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	205176	A. BUILDING _____ B. WING _____	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL MANOR	25 BOLDUC AVE FORT KENT, ME 04743

(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 From 2/25/24 through 2/27/24, on-site visits were conducted at Forest Hill Manor for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined that Forest Hill Manor was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that the Admission Minimum Data Set (MDS) 3.0 was coded accurately in the area of "Active Diagnosis" for 1 of 1 sampled residents reviewed for Pre-Admission Screening and Resident Review (PASRR) (Resident #40 [R40]). Finding: On 2/26/24, R40's clinical record was reviewed. On 12/14/23, R40 was admitted to the facility , the discharge paperwork from the hospital stated R40 had a diagnosis of anxiety and the admission physician orders, dated 12/14/23, included a medication, Clonazepam, that was used to treat anxiety. Review of R40's Admission MDS, dated 12/20/23, for Section: I Active Diagnoses (in the last 7 days) did not include I5700 - Anxiety.	F 641		

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

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F 641	Continued From page 1 On 2/26/24 at 11:55 a.m., during an interview with the Resident Care Coordinator, a surveyor confirmed the missing diagnosis on the MDS. On 2/26/24 at 12:40 p.m., during an interview with the Director of Nursing, a surveyor confirmed that R40 was receiving medication to treat the diagnosis of anxiety.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		

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F 645	Continued From page 2	F 645		

services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility

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failed to ensure a Pre-Admission Screening and Resident Review (PASRR), included current diagnosis, and was updated for 1 of 1 residents reviewed (Resident #40 [R40]).

Finding:

On 2/25/24, R40's clinical record was reviewed and indicated that R40 was admitted to the facility on 12/14/23. The PASRR was completed by the hospital and submitted to the State-designated authority on 12/12/23, (prior to admission to the facility) which indicated R40 had no mental health diagnoses known or suspected.

A review of R40's clinical record indicated that R40 had a diagnosis of anxiety that was added to the diagnosis list on 12/14/23 (the date of admission) and was also included on the discharge paperwork from the hospital. A review of R40's admission Minimum Data Set (MDS) 3.0, dated 12/20/24, under section I5950 was coded to indicate that R40 had "other psychotic disorder." The clinical record lacked evidence that the PASRR Level I Screen was corrected to include his/her diagnosis of anxiety and other psychotic disorder and was resubmitted to the State-designated authority to determine if a Level II assessment was needed.

On 2/26/24 at 12:45 p.m., during an interview with a surveyor, the Licensed Social Worker stated that she reviewed the PASRR that was submitted by the hospital to the State-designated authority but did not know that R40 had these diagnoses. The surveyor confirmed that the PASRR was not resubmitted with the correct information when R40 was admitted to the facility.

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F 684	Continued From page 4	F 684		
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 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 record review, policy and procedure review and interview, the facility failed to follow their fall policy and procedure for completing neurological checks for 3 of 3 residents who had a fall and sustained a head injury. (Resident #41 [R41], R12, R34) Findings: 1. Documentation on the facility's Fall risk protocol policy and procedure, with a revised date of June 2014, on page 6 of 7 directs staff for post fall interventions letter (f) for patients with head trauma and or cognitive changes, perform vital signs and neuro checks every hour times 4, then every 2 hours times 4, then every 4 hours for 24 hours. During record review for R41 he/she had a fall documented on 1/20/24 at 9:30 a.m., this was an unwitnessed fall and R41 stated he/she had hit his/her head. A review of the paper and electronic clinical record lacks evidence of completed neuro checks every hour times 4, then every 2 hours times 4, then every 4 hours for 24 hours per post	F 684		

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fall intervention directions listed in the facility's fall risk protocol policy and procedure. (Page 6).

During record review R41 had a documented fall on 1/27/24 at 9:30 p.m. where he/she was found on the floor, Review of the paper and electronic clinical record lacks evidence of completed neuro checks every hour times 4, then every 2 hours times 4, then every 4 hours for 24 hours per post fall intervention directions listed in the facility's fall risk protocol policy and procedure. (Page 6).

On 2/25/24 a surveyor observed R41 and noted bruising on his/her left eye area, During review of R41's clinical record it was documented that on 2/17/24 R41 had a fall at approximately 2:14 p.m., where he/she was on the floor in the dining room. It is documented that R41 did hit his/her head and he/she had a small bump on his/her right eyebrow (incorrect site, the bump was on her left eyebrow) it was clarified with the charge nurse that the location of the bump was on his/her left eyebrow. A review of the paper and electronic clinical record lacks evidence of completed neuro checks every hour times 4, then every 2 hours times 4, then every 4 hours for 24 hours per post fall intervention directions listed in the facility's fall risk protocol policy and procedure. (Page 6).

2. During record review for R12 the clinical record documents in a phone message note to the provider that R12 was found on the floor in the hallway around 8:35 p.m., sitting on the floor holding his/her head. R12 was noted to have had a bump on the back of his/her head this was an unwitnessed fall. A review of the paper and electronic clinical record lacks evidence of completed neuro checks every hour times 4, then

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F 684	Continued From page 6	F 684		

every 2 hours times 4, then every 4 hours for 24 hours per post fall intervention directions listed in the facility's fall risk protocol policy and procedure. (Page 6).

On 2/26/24 at 2:35 PM during an interview with the Director of Nursing (DON) the surveyor confirmed that he was not able to find where staff followed the fall policy dated June 2014, the documentation in the electronic clinical record shows that staff have been documenting neuro's every shift and not every hour as directed by policy.

On 2/26/24 at 3:08 PM during an interview with the Director of Nursing who supplied printed documentation that the neuro checks were not completed as outlined in policy for R41, R12 and R34, the surveyor confirmed the above findings.

3. On 2/25/24, a surveyor reviewed Resident #34's clinical record. The record included documentation that on 11/29/23 at 6:15 p.m., R34 was found in front of the radio with blood in the nose. Emergency Room documentation, dated 11/29/23, that indicated R#34 stated he/she fell onto his/her face and his/her nose hurts; the resident sustained a nose fracture. The record also included documentation, dated 1/10/24, that R34 was found with their head resting on the bottom shelf on the table next to the wheelchair and R34 was complaining of pain to the left temporal area. Emergency Room documentation, dated 1/10/24, that indicated R34 stated that he/she was trying to get out of his/her wheelchair when he/she fell forward striking his/her head on the bedside table; the resident sustained head abrasions.

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F 684	Continued From page 7 A review of the clinical record and neurological assessments for the dates of 11/29/23 thru 12/2/23 and 1/10/24 thru 1/13/24 lacked evidence of assessments being completed per facility policy. A surveyor confirmed this when the documentation was received from the Director of Nursing on 2/26/24 at 3:08 p.m. On 2/26/24 at 3:21 p.m., during an interview with a surveyor, the Charge Nurse reviewed the clinical record with the surveyor. He stated that the electronic software (Cerner) was not set up correctly to initiate neurological assessments to be completed at the times the facility policy indicated to complete them. He will contact the appropriate person to fix this issue.	F 684		
F 730 SS=B	Nurse Aide Peform 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 performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 2 of 6 sampled employees (Unit Care Taker, and Certified Nursing Assistant [CNA]). Findings: 1. The CNA's last annual performance evaluation was completed in 2022. The facility	F 730		

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F 730	Continued From page 8 was unable to provide evidence of a completed annual performance evaluation for 2023. 2. The Unit Care Taker's last annual performance evaluation was completed in 2022. The facility was unable to provide evidence of a completed annual performance evaluation for 2023. On 2/26/24 at 3:54 p.m., in an interview with the Administrator, a surveyor confirmed there was no facility documentation of a 2023 annual performance evaluation for the CNA and the Unit Care Taker.	F 730		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		

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Based on observation and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for drawers, cabinets, oven/stove overhead vent, propane pipe, bowls, dishes, ice machine, air fryer, and food in a reach-in freezer. Additionally, the facility failed to label and date food in a reach-in freezer. This was for 1 of 1 kitchen tours on 1 of 3 days of survey (2/25/24).

Findings:

On 2/25/24 from 10:13 a.m. to 10:40 a.m., a surveyor conducted a tour of the kitchen with the Cook in which the following were observed:

- Two drawers, and two cabinets to the right of the cook prep sink had chipped paint and missing paint exposing bare wood.
- The oven/stove overhead vent/fan hood had chipped paint.
- The propane pipe to the left of the oven/stove had chipped paint and dust.
- The table to the left of the oven/stove had bowls and plates facing upward directly under the propane pipe, exposing them to chipped paint and dust.
- The outside of the ice machine, and ice machine vent/filter was dusty, and the upper outside edge of the ice machine was corroded and had chipped paint.
- The top of the air fryer was dusty.
- The reach-in freezer had one bag of yellowish, breaded pieces of unidentified food, identified by the Cook as haddock wedges that was unlabeled and undated.
- The reach-in freezer had one bag of yellowish patties of unidentified food, identified by the Cook as hash brown's that was unlabeled and undated.

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F 812	Continued From page 10 - The reach-in freezer had two bags of red unidentified food, identified by the Cook as red hotdogs that was unlabeled and undated. - The reach-in freezer had two bags of yellow/brown unidentified food, identified by the Cook as peeled frozen bananas that was unlabeled and undated. - The reach-in freezer had two bags of pot roast that contained ice crystals on the food. - The reach-in freezer had one package of provolone cheese that contained ice crystals on the food. - The reach-in freezer had one package of turkey breast slices that contained ice crystals on the food. - The reach-in freezer had one bag of loose elbow macaroni that contained ice crystals on the food. A surveyor confirmed the above findings with the Cook at time of observation, and on 2/26/24 at 8:15 a.m. during an interview with the Dietary Manager, a surveyor confirmed the above findings.	F 812		
F 880 SS=E	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	F 880		

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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

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by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to implement infection prevention measures for 2 of 3 days of survey (2/25/24, and 2/26/24).

Findings:

1. On 2/25/24 at 10:49 a.m., a surveyor observed a personal protective equipment station outside a resident's room. There was no signage to indicate the necessary precautions needed before entering the room, thus leaving residents, staff, and visitors vulnerable to a transmission-based infection.

On 2/26/24 at 9:00 a.m., two surveyors observed a personal protective equipment station outside a resident's room. There was no signage to indicate the necessary precautions needed before entering the room, thus leaving residents, staff, and visitors vulnerable to a transmission-based infection.

On 2/26/24 at 9:05 a.m., in an interview with a

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F 880	Continued From page 13 Registered Nurse, a surveyor confirmed that there was no signage to indicate what precautions were needed for a resident room. 2. On 02/25/24 at 1:18 p.m., in an interview, Resident #28 (R28) stated he/she was on contact precautions for shingles. R28 stated concern that the facility does not label bed pans which resulted in R28 using the wrong bed pan on the previous evening. On 2/25/24 at 1:20 p.m., a surveyor observed two soiled bed pans stacked within commode bucket resting on the toilet tank in R28's bathroom, which is shared with 2 other residents. The bed pans were not labeled or stored in a manner to prevent the spread of infection. On 02/25/24 at 01:53 p.m., in an interview with the Director of Nursing, two surveyors confirmed that the bed pans were not labeled or stored to prevent the spread of infection.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205176	A. BUILDING _____ B. WING _____	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL MANOR	25 BOLDUC AVE FORT KENT, ME 04743

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F 883	Continued From page 14 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 15	F 883		

contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure 5 of 6 residents (Residents #41 [R41], R43, R18, R17, and R28) reviewed for immunizations were reviewed and offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations.

Findings:

On 2/26/24 at 11:15 a.m. a facility pharmacist faxed a copy of the "Pneumococcal Vaccine Timing for Adults" that CDC recommends that "adults > (greater than or equal to) 65 years old complete pneumococcal vaccine schedules, with a "shared clinical decision-making for those who already completed the series with 13-valent pneumococcal conjugate vaccine (PCV13) at any age and 23-valent pneumococcal polysaccharide vaccine (PPSV23) greater than or equal to 65 years pertaining to receiving 20-valent pneumococcal conjugate vaccine (PCV20).

1. During a review of Resident #41's immunization record, the surveyor could not locate evidence that R41 was reviewed, offered, or received the PCV20. The Resident is over 65 years of age.

2. During a review of R43's immunization record, the surveyor could not locate evidence that R#43 was reviewed, offered or received the PCV20. The Resident is over 65 years of age.

3. During a review of R18's immunization record, the surveyor could not locate evidence

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F 883	Continued From page 16 that R18 was reviewed, offered or received the PCV20. The Resident is over 65 years of age. 4. During a review of R17's immunization record, the surveyor could not locate evidence that R17 was reviewed, offered or received the PCV20. The Resident is over 65 years of age. 5. During a review of R28's immunization record, the surveyor could not locate evidence that R28 was reviewed, offered or received the PCV20. The Resident is over 65 years of age. On 2/26/24 at 1:40 p.m., during an interview with the Infection Prevention Nurse and the Administrator, a surveyor confirmed that R41, R43, R18, R17, and R28 weren't reviewed, offered, or received PCV20. The IP spoke with a facility pharmacist, and she said that Resident's should be receiving the PCV20.	F 883		