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 _____	R 02/01/2024

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 On 2/1/24 an unannounced on-site visit was conducted at Montello Manor to follow up on the deficiencies cited at the annual Long Term Care Survey Process for Federal Recertification for 12/12/23. It was determined that Montello Manor was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}		
{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. (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.	{F 655}		

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

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 _____	R 02/01/2024

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 655}	Continued From page 1 (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 facility policy, record reviews and interviews, the facility failed to ensure that residents and/or resident representatives were involved in the development of and/or were provided a summary of a resident's baseline care plan for 4 of 4 sampled residents (#1, #2, #3 and #4). In addition, the facility failed to ensure that the baseline care plan included interventions needed to provide minimum healthcare information necessary to properly care for 1 of 4 residents reviewed for new admissions. (#2) Findings: The facilities Baseline Policy and Procedure, revised 6/22, states: #1 "The baseline care plan includes instructions needed to provide effective, person centered care of the resident that meets professional standards of quality care and must include the minimum health care information necessary to properly	{F 655}		

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 _____	R 02/01/2024

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 655}	Continued From page 2	{F 655}		

care for the resident, but not limited to the following: initial goals based on admission orders and discussion with the resident/representative" #4 "The resident and/or representative are provided a written summary of the baseline care plan that includes but is not limited to the following, the stated goals and objects of the resident, a summary of the residents medications and dietary restrictions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility and any updated information based on the details of the comprehensive care plan as necessary."

1. Resident #1 was admitted to the facility on 1/29/24. The clinical record lacked evidence that the resident and/or resident representative were provided a summary of Resident #1's baseline care plan.

2. Resident #2 was admitted to the facility on 1/25/24 with a diagnosis of Atrial fibrillation with a pacemaker and receiving a blood thinner, use of opioids and psychotropic medications. The clinical record lacked evidence that the resident and/or resident representative were provided a summary of Resident #2's baseline care plan. In addition, the baseline care plan lacked evidence of care, monitoring or services needed for the above diagnosis and medications. On 2/1/24 at 1:13 p.m. during an interview Resident #2 was asked if he/she participated in his/her plan of care, and if a summary of his/her plan of care was provided, Resident #2 sated, "no, nope".

3. Resident #3 was admitted to the facility on 1/11/24. The clinical record lacked evidence that the resident and/or resident Representative were provided a summary of Resident #3's baseline

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 _____	R 02/01/2024

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 655}	Continued From page 3 care plan. On 2/1/24 at 1:16 p.m., during an interview, Resident #3 was asked if he/she participated in a care plan meeting within the first 2 days of admission, Resident #3 stated, "I don't think so" but did confirm he/she had a meeting with a lot of members of the team about a week after admission. 4. Resident #4 was admitted to the facility on 1/22/24. The clinical record lacked evidence that the resident and/or resident representative were provided a summary of Resident #4's baseline care plan. On 2/1/24 at 1:10 p.m., during an interview, Resident #4 was asked if he/she participated in his/her plan of care, and if a summary of his/her plan of care was provided after admission, resident #4 stated, "No, I don't think so." On 2/1/24 at 1:26 p.m., the above was confirmed during an interview with the Administrator, Director of Nursing and the Senior Healthcare Operations Consultant.	{F 655}		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F 867		

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 _____	R 02/01/2024

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 867	Continued From page 4	F 867		

resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to

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 _____	R 02/01/2024

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 867	Continued From page 5	F 867		

determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data

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 _____	R 02/01/2024

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 867	Continued From page 6 collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the annual Long Term Care Recertification Survey, dated 12/12/23, was effective. The Federal citation F655 was cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 2/1/24. Findings: During the annual Long Term Care survey, dated 11/28/2023 through 12/1/2023; 12/6/2023 through 12/8/2023 and 12/12/2023, a deficiency was cited at F655 for the facilities failure to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed	F 867		

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 _____	R 02/01/2024

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 867	Continued From page 7 to provide minimum health care information necessarily to properly care for residents. The facility's POC, dated 1/5/24, indicated that "all baseline care plans and comprehensive were reviewed and revised to resident's current status and needs also to include and ensure that resident and family participation was offered and documented in the resident's record" and "Director of Nursing/designee will complete audits for all admissions to ensure baseline care plans are completed timely and reviewed with resident and family timely". During the re-visit survey on 2/1/24, four newly admitted residents were reviewed for baselines care plans, all 4 medical records reviewed lacked evidence of residents and/or resident representatives being involved in the development of and/or provided a summary of a resident's baseline care plan. In addition, 1 of 4 residents baseline care plan did not included interventions needed to provide minimum healthcare information necessary to properly care for the resident. It was determined the same tag F655 would be recited. On 2/1/24 at 2:31 p.m., a surveyor confirmed this finding with the Administrator.	F 867		