STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205054	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainegeneral Rehab & Long Term Care - Gray Birch	37 Gray Birch Drive Augusta, ME 04330

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50218 Based on facility policy, record review and interview, the facility failed to provide an environment free of abuse and neglect for 1 of 2 residents reviewed for facility reported investigations (Resident #1). Findings: Review of facility policy titled ''Fall Risk Reduction and Fall Prevention last revised 4/22 states Upon incident of fall or found on floor: . A registered nurse is required to assess residents after a fall. Appropriate incident reports will be filled out and required documentation completed in the patient/resident EMR. Review of Policy titled Prevention and Reporting of Abuse, Neglect, Exploitation/Misappropriation last revised 11/22 defines verbal abuse as The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance regardless of their age, ability to comprehend, or disability, and defines neglect as the deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. On 10/26/23 the Division of Licensing and Certification received a 5 day Follow- Up Investigation for facility reported incident dated 10/22/23 which states [On 10/22/23 [Resident#1] had a fall from bed and states that the nurse made aware she came to the doorway and used profanity while speaking with him and did not come in the room at all to assess.]'' Further review of 5 day follow- up revealed Registered Nurse (RN)#4 interview stating, she did not reinsert the foley because she was busy doing the other tasks and she reported it off to the day nurse that it needed to be done.'' Resident #1 was admitted on [DATE] with diagnoses including paraplegia, neurogenic bladder, neuromuscular deficiency, and history of falls. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating he/she is cognitively intact. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident#1's clinical record revealed SBAR [Situation, Background, Assessment, Recommendation] .Progress Note dated 10/22/23 at 5:20 a.m., states [Certified Nursing Assistant] CNA was doing rounds when resident called out to her. Upon entering the room resident was noted sitting on the floor, [When] asked resident stated that [he/she] fell out of bed. It was also noted that resident had pulled out [his/her] foley catheter again. Assessment Done. No injuries noted. Further review of SBAR states, In LTC [Long Term Care] patients are required to be assessed by an RN after a fall . Resident#1's entire clinical record lacked evidence that RN#4 completed an assessment or notified provider after Resident #1's fall. Review of Resident #'1s clinical record revealed order dated 9/29/23 to .reinsert suprapubic foley cath [catheter] or external foley cath if accidental d/c. SBAR provider if reinserted. Review of Resident #1's 2023 Treatment Administration Record (TAR) revealed progress note dated 10/22/23 at 19:04 states: Done @ 10am this morning. Late entry. By oncoming RN #5, (approximately 5 hours after it dislodged). Review of CNA#5's written statement dated 10/23/23 revealed She [RN#4] swore at and about [Resident#1] & the situation in front of all 3 of us CNAs During an interview on 5/21/24 at 8:20 a.m., Resident#1 indicated that after he/she fell RN#4 stood in the doorway to his/her room and asked, why the fuck would you do that? Resident #1 further indicated that RN#4 refused to come into his/her room or provide care. During an interview on 5/21/24 at 3:48 p.m., RN #2 indicated that she was present during shift report on 5/21/24 at 6:45 a.m. and confirmed RN #4 did not notify oncoming nurse of Resident #1's fall or that his/her catheter had dislodged. RN #2 further indicated that she was approached by CNA #5 who notified her of Resident #1's fall and RN #4's refusal to provide care. During the interview on 5/22/24 at 9:11 a.m., Director of Nursing (DON) confirmed RN#4 failed to complete an assessment, notify the provider, or provide care to Resident #1 after his/her fall.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 5 residents, and failed to obtain a providers order for 1 of 1 residents reviewed for documentation (Resident's #1 and #5). Findings: Review of facility policy titled "Fall Risk Reduction and Fall Prevention last revised 4/22 states Upon incident of fall or found on floor: . A registered nurse is required to assess residents after a fall. Appropriate incident reports will be filled out and required documentation completed in the patient/resident EMR [Electronic Medical Record]. On 10/22/23 the Division of Licensing and Certification received a facility reported incident indicating Resident#1 fell in his/her room and Registered Nurse (RN)#4 was made aware. It further revealed that RN#4 was overheard swearing at Resident #1 and refused to do a post fall assessment. 1.Resident #1 was admitted on [DATE] with diagnoses including paraplegia, neurogenic bladder, neuromuscular deficiency, and history of falls. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating he/she is cognitively intact. Review of Resident#1's clinical record revealed incident report dated 10/22/23 at 5:20 a.m,. stating CNA was doing rounds when resident called out to her. Upon entering the room resident was noted sitting on the floor, When asked resident stated that [he/she] fell out of bed. It was also noted that resident had pulled out [his/her] foley catheter again. Assessment Done. No injuries noted. Further review of incident report states, In LTC patients are required to be assessed by an RN after a fall . Review of Resident#1's entire clinical record lacked evidence that a complete assessment was done after this incident. During the interview on 5/22/24 at 9:11 a.m., Director of Nursing (DON) confirmed RN#4 failed to complete an assessment on Resident #1 after his/her fall. 2. Resident #5 was admitted to facility on 2/24/24 for skilled services with diagnoses to include anxiety and depression. Review of Resident #5's active orders dated April 2024 revealed order with start date of 2/29/24 for Behavior Monitoring Two times daily .for increased agitation, refusal of care, physically abusive behavior, crying . Review of Resident #5's clinical record revealed provider note dated 4/10/24 states . Concern for cognitive dysfunction-apparently even prior to this surgery but has worsened which may be due to meds, hospitalization , etc; outpt [outpatient] eval with geriatrics may be reasonable. Further review of Resident #5's clinical record lacked evidence that a referral for with geriatrics was obtained for this resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 12:43 p.m., Nurse Practitioner confirmed Resident #5 was not referred to geriatrics for evaluation, and an order was not given for Resident #5's respiratory panel on 4/11/24. Review of provider note dated 4/11/24 states .depression/anxiety with emotional lability-poor safety awareness, concern for possible cognitive issues, . outbursts with staff . Review of Resident #5's clinical record revealed progress note dated 4/11/24 stating . self propels on the unit in [his/her] wheelchair .has mild anxiety this evening because [he's/she's] unable to recall how to unlock and lock her wheelchair and [he/she] can't remember to use the call light for help so [he/she] yells or calls for help. [He/she] is frantic by the time someone gets to her . Review of Residents Treatment Administration Record (TAR) dated April 2024 revealed Resident had no behaviors on 4/11/24 through 4/13/24 or 4/15/24 through 4/17/24. Review of Resident #5's clinical record revealed provider note dated 4/11/24 stating [.this afternoon found a lab result on my desk that was a resp [respiratory] panel from Friday April 6th that was positive for covid; there was no lab order for a resp panel and not of the providers had ordered this; there is a nursing note that indicates a resp panel was sent to due to gi sx, for throat and malaise; we were never notified of the pos result and it is unclear who put the lab on my desk .] Further review of Resident #5's clinical record lacked evidence that an order was obtained for above. During interview on 5/21/24 at 1:17 p.m. Registered Nurse (RN)#3 confirmed Resident #5 clinical record lacked documentation reguarding the above behaviors. 50218