STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205129	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MERCY HOME	**PO BOX 228 EAGLE LAKE, ME 04739**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) Level 1 was accurately completed for 1 of 9 sampled residents reviewed for PASRR (#24). Finding: Resident #24 was admitted to the facility on [DATE]; the clinical record included a [DIAGNOSES REDACTED]. The PASRR Level 1 screen in the clinical record lacked evidence of this mental health [DIAGNOSES REDACTED].#24's PASRR and current diagnoses. The SSC stated that Resident #24 was admitted from home and she completed the PASRR Level 1 over the phone with the Home Health Nurse on 1/17/20. She was unaware of the [MEDICAL CONDITION] [DIAGNOSES REDACTED]. The surveyor confirmed this finding at this time.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** Based on record review, and interview the facility failed to ensure that neurological status checks were assessed and documented/reported each shift for three days following a fall according to the Fall Prevention Policy and Procedure for 1 of 2 Resident's reviewed that had a fall. (Resident #12) Findings: A review of Resident #12's clinical record indicated that Resident #12 had a fall on 3/1/20 at 10:20 p.m., he/she hit his/her head on the door frame and has a raised area to the back of his/her head, 2 centimeters (cm) by 3 cm, area is red, blanchable, no bruising noted. The first neurological status check was done at this time. According to Northern Maine General, Mercy Home, Policy and Procedures: Fall Prevention, #2. When a fall occurs, the Nurse shall assess and document/report the following each shift for 3 days: e. Neurological status. The neurological status check was done on the night shift of 3/1/20; the day shift of 3/2/20, and the day shift 3/3/20. The neurological status checks were not done on the night shift of 3/2/20, the night shift of 3/3/20, or the day shift of 3/4/20. On 3/10/20 at 11:50 a.m., during an interview with the Director of Nursing (DON), a surveyor reviewed the Fall Prevention Policy and Procedure with the DON and confirmed that three of six neurological status checks where not completed after a fall for Resident #12. The DON reported that the neurological status checks should have been assessed.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection during 1 of 3 medication pass observations (3/11/20). Finding: On 3/11/20 at 8:25 a.m., during a medication pass observation, a surveyor observed the Certified Nursing Assistant-Medication (CNA-M) obtain a blood pressure on a resident. The CNA-M returned to the medication cart, placed the blood pressure cuff back into the cart, and started to prepare the resident's medications without washing or sanitizing her hands. The surveyor stopped CNA-M after she started to prepare the first medication and confirmed that CNA-M did not complete hand hygiene after resident contact at this time.

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.