

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025	
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
F 558 SS=E	From 2/18/25 through 2/20/25, on-site visits were conducted at Montello Manor for the purpose of completing the Annual Long Term Care Recertification Survey and investigating complaints #ME00050590, #ME00048847 and #ME00048824 . It was determined that Montello Manor is not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a residents call bell was within reach for 4 of 15 sampled residents for 2 of 3 days of survey with multiple observations. (Resident #24, #7, #15, #188) Findings: 1. On 2/18/25 at 10:11 a.m., observation of Resident #24 sitting in a wheelchair beside the middle of the bed. The call bell was at the head of the bed hanging down. At this time, Resident #24 attempted to move the wheelchair and was unable to twist his/her body to reach the call bell. 2. On 2/18/25 at 10:54 a.m., observation of Resident #7 sitting up in a broda chair with a			F 558			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 558	Continued From page 1 hoyer pad underneath him/her and the broda chair positioned at the foot of the bed. The call bell was wrapped up on the side rail at the head of the bed, not within reach. On 2/18/25 at 12:57 p.m., an additional observation of Resident #7, sitting in a broda chair at the foot of the bed, with a tray table in front of resident. The call bell was placed on the bed behind the broda chair, not within reach. 3. On 2/18/25 at 11:05 a.m. and at 12:57 p.m., observations of Resident #15, sitting in a broda chair placed at the end of the bed with pressure-relieving booties on both feet and the foot of the broda chair elevated. The call bell was not visible anywhere around the resident. 4. On 2/18/25 at 10:56 a.m. and at 12:57 p.m., observations of Resident #188 lying in bed with the call bell wrapped around the call box on the wall behind the bed. 5. On 2/18/25 at 2:10 p.m., 2 surveyors observed Residents #7, #15 and #188 with their call bells out of reach. On 2/18/25 at 2:14 p.m., during an interview, both the surveyor and the Licensed Practical Nurse #4 (LPN) observed Residents #7, #15 and #188 with their call bells out of reach. At this time, the LPN found Resident #15's call bell on the floor under the head of the bed and placed the call bells within reach for each resident. On 2/18/25 at 2:33 p.m., the above was discussed with the Administrator. 6. On 2/19/25 at 8:20 a.m., an additional	F 558			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 558	Continued From page 2 observation of Resident #7 sitting up in the broda chair positioned at the end of the bed with a breakfast tray in front of the resident. The call bell was on the side of the bed lying on the floor. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room leaving the call bell on the floor. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up and the call bell remained on the floor. At 8:54 a.m., CNA #2 entered the room, lowered the resident's bed and moved the broda chair to the side of the bed and gave him/her the call bell. At this time, CNA #2 confirmed Resident #7 did not have the call bell.	F 558			
F 584 SS=E	On 2/19/25 at 9:04 a.m., the above was again discussed the above with the Administrator. 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.	F 584			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 3 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, 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 interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 2 wings (North and East) and the Laundry room for 1 of 1 facility tour. Findings: On 2/20/25 from 9:05 a.m. to 10:00 a.m., a surveyor conducted an Environmental Tour with the Maintenance Director in which the following findings were observed: North Wing: - Resident Room 43 - The wooden board to the	F 584			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 584	Continued From page 4 right of the bed holding the metal base board heating unit, had chipped/gouged paint exposing untreated wood. The metal base board heating unit had chipped/gouged paint creating an uncleanable surface. - Resident Room 49 - The wheelchair right arm rest had a ripped/torn/peeling plastic surface and the wheelchair was visibly dirty with food debris and dust. The bathroom floor had three stained and broken floor tiles around the toilet. - Resident Room 60 - There was a bed pan and wash basin on the floor next to the toilet. - The exit area vestibule on the North Wing had four bags of trash stored on the floor and not secured in a sealed container. East Wing: - Resident Room 61 - The cove base around the room was visibly soiled and dirty. - The ceiling vent in the hallway outside resident room 64 was dirty and dusty. - Resident Room 68 - There were three cracked/broken floor tiles in the bathroom. - Resident room 71 - There was a large crack in the sheetrock wall by the window. Laundry Room: - The cement floor had chipped/missing paint creating an uncleanable surface. - The large folding table had chipped/missing paint and had duct tape on the top edges creating uncleanable surfaces. On 2/20/25 at 10:00 a.m., in an interview, the Environmental Services Director confirmed the findings.	F 584			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 623	Continued From page 5 §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 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	F 623			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 623	Continued From page 6 (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 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.	F 623			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 623	Continued From page 7 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(k). 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 for a facility-initiated transfer/discharge for 1 of 2 Resident's reviewed for hospitalization (Resident #11). Findings: Review of Resident 11's clinical record revealed that on 7/12/24 resident was transferred to an acute care hospital and subsequently admitted. Further review of Resident 11's clinical record lacked evidence that the resident and/or resident representative and the Ombudsman's office were provided a written transfer/discharge notice. On 2/19/25 at 12:45 p.m., in an interview, the Administrator confirmed the clinical record lacked evidence that a transfer notice was provided in	F 623			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 623	Continued From page 8	F 623			
F 625 SS=D	writing to the resident and/or resident representative and the Ombudsman's office. 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 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 include cost of care to the Resident and/or resident	F 625			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 625	Continued From page 9 representative for 1 of 2 sampled Resident's reviewed for transfer to an acute care hospital (Residents #11). Finding: Review of Resident 11's clinical record revealed that on 7/12/24 resident was transferred to an acute care hospital and subsequently admitted. Review of Resident 11's clinical record lacked evidence that the resident and/or resident representative was provided a written bed hold notice upon this transfer. On 2/19/25 at 12:45 p.m., in an interview, the Administrator confirmed the clinical record lacked evidence that a bed hold notice was provided in writing to the resident and/or resident representative.	F 625			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 10 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure a person-centered comprehensive care plan was developed in the area of Chronic Obstructive Pulmonary Disease (COPD) and failed to implement the care plan in the area of ADL (Activities of Living) and oxygen maintenance for 4 of 15 residents care plans reviewed (#8, #7,	F 656			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 11 #10 and #24) Findings: 1. Review of Resident #8's current physician orders noted "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg(milligram)/3ml(milliliter)-1 application Inhale orally four times a day for COPD- start date- 1/15/25 1100, morning(am) 06, noon, evening(pm) 15, night(hs)18." Resident #8's current care plan was reviewed and it lacked evidence that the care plan was updated to include goals and interventions for the care area of COPD/Nebulizer use. On 2/20/25 at 2:00 p.m., in an interview, the Administrator confirmed that Resident #8's care plan was not updated to include goals and interventions for the care area of COPD/Nebulizer use. 2. On 2/18/25 at 10:54 a.m., and on 2/18/25 at 12:57 p.m., Resident #7 was observed sitting up in a broda with the call bell out of his/her reach. On 2/19/25 at 8:20 a.m., an additional observation of Resident #7 sitting up in the broda chair positioned at the end of the bed with a breakfast tray in front of the resident. The call bell was on the side of the bed lying on the floor. He/she was eating breakfast independently, no staff supervision and using a metal spoon, scooping up egg yolk. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room leaving the call bell on the floor. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up. At 8:54 a.m., CNA #2 entered the room, lowered the resident's bed and moved the broda chair to the side of the bed	F 656			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 12 and gave him/her the call bell. At this time, during a brief interview, CNA #2 confirmed Resident #7 did not have the call bell available. The surveyor asked what eating assistance is required for Resident #7, she stated "you have to sit with [him/her], [he/she's] supervision". At this time, the surveyor discussed the lack of supervision while he/she ate breakfast using a metal spoon. Review of Resident #7's care plan for "ADL (Activities of Living) self-care performance deficit r/t dementia" revised on 12/8/23 has an intervention of "Eating: [Resident] requires total assist by 1 staff to eat; Should use small plastic spoon and give small bites to promote increased intake." The care plan for "swallowing problem r/t dementia, coughing or choking during meals or swallowing med, difficulty with thin liquids" revised on 12/4/23 has an intervention of "Resident to eat only with supervision". The care plan for "communication problem r/t Alzheimer's dementia" revised on 6/26/24 has an intervention of "Ensure/provide a safe environment: call light in reach". On 2/19/25 at 9:04 a.m., the above failure to have the call bell available, the lack of supervision while eating and the use of a metal spoon was discussed with the Administrator. 3. On 2/18/25 at 10:33 a.m., and at 2:10 p.m., Resident #10 was observed using a nasal cannula for his/her oxygen administration with the tubing dated 1/28/25. Review of Resident #10's care plan for "Altered	F 656			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 13 cardiovascular status r/t CHF (congestive heart failure) Hypertension, AFIB (atrial fibrillation), Aortic stenosis, revised on 10/25/23 has an intervention of "change O2 (oxygen) tubing weekly and PRN (as needed)" 4. On 2/18/25 at 10:11 a.m., Resident #24 was observed sitting in a wheelchair bedside the middle of the bed. The call bell is at the head of the bed hanging down. At this time, resident #24 attempted to move the wheelchair and was unable to twist his/her body to reach the call bell. Review of Resident #24's care plan for "ADL self-care performance deficit r/t Alzheimer's dementia, impaired balance/unsteady gait, arthritis", revised on 5/2/23 has an intervention of "Encourage [Resident] to use the call bell for assistance" and the care plan for "high-moderate risk for falls relating to confusion, gait/balance problems, psychoactive drug use and unaware of safety needs", has an intervention of "be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance."	F 656			
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 684	Continued From page 14 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 observations, interviews and record review, the facility failed to follow physician orders in the area of urinary care, activities of daily living, and respiratory care for 3 of 15 residents sampled (Resident #12, #7, and #10). 1. Review of Resident #12's clinical record contained a physician order dated 1/8/25 instructing nursing to flush resident's foley catheter with 60 cc (cubic centimeter) of normal saline every day for obstructive uropathy. The clinical record lacked evidence of this was being completed. On 2/19/25 at 9:59 a.m., during an interview, the Administrator confirmed the above physician order was not completed daily by staff. 2. Review of Resident #7's provider order, dated 9/14/24 instructs nursing to provide, "Minced and Moist diet, minced texture, Nectar consistency, Fed by Staff, use plastic spoon." On 2/19/25 at 8:20 a.m., observation of Resident #7 eating breakfast independently, no staff supervision and using a metal spoon, scooping up egg yolk. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up. At 8:54 a.m., during a brief interview, the surveyor asked what eating assistance is required for Resident #7, she stated "you have to sit with [him/her], [he/she's] supervision". At this time, the surveyor discussed	F 684			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 684	Continued From page 15 the lack of supervision while Resident #7 ate breakfast using a metal spoon. 3. Review of the Resident #10's provider order, dated 12/2/24 instructs nursing to, "change and date O2 and C-pap tubing Clean concentrator filter every night shift every Mon". On 2/18/25 at 10:33 a.m., and at 2:10 p.m., observations of Resident #10 using a nasal cannula for his/her oxygen (O2) administration with the tubing dated 1/28/25. On 2/19/25 at 2:20 p.m., the above was discussed with the Administrator.	F 684			
F 689 SS=E	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 observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured for 4 of 4 observations for 2 of 3 days of survey (2/18/25 and 2/20/25). Findings:	F 689			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 16 1. On 2/18/25 at 10:28 a.m., a surveyor observed an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident Room 71's bathroom, which is shared with occupied resident Room 69. 2. On 2/18/25 at 11:08 a.m., 2 surveyors observed an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident Room 71's bathroom, which is shared with resident Room 69 and occupied. 3. Resident #4, who occupies Room 69, stated in an interview that he/she accesses the bathroom for use. On 2/18/25 at 12:36 p.m., , in an observation and interview, the Environmental Services Director confirmed there was an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident Room 71's bathroom. The Safety Data Sheet for Ajax Classic Heavy Duty Liquid Laundry Detergent noted the following: 4. First Aid Measures Eye contact: flush affected areas with water for at least 15 minutes. Seek medical assistance if required. Skin contact: Rinse with water. If skin irritation occurs in use, seek medical assistance. Inhalation: Give the subject access to fresh air. If symptoms do not resolve quickly, seek medical assistance. Ingestion: may be harmful if swallowed and large quantities. On 2/18/25 at 12:44 p.m., in an interview, a surveyor discussed the findings with the	F 689			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 17 Administrator.	F 689			
F 695 SS=E	4. On 2/20/25 at 9:33 a.m., a surveyor and the Environmental Services Director observed 5 pieces of metal approximately 2 feet long, which appeared to be brackets laying on the floor in the North wing staff exit vestibule. At this time this was confirmed by the Environmental Services Director that the metal brackets were on the floor, creating an accident hazard, and that residents had access to this area. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to maintain a respiratory program to help prevent the development and transmission of disease and infection related to respiratory equipment care for 4 of 4 residents reviewed for respiratory care (Resident #19, #7, #10, and #187) for 3 of 3 days of survey. (2/18/25, 2/19/25 and 2/20/25) Findings: 1. On 2/18/25 at 11:02 a.m., a surveyor observed an unbagged oxygen tubing and a nasal canula	F 695			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 695	Continued From page 18 hanging on an oxygen tank that was secured to the back of Resident #19's wheelchair which was stored in the hallway outside of the resident's room. The oxygen tubing was not dated. 2. On 2/18/25 at 2:20 p.m., 2 surveyors observed an unbagged oxygen tubing and a nasal cannula hanging on an oxygen tank that was secured to the back of Resident #19's wheelchair which was stored in the hallway outside of the resident's room. The oxygen tubing was not dated. 3. On 2/19/25 at 8:20 a.m., Observation of Resident #7's nebulizer machine with an unlabeled mask and tubing stored on the dresser next to the television. Review of the Resident #7's Medication Administration Record states, a nebulizer treatment was last administered on 2/13/25. The Medical record lacked evidence of orders for, or the changing of the nebulizer mask and tubing weekly. 4. On 2/18/25 at 10:33 a.m., and 2:10 p.m., observations of Resident #10's oxygen nasal cannula tubing labeled with the date of 1/28/25. On 2/19/25 at 8:24 a.m., and 12:21 p.m., observations of a nasal cannula tubing draped over personal belongings on the bedside dresser, not hooked to the oxygen concentrator. Review of Resident #10's medication administration record for January 2025 has documentation of the O2 nasal cannula tubing being changed on 1/27. February 2025 record has documentation of the O2 nasal cannula tubing being changed on 2/3, 2/10 and 2/17. 5. On 2/18/25 at 9:47 a.m., and on 2/19/25 at	F 695			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 695	Continued From page 19 12:35 p.m., Resident #187's oxygen nasal cannula tubing was wrapped up and stored under the oxygen concentrator handle On 2/19/25 at 2:20 p.m., the above findings were discussed and observed by the administrator and the surveyor. 6. On 2/20/25 at 7:49 a.m., an additional observation of Resident #187's nasal cannula tubing wrapped up and stored under the oxygen concentrator handle. At 8:02 a.m., Resident #7's nebulizer mask and tubing, undated and still stored on the dresser and available for use. On 2/20/25 at 9:00 a.m., during an interview with the Administrator, the surveyor again the confirmed the oxygen and nebulizer mask/tubing were still being stored improperly and available for use. The facilities Policy: "Respiratory Therapy" last revised on 2/2022 states, "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff." Infection control considerations related to oxygen administration" states, "Change the oxygen cannula and tubing every seven (7) days, or as needed" and "Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use." " "Infection control considerations related to medication nebulizers continuous aerosol" states, "Store the circuit in plastic bag, marked with date and resident's name, between uses" and "Discard the administration "set up" every seven (7) days."	F 695			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 726 F 726 SS=E	Continued From page 20 Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and the facilities Medication Administration Policy, the facility failed to ensure that licensed staff are provided with training and are assessed for	F 726 F 726			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 726	Continued From page 21 competency which includes transcription of physician orders in the facilities electronic clinical documentation program Point Click Care (PCC) the facility utilizes for 2 of 7 residents reviewed for medications. (Resident #1 & Resident #34) Findings: 1. A Nursing Progress note dated 9/12/24 indicating Resident #1 was seen by the provider regarding increased delusions and complaints of visual hallucinations. The progress notes further indicated the resident had received Bupropion 300 milligrams (mg) and Bupropion 450 mg daily for 4 days. Physicians' orders were obtained to immediately discontinue the Bupropion ER 450 mg, hold the Bupropion ER 300 mg for 4 days and hold the antidepressant medication Duloxetine for 4 days. Continue to monitor resident and send to the emergency room for evaluation or deterioration of condition. A review of the September 2024 Medication Administration Record (MAR) for Resident #1 indicates that he/she received Bupropion ER 300 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24 & 9/12/24 and Bupropion ER 450 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24, 9/12/24. 2. Resident #34's MAR indicates that a physician's order dated 10/8/24 instructs staff to administer Reglan 5 mg Give one tablet 4 times a day for 14 days. The MAR indicates that the resident received the medication Reglan 5 mg 4 times daily from 10/8/24 - 10/27/24. Resident #34 received 6 additional days of Reglan 5 mg 4 times daily. (24 doses) A Medication Incident Report dated 10/28/24 for	F 726			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 726	Continued From page 22 Resident #34 indicates that on 10/7/24 Reglan was ordered for 14 days and did not have a stop date entered in the electronic clinical documentation program, Point Click Care (PCC). On 2/20/25 at 10:10 a.m., during an interview with the Director of Nursing (DON), she stated the physicians order for Bupropion ER 450 mg was entered into the electronic clinical charting software, PCC incorrectly. The physicians order for Bupropion ER 450 mg should have been put on hold until the facility received the medication from the pharmacy. The surveyor asked if new staff and agency staff are required to complete training on the Point Click Care system. The DON stated that "It varies. Some nurses do not want any training. Most of them have used PCC because it's so widely used. If we see something amiss, we will do reeducation." Resident #34's physicians order for Reglan 5 mg one tablet four times a day for 14 days did not have a stop date entered in the PCC system. The stop date should have been entered 10/21/24. A review Licensed Nurse Orientation Checklist states All items require the initials of the staff person teaching the skill: Point Click Care Electronic System: - Order entry for medications & treatments - Using MARS & TARs - Medication Error Report I. Medication: - Medication pass - time frames and standards - New medication orders - entry into PCC & communication with the pharmacy II. Documentation - Physician orders, transcription into PCC, noting & 2nd noting - Written & Telephone	F 726			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 726	Continued From page 23 - Medication Error Report The facility policy, Administering Medications revised 2/2022, Policy Interpretation and Implementation, 3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 2/20/25 at 12:08 p.m., a surveyor confirmed that licensed staff are not provided training on the facilities electronic clinical documentation program (PCC) the facility utilizes with the Administrator.	F 726			
F 730 SS=E	Nurse Aide Perform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on the review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 5 of 5 CNA's reviewed with employment greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5)	F 730			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 730	Continued From page 24 Finding: 1. CNA #1 was hired on 11/26/2018. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 2. CNA #2 was hired on 7/31/2023. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 3. CNA #3 was hired on 9/5/1991. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 4. CNA #4 was hired on 7/31/2023. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 5. CNA #5 was hired on 2/6/2017. The employee record lacked evidence of an annual performance evaluation being completed for 2024. On 2/20/25 at 11:47 a.m., during an interview with the Facility Administrator and 2 surveyors present, the above information was confirmed.	F 730			
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on reviews of facility report sent to the Division of Licensing and Certification, record reviews, and interviews, the facility failed to ensure that 2 of 5 sampled residents reviewed for	F 760			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	Continued From page 25 medications was free of significant medication errors. (Resident #1 & Resident #34) Findings: 1. On 9/18/24 a facility report was submitted to the Division of Licensing and Certification. A review of the facility report and the five day follow-up report stated the following: Adult Protective Services (APS) received an anonymous report of an overdose. A medication error was discovered on 9/12/24 involving incorrect dosing of the antidepressant Wellbutrin (Bupropion). Provider on-site and evaluate Resident #1. Orders obtained to hold Wellbutrin (Bupropion) and Duloxetine for four days. Monitor for seizures or worsening of condition and send to the emergency room if any decline in status or seizure activity. Resident #1 was removed from the facility by Emergency Medical Services (EMS) shortly after. A Nursing Progress note dated 9/12/24 indicating Resident #1 was seen by the provider regarding increased delusions and complaints of visual hallucinations. The progress notes further indicated the resident had received Bupropion 300 milligrams (mg) and Bupropion 450 mg daily for 4 days. Physicians' orders were obtained to immediately discontinue the Bupropion ER 450 mg, hold the Bupropion ER 300 mg for 4 days and hold the antidepressant medication Duloxetine for 4 days. Continue to monitor resident and send to the emergency room for evaluation or deterioration of condition. A review of Emergency Room Documentation indicates that Resident #1 was evaluated for	F 760			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	Continued From page 26 complaints of "feeling dry", intermittent visual hallucinations and staff and resident are worried that he/she may be receiving too much Bupropion. Resident #1 had complaints of feeling nauseous for 1 week with occasional vomiting and having trouble with oral intake. Resident #1 was admitted to the hospital on 9/15/24 and discharged from the hospital on 9/16/24 with a diagnosis of Lactic acidemia with elevated anion gap, resolved and a UTI. A review of the September 2024 Medication Administration Record (MAR) for Resident #1 indicates that he/she received Bupropion ER 300 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24 & 9/12/24 and Bupropion ER 450 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24, 9/12/24. 2. Resident #34's MAR indicates that a physician's order for Reglan 5 mg, give one tablet 4 times a day for 14 days. The MAR indicates that the resident received the medication Reglan 5 mg 4 times daily from 10/8/24 - 10/27/24. Resident #34 received 6 additional days of Reglan 5 mg 4 times daily. (24 doses) A Medication Incident Report dated 10/28/24 for Resident #34 indicates that on 10/7/24 Reglan was ordered for 14 days and did not have a stop date entered in the electronic clinical charting software, Point Click Care (PCC). On 2/20/25 at 10:10 a.m., during an interview with the Director of Nursing (DON), she stated the physicians order for Bupropion ER 450 mg was entered into the electronic clinical charting software, PCC incorrectly. The physicians order for Bupropion ER 450 mg should have been put on hold until the facility received the medication	F 760			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025	
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 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 760	Continued From page 27 from the pharmacy. Staff did not review the medication order completely that would have instructed them to discontinue the Bupropion ER 300 mg when the Bupropion ER 450 mg was received from the pharmacy. The surveyor asked if new staff and agency staff are required to complete training on the Point Click Care software. The DON stated that "It varies. Some nurses do not want any training. A lot of them have used PCC because it's so widely used. The staff orientation consists of "where things are located, the residents and we will get them into the Pyxis system. If we see something amiss, we will do reeducation." Resident #34's physicians order for Reglan 5 mg one tablet four times a day for 14 days did not have a stop date entered in the PCC system. The stop date should have been 10/21/24.			F 760			
F 806 SS=D	On 2/20/25 at 12:08 p.m., a surveyor confirmed the significant medication errors for Resident #1 and Resident #34 with the Administrator. 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; §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 and record reviews, the			F 806			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	Continued From page 28 facility failed to provide food that accommodates the resident preferences and failed to provide a second-choice meal/alternative that is similar in nutritive value as the first-choice meal for 1 of 1 resident reviewed for food choices (Residents #10), this has the potential to affect all residents who have a "Minced and moist" diet and "Puree" diet. Findings: 1. On 2/18/25 at 10:42 a.m., during an interview, Resident #10 stated, there is "not enough staff to do mechanical soft for just me. I get minced moist. Speech therapist tested me and gave me a list of what I could and could not eat and they still said no." On 2/19/25 at 8:24 a.m., in an additional interview, Resident #10 stated, "Speech ok'd a list of foods that are good but they are not giving them to me because it's too much trouble for the kitchen. All those foods, I can only choose 2 items. I used to have graham crackers" ... "They serve French toast here but I'm not able to have it." He/she then stated, he/she is not able to choose his/her foods and there are no alternatives for his/her meals, stating "I do ask for hot cocoa", "I often have gone without a meal" and "It's unjust, but I don't want to be a burden to the kitchen. I'm working on dealing with the injustice of the situation." At this time, he/she confirmed he/she has not been offered a waiver discussing the potential risks involved with eating the foods of his/her choice. Review of Resident #10's Quarterly Minimum Data Set with the Assessment Reference Date of 11/27/24 revealed he/she had a Brief Interview for	F 806			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	Continued From page 29 Mental Status of 14 out of 15 indicating [he/she] is cognitively intact. Further review of the medical record stated he/she is responsible for decision making for him/herself. Review of the current care plan for Activities of Daily Living self-performance deficit included an intervention of "Eating: [Resident#10] is able to feed [him/herself] after set-up, 1:1 staff supervision for exception foods". Review of the Speech Therapy recommendations given by the Master's degree in Speech-Language Pathology and the Certificate of Clinical Competence in Speech-Language Pathology (MS CCC-SLP) upon discontinued speech services dated 8/29/24 states: "Response to treatment: patient has made functional gains with [his/her] swallowing and maintained safety on several mechanical soft foods, however the facility is only allowing 2 exceptions to [his/her] minced and moist diet, stating more is too complicated" ... "Impact to daily life: Patient would be most appropriate on a mechanical soft diet which is not offered by [his/her] living facility. Consequently there are several food items [he/she] is judged to be safe on that [he/she] is denied." Short term goal not met with the explanation of: "Patient would be most appropriate on mechanical soft textures, but the facility does not offer that consistency as a meat choice and is only allowed 2 of the foods [he/she] has been cleared for, stating more is too complicated. Review of Speech Therapy dietary recommendations dated 8/29/24 and signed into order by provider on 9/5/24 states, "Pt now only needs supervision when consuming diet	F 806			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	Continued From page 30 exceptions." Review of the resident notes states the following: A dietary note on 8/16/24 at 10:19 a.m. states, "This writer met with [Resident] to explain that [him/her] diet had indeed been upgraded to ground meat with no raw vegetables, rice or nuts." A dietary note on 8/16/24 at 2:31 p.m. states, "[Resident's] diet has been downgraded to Minced and Moist. In a conversation with [resident] it was explained by this writer and the DON (Director of Nursing) that [he/she] could choose two items off the diet that had been deemed safe to continue to be offered. [Resident] commented that the raisins [he/she] provides on [his/her] own so they should not count. [Resident] was advised that even though [he/she] purchased them, they were not on [his/her] diet and therefore if [he/she] ate them without choosing them as one of her 2 foods [he/she] wishes to have. It was explained to [him/her] that blended diets was not a good practice so [he/she] would continue to receive speech with the goal of upgraded [him/her] to the next diet, and allowing one food and a time would not be done moving forward." A dietary note on 8/26/24 states, "when this write was auditing the resident refrigerator in the nourishment kitchen there was a piece of cake with [Resident #10's] name on it dated 8/22/24. This writer took the piece of cake and will inquire tomorrow when [family] visits if [family] brought that to [him/her]." A dietary note on 9/11/24 during the	F 806			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	Continued From page 31 Interdisciplinary Team Meeting, Resident #10 stated that [he/she] is allowed to have cornflakes and many other things per speech. [Resident] was reminded that ST (Speech) is no longer involved in [his/her] care at this time and when discharged [he/she] was put on a minced and moist diet with only those exceptions noted, with supervision." A dietary note on 12/11/24 during the Interdisciplinary Team Meeting, Resident #10 stated, "Well if I can manage all these things I should just be able to have regular food." "It was then explained to [Resident] that [he/she] was not safe to have regular food, and that was not going to occur ... [Resident asked to speak with the MD (Doctor) in regards to upgrading [his/her] diet. [He/she] was informed that the MD would be made aware of [his/her] wish, but [his/her] likelihood of ever having a "regular diet" were rare." A dietary note on 12/27/24 states a discussion with Resident #10's family, "It was explained to [family] the reason behind the diet, and the entire purpose of the diet was to keep [him/her] safe as this was the most appropriate diet for [him/her] as recommended by speech therapy. It was explained to [family] about additional diet textures offered by larger facilities and should [he/she] want to explore that option we would help facilitate that move. [Family] stated he believes [Resident #10] is ordering takeout and having it delivered. I explained that [he/she] should not be doing that, and I would notify the DON (Director of Nursing) so she can educate her staff that any food ordered from outside should be in compliance with [his/her] minced and moist diet, or should not be allowed, due to safety concerns."	F 806			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	Continued From page 32 Review of a MediTelecare note dated 1/30/25 states, [Resident #10 ...being seen today for an initial evaluation for psychotropic medication management[he/she] is a good historian ...Reports depression only when [he/she] cannot eat [his/her] favorite foods ...Reports at times [he/she] does not enjoy [his/her] food." A review of the admission contract signed on 9/1/23 under section "Dining/Meals/Guest Meals/Diet/Food from outside" states, "Special diets will be prepared if ordered by a physician. Any resident that chooses a diet different from what the physician has ordered, may have a regular diet order if he/she signs a waiver." The facilities Resident Diet Policy effective 1/1/2017 states: "Should a patient fail to follow the therapeutic diet on a regular basis, the noncompliance will be documented, and the dietary director will advocate for the diet to be changed to regular." On 2/19/25 at 8:44 a.m., during an interview with 2 surveyors, the Director of food and dietary confirmed there are no residents with a current food waiver stating, they try not to because of their previous immediate Jeopardy (IJ), they don't want to end up in IJ again and the Physician and Nutritionist push everyone to be on a regular diet. 2. Review of the posted "Minced and Moist" and "Puree" menus for the 4-week meal rotation lacks an alternative option for all meals; Breakfast Lunch and Dinner. In addition, both the "Minced and Moist" and "Puree" Breakfast menus have oatmeal and eggs served every day of the week.	F 806			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	Continued From page 33 On 2/19/25 at 11:12 a.m., during an interview with 4 surveyors, the DON stated the doctor had very clear conversation with the resident on the risks involved with eating foods outside of his/her diet. Surveyor asked about staff supervision while the resident is consuming these restricted foods, the DON stated, "I don't have the staff to go in every hour and sit with [him/her] while [he/she] eats a cracker and doesn't dunk it in the milk. [He/she] would not follow Speech recommendations." At this time, the Surveyor discussed the admission contract which states a waiver would be given to residents who choose a different diet, reviewed speech recommendations for the resident to have foods outside of the diet with supervision, the MediTelecare note which states the resident experiences depression for not eating his/her favorite foods and the lack of alternative choices in meals for residents who have a "minced and moist" and "puree" diet. At this time, the DON confirmed resident #10 is his/her own decision maker and had not been offered a waiver for the diet of choice.	F 806			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted	F 842			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 842	Continued From page 34 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 legal age under State law.	F 842			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 842	Continued From page 35 §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 and interviews, the facility failed to ensure that the clinical records were complete and contained accurate documentation for 1 of 4 residents review for respiratory care. (Resident #10) Findings: On 2/18/25 at 10:33 a.m., and at 2:10 p.m., observations of Resident #10 using a nasal cannula for his/her oxygen (O2) administration with the tubing dated 1/28/25. Review of Resident #10's provider order dated 12/2/24 instructs nursing to, "change and date O2 and C-pap tubing Clean concentrator filter every night shift every Mon". Review of the medication administration record for January 2025 has documentation of the O2 nasal cannula tubing being changed on 1/27. February 2025 record has documentation of the O2 nasal cannula tubing being changed on 2/3, 2/10 and 2/17.	F 842			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 842	Continued From page 36	F 842			
F 867 SS=E	On 2/19/25 at 2:20 p.m., the above was discussed with the Administrator. 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 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 §483.71 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	F 867			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 37 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 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.	F 867			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 38 §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 §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data 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:	F 867			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 39 Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 12/12/23, were effective. The Federal citations F584, F623, F625, F689, and F806 were cited again during the annual Long Term Care Recertification Survey dated 2/20/25. Findings: During the Annual Long Term Care Survey Process for Federal Recertification dated 2/20/25, it was determined that F584, F623, F625, F689, and F806 would be recited for the same reasons: F584 for failure to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment; F623 failure to issue a written transfer/discharge notice to a Resident or their legal representative for a facility-initiated transfer/discharge; F625 failure to issue a written bed hold notice to include cost of care to the Resident and/or resident representative; F689 failure to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured; and F806 failure to provide food that accommodates the resident preferences and failed to provide a second-choice meal/alternative that is similar in nutritive value as the first-choice meal. On 2/20/25 at 12:28 p.m., during an interview, the above findings were discussed with the Administrator.	F 867			
F 868 SS=D	QAA Committee	F 868			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 868	Continued From page 40 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §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: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 868			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 868	Continued From page 41 Based on review of the Quality Assessment and Assurance (QAA) attendance sheets and interview, the facility failed to ensure that an Infection Preventionist and the Director of Nursing attended 1 of 4 quarterly QAA meetings. Findings: A review of the quarterly QAA meeting attendance sheets indicated that the Director of Nursing did not attend the February 20, 2024 quarterly QAA meeting and an Infection Preventionist did not attend the June 4, 2024 quarterly QAA meeting. On 2/20/25 at 12:28 p.m., in an interview, the above was confirmed with the Administrator.	F 868			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 42 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 (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	F 880			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 43 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 observation, record review, and interview, the facility failed to disinfect reusable resident equipment during medication administration for 2 of 4 residents observed during medication administration. In addition, the facility failed to implement infection prevention measures for 1 of 3 days of survey (2/20/25). Findings: 1. On 2/19/25 at 8:44 a.m., Certified Nursing Assistant (CNA)- Med Tech was observed taking a blood pressure (BP) with a BP cuff for Resident #10 with a reading of 97/60. The CNA-M removed the BP cuff and did not sanitize afterwards. On 2/19/25 at 9:13 a.m., Certified Nursing Assistant - Med Tech was observed taking a blood pressure with a BP cuff for Resident #31 with a reading of 109/79. The CNA-M removed the BP cuff and did not sanitize afterwards. During an interview on 2/19/25 at 9:22 a.m., the CNA-M indicated equipment should be cleaned in between residents with a sanitizing wipe but she forgot today. The facility policy Cleaning and Disinfecting Resident Care Items and Equipment revised 2/2022 Policy Interpretation and Implementation - 4. Reusable resident care equipment will be	F 880			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 44 decontaminated and/or sterilized between residents. On 2/19/25 at 11:35 a.m., a surveyor discussed the above finding in an interview with the Administrator. 2. On 2/20/25 at 9:40 a.m., during an environmental tour, a surveyor asked to go into Resident room 60 on the North wing and was told by the Maintenance Director that Resident #1 had Norovirus and that room is under contact precaution. The surveyor and the Maintenance Director observed no contact precaution sign stating that there was contact precaution or what staff needs to wear when going into that room. He said the room will not be cleaned until he is told by Nursing administration that the room is no longer on contact precaution. On 2/20/25 at 9:43, the Administrator observed resident room 60 with a surveyor and the Maintenance Director, stated the resident had been sent to the hospital and confirmed that there should be a contact precaution sign on the door. On 2/20/25 at 10:06 a.m., in an interview, the Infection Preventionist(IP0 confirmed that if a resident on Transmission Based Precaution(TBP) was sent to the hospital then the room stays shut with precaution signs on the door and remains on precautions. The IP went on to state that it is still a precaution room and there are germs in side of it and the 48 hours hasn't passed where that resident would be off precaution.	F 880			
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3)	F 909			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 909	Continued From page 45 §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to conduct regular inspection of all bed frames and mattresses as part of a regular maintenance program to ensure that the mattresses and bed frames are compatible and identify areas of possible entrapment for 1 of 37 beds.(Resident #11's) Finding: On 2/18/25 at 10:28 a.m., a surveyor observed Resident #11's bed and found the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 11:08 a.m., 2 surveyors observed Resident #11's bed and found the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 12:36 p.m., in an interview, the Maintenance Director confirmed the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the	F 909			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 909	Continued From page 46 footboard of the bed creating an area of possible entrapment. On 2/18/25 at 12:44 p.m., in an interview, a surveyor discussed the finding with the Administrator.	F 909			
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year. Furthermore the facility failed to ensure that the	F 947			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 947	Continued From page 47 CNA attended the mandatory yearly dementia trainings for 3 of 5 CNA's employed greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5). On 2/20/25 a surveyor reviewed the following employee files: 1. CNA #1 was hired on 11/26/2018. Review of CNA #1 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 2. CNA #2 was hired on 7/31/2023. Review of CNA #2 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 3. CNA #3 was hired on 9/5/1991. Review of CNA #3 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year of 2024. 4. CNA #4 was hired on 7/31/2023. Review of CNA #4 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 5. CNA #5 was hired on 2/6/2017. Review of CNA #5 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year of 2024. On 2/20/25 at 11:47 a.m., During an interview with the Facility Administrator and 2 surveyors present, the above information was confirmed.	F 947			

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

PRINTED: 03/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER MONTELLO MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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