseboard heater next to Resident [redacted] was broken and falling apart.
> Resident [redacted] - The cabinet to the left as you enter the room was marred and dirty. The door and frame to the bathroom was marred and dirty. The floor around the base of the toilet was dirty.
> Resident #22's wheelchair brake handles had ripped tape on them creating uncleanable surfaces.
> [redacted] - The base board heater cover was bent/dented and had chipped/missing paint creating an uncleanable surface.
> Resident [redacted] - There was dried red liquid spatter on the wall under the light switch.
> Resident [redacted] - The cabinet to the left as you enter the room was marred and dirty. The door and frame to the bathroom was marred and dirty. The floor around the base of the toilet was dirty.

East Unit:
> Resident [redacted] - The bathroom floor had 2 cracked/broken floor tiles.
> Resident [redacted] - The room floor was dirty with debris and trash and had dried liquid residue on it. The bathroom floor was dirty around the base of toilet. The baseboard heater had chipped/missing paint creating an uncleanable surface.
> Resident [redacted] - The bathroom exhaust vent was dirty/dusty. The sink was stained yellowish and the drain metal was rusty.
> Resident [redacted] - The room floor was dirty with debris and trash and had dried liquid residue on it.
> The hallway wooden hand railings were missing surface treatment exposing bare wood creating uncleanable surfaces.

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F 584	Continued From page 6 > The hallway baseboard heater by resident room 61 was bent and the cover was falling off. > Resident [redacted] - The room floor was dirty with debris and trash and had dried liquid residue on it. > There was 1 ceiling tile at end of the wing by exit door that was stained brown and the floor cement was cracked/broken and had chipped/missing paint. On 11/28/23 at 10:20 AM, in an interview, the Environmental Services Director confirmed the findings.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623	• Resident #22 and # 35 were affected by this practice with no harm. • All residents who are transferred or discharged can be affected by this practice • No resident was harmed by this practice • Transfer discharge notifications will be completed with each transfer or discharge • Social worker to check daily for prior day transfers to hospital and validate completion of transfer/discharge notification and follow up on any variances to assure compliance is sustained • Appropriate staff educated on process for notification of all transfer and discharge to prevent non-compliance. Date: 12/31/23 and ongoing • Nurse managers will review each transfer/ discharge for evidenced of notification and report findings within the Monthly QAPI committee meeting and the committee will evaluate effectiveness of education and compliance for next three months once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained. **Correction date 1-3-2024**	

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resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative of a resident transfer/discharge for a facility initiated transfer/discharge for 2 of 3 residents whose discharge records were review (Resident #22,

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#35).

Finding:

1. Documentation on Resident #22's clinical record indicated that he/she was admitted to the facility in April of 2023 and transferred to an acute hospital in mid October of 2023 and mid November of 2023. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.

On 11/29/23 at approximately 1:00 PM, in an interview with the Director of Nursing, a surveyor confirmed that discharge/transfer notices were not provided for Resident #22's transfers to the hospital in October and November of 2023.

2. Documentation in Resident #35's clinical record indicated that the resident was transferred to an acute care hospital in mid September 2023. The clinical record lacked evidence that the facility had provided written transfer/discharge notices to the resident and his/her representative.

On 12/1/23 at 11:36 AM, in an interview, the Director of Nursing confirmed that a written transfer/discharge notice was not provided to the resident and his/her representative.

F 625 SS=B Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the

F 625

- Resident #22 and #35 were affected by this practice with no harm.
- All residents who require a bed hold can be affected by this practice
- No resident was harmed by this practice

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nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to issue a written bed hold notice to a resident and/or legal representative for 2 of 3 sampled residents who was discharged to the hospital (Resident #22, #35).

Finding:

Documentation in Resident #22's clinical record indicated that he/she transferred to an acute care hospital in mid October of 2023 and mid November of 2023. And was subsequently admitted to the acute care hospital. The clinical

- Bed hold notifications will be completed with each transfer to hospital by the nurse on duty.
- Appropriate nursing staff and social worker educated of completing bed hold notification. Date: 12/31/23
- Social worker to check daily for prior day transfers to hospital and validate completion of bed-hold notification and follow up on any variances to assure compliance is sustained
- Nurse managers will review each transfer/ discharge for evidenced of notification and report findings within the Monthly QAPI committee meeting and the committee will evaluate effectiveness of education and compliance for next three months once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained. **Correction date 1-3-2024**

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F 625	Continued From page 11 record lacked evidence that the facility issued a bed hold notice to the resident, a family member, or legal representative upon transfer either transfer. On 11/29/23 at approximately 1:00 PM, in an interview with the Director of Nurses, a surveyor confirmed that written bed hold notices were not provided for Resident #22's transfers to the hospital in October and November. 2. Documentation in Resident 35's clinical record indicated that the resident was transferred to an acute care hospital in mid September of 2023. The clinical record lacked evidence that the facility had provided bed hold notices to the resident or his/her representative. On 12/1/23 at 11:36 AM, in an interview, the Director of Nursing confirmed that written bed hold notices were not provided for Resident #35's transfer to the hospital in mid September of 2023.	F 625		
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.	F 655	• Residents (#188) had an incomplete or late baseline care planning, this resident was not affected by this finding. • All residents have the potential to be affected by these findings. • All base line care plans and comprehensive were reviewed and revised to resident's current status and needs also to include and assure that resident and family participation was offered and documented within the resident's record.	

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F 655	Continued From page 12 (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. (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 interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 2	F 655	• All residents plan of care was reviewed related to current status and are updated to reflect current level of care. • Process and procedure for timely completion of the baseline care plan on admission which is to include diagnosis, ADL assistance needs, and any health and safety needs within that baseline care plan within 48 hours was reviewed with the MDS and admission nurse. Date 12-29-2023 • Nurse's aware of need to review changes in resident plan of care and report changes to nursing to assure changes made timely. • MDS to review care plans for accuracy at time of MDS and report to manager for review. • Director of Nursing/designee will complete audits of all admissions to assure baseline care plans are completed timely and reviewed with resident and family timely identify any changes needed and revise to assure current baseline care represents up to date needs. • The director or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing. **Correction date 1-3-2024**	

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F 655	Continued From page 13 residents that was reviewed for baseline care plans. (Resident #188). Finding: Review of Resident #188's clinical record noted that he/she was admitted to the facility in November of 2023 with a primary diagnoses of Iron Deficiency, Cirrhosis of Liver, Chronic obstructive pulmonary disease(C0PD), Crohn's Disease, Type 2 diabetes, Depression, Anxiety Disorder, 0bsructive sleep apnea, Gastro esophageal reflux disease(GERD) and Hyperlipidemia. The medical record lacked evidence that a base line care plan was developed within 48 hours that included the problems, interventions, and goals. On 11/30/23 at 2:00 PM, in an interview, a Registered Nurse confirmed that the baseline care plan was still in progress and had not been completed within 48 hours for Resident #188.	F 655		
F 689 SS=J	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 record reviews and interviews, the facility failed to provide supervision and assistance to a resident who was identified with	F 689	• While one resident #11 was directly affected by these findings, 16 residents who have dysphagia and or swallow deficit who require set –up to total assistance with eating have the potential to be affected by this finding. • All staff who were on duty starting 12-3-2023 who assist residents with meals had review with DON and Staff RN on resident plan of care and use of Kardex each shift to assure current plan of care is followed. Also typed list of residents who require total assistance with food and fluid intake was reviewed and is posted on the front of the kardex and is updated by RN with any changes in orders or staff identifying those requiring feeding and if altered fluid consistency is required during meal times on 12-3-2023-12-8-2023 • All residents current diet plan has been assessed for accuracy and appropriateness and POC and Kardex reflective of current status requirements. 12/3/2023.Modifications will be made immediately as needed.	

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F 689	Continued From page 14	F 689		

swallowing issues and requiring assistance with meals. This failure to provide supervision and assistance at the supper meal on 12/1/2023 resulted in the death of one resident and placed the remaining 11 residents, who had been identified as having swallowing issues at risk; thus it was determined an immediate jeopardy situation existed. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements.

In addition, based on observation and interview the facility failed to ensure that a portable oxygen (O2) cylinder located in a resident's room was secured in a stand/holder to prevent tipping over.

Findings:

1. On 12/1/23, the Division of Licensing and Certification (DLC) received a Facility Reportable Incident Form stating a "Resident was found to be choking at dinner, 911 was called Resident was not able to be revived and died ..." On 12/4/23, DLC received the facility's "5 day follow-up". This follow-up stated the following: "At 1645 [4:45 p.m.] resident was found during meal time gasping for air. Nurse attempted Heimlich maneuver several times without effect. EMS [Emergency Medical Services] was called at 1648 [4:48 PM] EMS arrived at 1701 [5:01 p.m.] and was also unable to revive. Time of death was pronounced at 1705 [5:05 PM] EMS stated that the death was unattended and call police and medical examiner."

- The Plan of Care for residents previously identified as needing assistance or have altered swallowing or chewing ability was reviewed and residents who are at risk related to dysphagia, altered diet were monitored during meal time on 12/3/2023 -12-8-2023 By Director of Nursing, and or Nurse Manager, Health care Clinical Operations Consultant to ensure POC is accurate and compliance is sustained with total assistance with food or This is to assure staff are aware of any changes and are reviewing the kardex and being followed by staff to ensure safety of residents.

- Reeducation for staff that assist with food and fluid intake was provided by the DON starting on 12-3-2023 and is ongoing with staff who were not on duty on Sunday and Monday DON reviewed use of the kardex and implementation of resident's plan of care as it relates to safety risk and level of assistance with meals to meet current safety needs.

- An In-service will be completed by BLS instructor for CNAs on 12/12//2023 1:00 pm on Choking and Heimlich procedure to assure understanding and safety related to handling of a Choking resident.

- On 12/3/23 facility leadership observed facility & contract staff during meal time assisting residents during meal to assure all residents who required total assistance during meal was being assisted on 12-3-2023 to-12-8-2023 and ongoing to ensure understanding of resident's needs, physician's orders, and the overall plan of care.

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Resident #11 was admitted to the facility in early August 2023 with diagnoses that included, but not limited to, Cerebrovascular Accident (damage to the brain from interruption of its blood supply), hemiplegia (one sided muscle paralysis or weakness), and dysphagia (difficulty swallowing).

The resident's Minimum Data Set 3 (MDS), dated 8/22/2023, in Section GG, indicted the resident was dependent on staff for eating and did not make any effort to complete this activity.

On 12/6/2023 Resident #11's Kardex (a system used by the facility staff to communicate with each other about resident needs) indicated the resident required the following in relation to safe eating:
-a regular mechanical soft ground diet;
-aspiration precautions [which means practices that help to prevent foods and fluids getting into the airway]; and
-total assistance [which means the resident required direct supervision or assistance to ensure safety during eating].

Resident #11's care plan, dated 9/4/2023, stated the resident required extensive to total assistance of one staff to eat.

A review of a nursing communication note, dated 11/27/2023, indicated the following concerns from the nurse :
-Resident choking on big chunks of carrot;
-found by staff with difficulty breathing;
-several pieces of carrot were coughed out with plenty of saliva;
-resident continued to cough;
-Nursing request made to please order a mechanical soft diet possibly with ground meat;

- Reviewed processes on dietary management of therapeutic diets and management of staff supervision with meals related to dysphagia and swallowing deficits adjustments made 12-3-2023 and list of residents requiring total assist, altered diet or fluid consistency changes is posted on kardex book also those residents required feeding assistance by staff are identified also on their meal ticket provide on the tray each shift. The Dietician to review current menus and process with Dietary manager.

- Dysphagia, choking, first aid policies reviewed with working licensed staff on duty and ongoing Direct Care staff received written review and reeducation of Safety and Emergency Care for a choking by ACHA/NCAL12-7-23 and12-8-2023 and will be completed ongoing until all staff who come to work have completed review.

- All diet cards were reviewed to assure diets were correct and feeding assistance was present when required.
- An audit of meal tickets will be conducted on an ongoing basis. Nursing will supply dietary with notification of any changes.
- Director of Food & Nutrition will provide nursing educator with a plate of puree, mech soft and regular. Director of food and Nutrition will educate nursing staff of the difference to assure understanding. Pictures will be taken of each and education will be provided by nursing to all new staff and staff not present at initial training. Mech soft menu will be posted by Director of Food & Nutrition in the nourishment kitchen, visible by all nursing staff. 1-3-2024

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F 689	Continued From page 16	F 689		

and the Physician/Nurse -Practitioners response was the patient was evaluated and;
-Diet clarification: Mechanical soft with ground meat.

On 12/6/2023 at 9:12 AM, the Director of Nursing was interviewed. She stated and confirmed the following:
-Resident #11 had a care plan that indicated the resident required supervision with eating;
-On Friday on 12/1/2023, the resident was alone at suppertime;
-Changes were made to the Kardex and the resident ' s care plan since Friday 12/1/2023.

On 12/6/2023 at 10:36 AM, an interview was conducted with the CNA[#3] who observed Resident #11 "choking" on 12/1/2023 . She stated the following :
-she was doing checks of residents who were eating in their rooms;
-she observed Resident #11 "choking";
-she yelled for the Registered Nurse (RN #4), who was nearby in the hallway;
-RN #4 responded immediately; and
-the RN initiated the Heimlich maneuver

On 12/6/2023 at 12:09 PM, CNA #6 was interviewed. This CNA was the individual who was assigned to Resident #11 and delivered Resident #11 his/her meal tray on 12/1/2023 at supper time. She stated the following:
-the meal served to Resident #11 appeared to be a regular diet "that everyone else received";
-she had started to assist the resident with his/her meal and was told by CNA #3 that this resident did not need assistance with meals;
-she cut the sandwich into 4 pieces and left the

- Updates and changes reviewed by DON and or Nurse Manager with direct care staff who assist with set up and assistance of meals to review of current kardex and plan of care with safety risks identified on 12-3-2023 and 12-4-2023. Is ongoing to assure staff have understanding Current staff on duty have been provided education tools are available on handling resident with signs of choking during meal assistance

- Audit tool developed and completed on 12-3-23 to assess compliance and safety with meal assistance the 6 residents requiring extensive to total assist with feeding during meals.
- Director of Nursing/designee will continue to complete meal audits and report on compliance and any identified opportunities noted and any revision that were or may be needed. Once 100 percent compliance achieved for 4 consecutive weeks the QAPI teams will determine time frames for ongoing audits.
- The director or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained for 3 consecutive months. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing
- Facility will ensure that oxygen tanks are secured properly when in a resident room.

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room;

In addition, the CNA stated that she was worked for an agency and was assigned to this facility and she did not remember anyone showing her where the Kardex Binder was located prior to accepting a resident assignment.

On 12/6/2023 at 12:52 PM, RN #4, who was the RN who performed the Heimlich maneuver on Resident #11 on -12/1/2023, was interviewed. He/she stated the following:
-about 4:45 PM; [redacted] heard a CNA screaming;
-he/she went to the room and found the resident sitting upright in bed
-he/she assessed the resident and determined the resident was choking;
-he/she performed the Heimlich maneuver; and
-EMS arrived about 5:01 PM;

In addition, the RN confirmed that Resident #11 was to supposed to be supervised with meals.

Based on the above information, it was determined that the facility's failure to supervise a resident, who was dependent on staff for eating safely, on 12/1/2023 constituted an immediate jeopardy situation that resulted in the death of Resident #11.

Please see F-0000 initial comments related to the IJ removal plan.

2. On 11/30/23 at 10:05 AM, during a tour of the facility, the Environmental Service Director and a surveyor observed an unsecured oxygen cylinder

- While one resident was impacted, any residents requiring O2 has the potential to be affected.
- All in-house staff who handle oxygen will be re-educated on safe storage of O2 tanks in resident rooms. Date.12-31-2023 and ongoing
- Weekly resident room audits by Director of Nursing/Designee will note any unsecured tanks and be reported to QAPI meeting monthly for review and will continue until 100 percent compliance is achieved for three consecutive months.

Correction date 1-3-24

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F 689	Continued From page 18 to the right of the bed in resident room #68. On 11/30/23 at 10:11 AM, in an interview, a Licensed Practical Nurse (LPN) observed and confirmed that the oxygen cylinder was left unsecured in resident room #68	F 689		
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 observation, interview, and record review, the facility lacked evidence to support the	F 761	• No residents were directly affected by this practice • All residents who received refrigerated drugs have the potential to be affected by this practice. • All medication carts/fridges and storage areas were checked for expired and discontinued medications and that refrigerated medications temperatures are monitored per policy. • All staff who handle medications were re-educated on policy and procedure related to monitoring and documenting temperatures twice daily and assuring temperatures were within acceptable range. Date12-31-2023 • Medication Refrigerator Temperatures will be taken twice daily and logged on the monthly sheets. • Temperatures that are not 41 degrees or less will be reported to the DON, Charge Nurse for corrective action • Nurse managers/designee to complete monthly audits of drug storage areas and refrigerator temperature monitoring to assure compliance is achieved and maintained per policy and procedure any variance will be identified and process revised to assure compliance is maintained and sustainable.	

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monitoring of medication storage room refrigerator temperatures per facility policy to ensure proper medication and vaccine storage temperatures for 1 of 1 medication storage rooms.

Finding:

The Medication Refrigerator Temperature Policy and Procedure reads, "All temperatures will be taken on the refrigerator twice per day. The temperatures will be logged on the sheet provided by the door. Refrigerator temperatures will be at 41 degrees Fahrenheit or less. Any temperature that does not fall within these parameters will be reported to the Director of Nursing, (DON) or the Charge Nurse immediately, who will then take corrective action to remedy the situation."

On 11/29/23 at 11:35 AM, during a tour of the facility's medication storage room, a surveyor observed the medication storage room refrigerator had an internal temperature reading of 41 degrees Fahrenheit. The DON confirmed that the medications and vaccines in the refrigerator were intended for resident use. There was a temperature log for the medication storage room refrigerator for November 2023 which lacked monitoring for 5 dates. The DON was unable to produce a temperature log or written evidence that the refrigerator temperatures were being monitored to ensure that medications and vaccines were stored at their appropriate temperatures for the month of September and October.

The refrigerator contents contained 1 Insulin Emergency Kit containing: 1 multi-dose vial

- Nurse manager/designee will report findings of medication storage and refrigerator temperature monitoring audits within the monthly QAPI meeting and address needs for re-education and revisions.
- All audits will be reported to the committee by DON/designee and reviewed in monthly QAPI meeting for compliance until 100% compliance is achieved for 3 consecutive months.

Correction date 1-3-2024

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F 761	Continued From page 20 Lantus 10 milliliters (ml.), 1 multi-dose vial Levemir 10 ml., 1 multi-dose vial Novolog 10 ml., 1 multi-dose vial Humulin 70-30,10 ml., 1 multi-dose vial Humulin N 10ml, 1 multi-dose vial Humulin R 10 ml., 1 preloaded Kwik pen Humalog 3 ml., 1 Phenergan suppository 12.5 milligram, mg. 1 opened multi-dose vial Pantoprazole suspension 2mg./ml., 1 opened multi-dose vial Lorazepam, 2mg./ml. 1 opened multi-dose vial Glargine 100U/ml., 1 opened multi-dose vial Novolog 100U/ml., 1 opened multi-dose vial Tuberculin Purified Protein Derivative. 1 preloaded single dose syringe of influenza vaccine, 1 preloaded pen Trulicity,1.5 mg./0.5 ml, 2 preloaded pen Lantus Solostar 100 U/ml., 3 preloaded pen Lantus 100U/ml., 2 preloaded pen Insulin Glargine U100/ml., 6 Acetaminophen suppositories 650 mg. No observed medications or vaccines in the refrigerator had expired. On 11/29/23 at approximately 12:40 PM, in an interview, the DON confirmed that temperatures of the Medication Storage Refrigerator were not being monitored.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806		

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F 806	Continued From page 21 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interviews, it was determined that the facility failed to provide food that accommodated preferences for 1 out of 1 resident receiving Hospice services. (#8) On 11/30/23 at 12:31 PM, during an interview with Resident #8, it was revealed that he/she was told to purchase his/her own ice cream because he/she ate too much of it (6 individual containers/day). Confirmed findings with Dietary Manager and the Director of Nursing (DON). The DON agreed that ice cream was a reasonable request impacting the resident's quality of life and the facility should be providing ice cream.	F 806	• Facility shall accommodate resident food preference. • While one resident was impacted, any resident has the potential to be affected. • All in-house staff who provide meals and snacks to residents will be re-educated on resident food preferences. Date 12-31-2023 and ongoing • Any special food requests will be shared with Administrator for final approval. • All requests will be reviewed in QAPI meeting to determine residents' requests are being honored based on reasonable accommodation and preferences **Correction date 1-3-24**	
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 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.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. BUILDING _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTELLO MANOR	540 COLLEGE ST LEWISTON, ME 04240

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F 812	Continued From page 22	F 812		

§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 observations, interview, the facility's "Resident Food Storage" policy and procedure, "Food Storage" policy and "Refrigerator and Freezer Temperature" policy and procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the walk-in freezer, the ice machine, an exhaust vent, a ceiling air intake vent, a food slicer and fans four one of one kitchen tour (28/23). In addition, the facility failed to ensure that the dish machine was maintaining proper temperature ranges for proper cleaning and sanitizing. Further, the facility failed to monitor and document refrigerator and freezer temperatures for the resident food refrigerator kept in the medication room.

Findings:

The Facility's "Food Storage" policy and procedure:
7. b. Food should be dated as it is placed on shelves if required by state regulation.
c. Date marking will be visible on all high risk food to indicate the date by which a ready to eat.
8. All containers must be legible and accurately labeled and dated.

The Facility's "Resident Food Storage" policy and procedure:
1. Food or beverages brought into the facility for resident consumption will be labeled and dated for monitoring food safety.

- While no residents were impacted, all residents have the potential to be impacted by this finding.
- The FSD will conduct an in-service reviewing the policy for labeling and dating foods. Date: 1-2-2024
- Cooks will monitor the cooler and freezer daily for any unlabeled or undated items which will be disposed of if indicated upon discovery and ongoing.
- FSD will monitor refrigerator cleaning schedule monthly and direct dietary staff if additional cleaning is needed.
- FSD will monitor cleanliness of fans, exhaust vents, and ceiling intake vents monthly and notify Environmental Services of any issues.
- All items will be cleaned or replaced as deemed necessary
- An audit of all equipment will be conducted to assure cleanliness and assure all items are labeled and dated.
- The slicer was removed from service and is being replaced.
- The bathroom exhaust fan was cleaned at time of survey and all fans will be included on the cleaning schedule and monitored daily by kitchen staff and cleaned as needed if more than weekly.

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F 812	Continued From page 23	F 812		

The Facility's "Refrigerator and Freezer Temperature" policy and procedure:
All temperatures will be taken on the cooler and freezer twice per day. The temperatures will be logged on the sheet provided by the door. Refrigerator temperatures will be 41 degrees or less. Freezer temperatures will be a 0 degrees or less. Any temperature that does not fall within these parameters will be reported to the Food Service Direct immediately, who will then take corrective action to remedy the situation.

On 11/28/23 from 9:10 AM to 9:55 AM, an initial Kitchen Tour was conducted with the Food Service Director in which the following findings were observed:

1. > The walk-in freezer had large ice chunks built up on three(3) frozen turkeys and one(1) box of meat nuggets. Additionally, there were two(2) bags of chicken leg quarters that we're not labeled or dated.
> The ice machine filters were dusty/dirty.
> The kitchen bathroom exhaust vent was heavily soiled with dust.
> The food slicer had dried food debris and glue on the food thickness gauge plate.
> The large ceiling intake vent was dirty dusty and rusty.
> There were two(2) wall mounted fans in the kitchen area that were heavily soiled with dust.
> The dish room had two(2) wall mounted fans that were dirty and dusty.
On 11/28/23 at 9:55 AM, in an interview, the Food Service Director confirmed the findings.

2. > The medication room resident food refrigerator had food debris and dried liquid residue on the shelving in both the refrigerator

Facility has provided the following cleaning, repairs or replacements as noted:

- The 4 Wall fans were cleaned on 11-28-23.
- Walk in freezer was cleaned of ice and unlabeled food discarded.
- Kitchen bathroom exhaust vent was cleaned of dust.
- Ceiling Intake vent was cleaned of dirt and dust.
- Current Food slicer will be replaced with new equipment.
- Ice machine vendor contacted for cleaning of filters in conjunction with normal cleaning.
- Dish machine vendor contacted for review of correct temperature ranges for proper cleaning and sanitizing with FSS.
- Resident Food refrigerator and Facility refrigerator have temperature logs to monitor temps as required, twice daily.
- Any Freezer temps greater than 0 or refrigerator temps greater than 41 must be reported to the FSD for corrective action.
- Resident food refrigerator and Facility refrigerator will store food and beverages that are labeled and dated accurately and legibly.
- Resident Food refrigerator and Facility refrigerator will be cleaned by kitchen staff weekly.
- Audits will be completed by the FSD weekly for 4 weeks on cleanliness, temperatures and labeling and will report compliance and or revisions required within the monthly QAPI meeting.
- All audits will be reported to the committee by FSD/designee and reviewed in monthly QAPI meeting for compliance until 100% compliance is achieved for 3 consecutive months

Correction date 1-3-24 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 24	F 812		

and the freezer. Additionally, no refrigerator and freezer temperatures were monitored and documented for certain dates for September 2023(9, 14-19, 21-26 and 28-30), October 2023(1-31) and November 20231-30).
> The dish machine daily temperature record log was not documented for the October 29th lunch meal and the October 31st 2023 lunch meal; and the November 26, 2023 dinner meal.

On 11/30/23 at 10:00 AM, in an interview, the Food Service Director confirmed the findings.