STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205004	A. BUILDING _____ B. WING _____	C 01/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/23/24, an unannounced visit was conducted at Hibbard Skilled Nursing and Rehab Center for the purpose of completing the investigations for complaints #ME00043249, ME00044259, ME00044811, ME00046079. It was determined that Hibbard Skilled Nursing and Rehab Center is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		

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

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F 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on facility's investigation, written statements, record review and interviews, the facility failed to complete a resident assessment and notify a physician regarding a resident's complaint of increased pain with signs and symptoms of a hip/leg injury including a bump and bruising to residents left leg/hip area, causing a delay in medical treatment for 1 of 1 residents (Resident #1[R1]) for 4 days (7/8/23, 7/9/23, 7/10/23, and 7/11/23). Finding: On 7/11/23 the facility investigated an injury of unknown origin, during this investigation staff's	F 580		

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F 580	Continued From page 2 written statements were obtained. On 1/23/24 during review of CNA#1's written statement, the statement for 7/8/23 reflects that [R1] reported to Certified Nursing Assistant (CNA#1) he/she was unable to bring his/her legs to the side of the bed or stand up. R1 was asked to roll on his/her left side to assist with incontinence care, R1 then reported increased pain to left hip area. R1 then stated to CNA #1 that resident broke his/her hip. The statement reflects the charge nurse was made aware. In addition, CNA #1's written statement indicated on 7/9/23, that during morning care, R1 reported that resident was in severe pain during care, a bump on R1's left thigh was observed. The statement reflects the charge nurse was made aware. During review of medical record, On 7/10/23, medical record indicated R1 remained in bed on 7/9/23 and 7/10/23 due to immobilizing pain and R1 did not feel well. On 7/11/23, medical record indicated CNA#1 provided incontinence care and noticed the bump with redness and bruising. The Nurse Manager went to assess R1, and resident was sent out for an evaluation at the Emergency Department where R1 was diagnosed with a hip fracture and was scheduled for surgery for repair. On 1/23/24, during review of LPN#1's written statement, the statement reflected that R1 was seen on 7/9/23 and in the evening hours had scheduled Tylenol and when asked if in pain, R1 stated from the waist up. On 7/10/23, LPN#1's statement reflects that R1's family was made aware that R1 was not feeling well and had a bruise on his/her leg.	F 580		

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F 580	Continued From page 3 On 1/23/24, during review of LPN#2's written statement, the statement reflected that on 7/8/23, R1 reported pain and was medicated with his/her scheduled Tylenol. On 7/9/23, R1 was having pain and reported that to LPN#2 and was provided with his/her scheduled Tylenol. The surveyor could not find any evidence in R1's clinical record paper or electronic, that he/she was assessed, treated for pain or that the Provider was made aware on 7/8/23, 7/9/23, and 7/10/23. On 1/23/24, during a clinical record review, R1's Medication Administration Record/Treatment Administration Record (MAR/TAR) for July 2023 indicated that on the days 7/8/23, 7/9/23, 7/10/23 and 7/11/23, during his/her pain screening, R1's pain levels were all documented as 0 indicating no pain. The written statements indicate that R1 was having increased, immobilizing pain on those days. There is no evidence that the facility used ordered as needed treatments to address R1's increased pain. Review of his/her nursing notes from the date of 7/1/23 to 7/11/23, lacked evidence that R1 was assessed by a nurse or that a Provider was made aware of the increased pain, bruising and bump to his/her left leg until 7/11/23 at 10:15 a.m. On 1/23/24 at 3:01 p.m., during an interview with the Nurse Manager, two surveyors reviewed R1 clinical record paper and electronic and the staff's written statements and confirmed that R1 had displayed and stated he/she had increased pain and signs and symptoms of a possible leg injury that was not assessed and the Provider was not made aware of the possible left leg injury. R1's	F 580		

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F 580	Continued From page 4 MAR/TAR was reviewed with the nurse Manager, his/her MAR/TAR showed documentation that his/her pain was not assessed or addressed. At this time the two surveyors confirmed that on 7/8/23 thru 7/11/23, R1 expressed increase pain, immobilizing pain, and stated he/she had a broken hip. In addition, confirmed by the Nurse Manager, a nurse did not assess R1 and that the Provider was not made aware of this change in condition which caused the delay in medical treatment and pain control until 10:15 a.m. when R1 was sent out to the Emergency Department for an evaluation and diagnosed with a hip fracture.	F 580		