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	08/07/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49635 Based on observations and interviews, the facility failed to promote care to residents in a manner that maintains each resident's dignity for 2 of 3 meals observed. (Resident #21 [R21], R11, and R7). Findings: 1. On 8/05/24 from 12:00 through 12:45 p.m., during observation of lunch meal pass, a surveyor observed R21, R11 and R7 sitting at the same table. At 12:10 p.m., Staff served R21 and R7. R11 was observed watching R21 and R7 eat, while staff served other tables. At 12:24 p.m., R11 was served lunch. 2. On 8/6/24 from 8:20 a.m. through 8:30 a.m. during observation of breakfast meal pass, R21, R11, and R7 were observed sitting at the same table. At 8:20 a.m. staff served breakfast to R21 and R7. R11 was observed watching R21 and R7 eat, while staff served other tables. At 8:30 a.m., R11 was served breakfast. On 8/06/24 at 2:13 p.m., in an interview with the Administrator, a surveyor confirmed residents were not served with dignity when meals were not served to all residents at a table at the same time. 51331

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 17282 Based on observations and interviews, the facility failed to ensure the confidentiality of protected resident health information by displaying on monitors next to a resident's name and room number identification, what therapeutic needs they required, time of a meal corresponding with a group activity, what device was required to obtain the resident's weight, walking program, and shower day for 2 of 3 days of survey. In addition, the facility failed to protect and promote a resident's privacy and confidentiality for 1 of 1 residents reviewed for privacy (Resident #54 [R54]). Findings: 1. On 8/5/24 at noon, during an initial tour, it was observed that on the corridor walls, outside the resident's room, on the Birch Unit and the Pine Unit, the resident's full name, room number and bed location ('A' means bed by door of room/'B' means bed by window of room) is posted. On 8/5/24 between noon and 1:00 p.m., the surveyors observed a large monitor on the wall across from the Birch Unit nurse's station and a large monitor on the wall near the Pine Unit nurse's station that could be seen by other residents, and visitors. In bright colors, the monitors displayed the residents first name, first initial of last name, room number and bed location. Next to the resident's name indicated the time the resident was going to receive Occupational Therapy, Physical Therapy, or Speech Therapy. Also displayed is the type of device the resident would be weighed on (floor scale or chair scale) and what day they received a shower. Also displayed is who is on a walking program and what time a resident will be eating-corresponding with a group. On the bottom left hand side of the monitor is a key indicating information in a color code. On 8/6/24 at approximately 10:00 a.m., in an interview with the Director of Nursing, she confirmed that this information was on monitors in the corridors and at 2:15 p.m., this finding was discussed with the Administrator. 49635 2. On 4/30/24, R54 was admitted with Developmental disorder of scholastic skills and severe intellectual disabilities. On 8/05/24 at 1:00 p.m., a surveyor observed the MDS Coordinator (MDS2) conduct an interview for depression with R54 in the hallway. On 8/05/24 at 1:03 p.m., in an interview MDS2, a surveyor confirmed that the depression interview was held in a public space and did not protect the resident's privacy.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51331 Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately for 1 of 1 resident reviewed for discharged to the community (Resident #68 [R68]) and 1 of 3 residents reviewed for Pre Admission Screening And Resident Review (PASARR) (Resident #47 [R47]). Findings: 1. On 8/7/24, R68's clinical record was reviewed for discharge. Medical record indicated R68 was discharged to the community on 5/8/24. Review of the discharge MDS dated [DATE], section 2A105 states R68 was discharged to short term general hospital. On 8/7/24 at 10:35 a.m. during an interview, the MDS coordinator confirmed the MDS was coded inaccurately for discharge. 33242 2. On 8/5/24, R47's clinical record was reviewed. On 4/8/24, R47's PASSAR was completed and indicated that R47 qualified for Level II services. Review of R47's Annual MDS, dated [DATE], Section: A1500 was coded to indicate that R47 did not have a Level II PASSAR. On 8/7/24 at 9:27 a.m., during an interview with a surveyor, the MDS coordinator stated the MDS was coded inaccurately. The surveyor confirmed this finding during this interview.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 33242 Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 3 sampled residents reviewed for PASRR (Resident #56 [R56]). Finding: On 8/6/24, a surveyor reviewed R56's clinical record which included a PASRR evaluation completed by the hospital, dated 11/5/21, that indicated no PASRR level II was required and there was no mental health diagnosis. A review of R56's diagnosis list included in the clinical record: Post-traumatic stress disorder (PTSD) , Major depressive disorder, and Generalized anxiety disorder, all added to the clinical record on 11/5/21, the date of admission. A physician progress note with the topic of PTSD, dated 12/14/21, talked about trauma, abuse, and that R56 was having nightmares. On 1/24/22, R56 started medication for anxiety and on 3/17/22, R56 started medication for depression. On 8/07/24 at 2:12 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed that information for R56 was not sent to the State mental health authority for re-evaluation since the original PASRR did not include the mental health diagnosis on the original submission and R56 had started to have symptoms related to the diagnosis of PTSD. The DON stated that the facility had just done an audit of residents with PTSD and R56 must have been missed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record reviews and interview, the facility failed to develop a Comprehensive Care Plan that addressed the physical needs of 1 of 5 residents reviewed for Respiratory (Resident #15 [R15]) and failed to ensure that a care plan was developed in the area of Post Traumatic Stress Disorder (PTSD) for 1 of 1 residents reviewed for PTSD (R56). Findings: 1. On 8/7/24, clinical record review indicated R15 was admitted on [DATE]. Admitting diagnoses included Obstructive Sleep Apnea (OSA) and Congestive Heart Failure (CHF). Orders for these diagnoses include the use of 2 liters of oxygen at night and daily weight monitoring. On 8/7/24 at 11:02 a.m., the surveyor confirmed with the Director of Nursing that the Care Plan does not address R15's use of oxygen, or the diagnoses of OSA or CHF. 33242 2. On 8/6/24, a surveyor reviewed R56's clinical record which included a diagnosis of Post-traumatic stress disorder (PTSD) with a start date of 11/5/21, which was the admitted for R56. A physician progress note with the topic of PTSD, dated 12/14/21, talked about trauma, abuse, and that R56 was having nightmares. There was no evidence of a problem area of PTSD or triggers and interventions that addressed R56's PTSD in the current care plan. On 8/07/24 at 2:12 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed this finding. The DON stated that the facility had just done an audit of residents with PTSD and R56 must have been missed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37648 Based on observations, record review and interview the facility failed to update a care plan in the area of Diabetes for 1 of 1 sampled resident who utilizes a continuous glucose monitoring device. (Resident #20 [R#20]) Finding: On 8/5/24 at 3:28 p.m., observation of R20 with a continuous glucose monitoring device attached to back of his/her right arm. Review of physician orders dated 1/22/24, states, FreeStyle Libre 2 Sensor kit (1) KIT Subcutaneous Every Fourteen Days Starting 1/26/24 .Notes: Change per package instructions. Check finger stick if reading is <70 or >350 or if pt is having symptoms of hypoglycemia Dx type 2 dm on insulin. R20's care plan for Diabetes Management, last revised on 4/19/23 lacks evidence of a glucose monitoring device and/or safety instructions/interventions. On 8/7/24 at 11:20 a.m., during an interview, the Director of Nursing confirmed the care plan did not contain the continued glucose monitoring device and/or safety interventions.

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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. 37648 Based on record review, observations and interviews, the facility failed to ensure that physician's orders were followed for 1 of 2 sampled residents for wound management (Resident #12 [R12]) and 1 of 5 residents reviewed for unnecessary medications. (Resident #47 [R47]) Findings: 1. On 8/5/24, R12's clinical record was reviewed and included a physician order for wound care instructing nursing to Cleanse legs with Vashe - apply clobetasol to legs- cover open areas with xeroform, then Abd pads and the hold in place with netting. DX: venous insufficiency (chronic) (peripheral). On 8/5/24 from 12:49 p.m. through 1:36 p.m., 2 surveyors observed the Licensed Practical Nurse (LPN #1) perform R12's bilateral leg dressing changes. The LPN #1 wet a facecloth with faucet water and cleansed R12's legs and then applied clobetasol to the open wounds. On 8/5/24 at 1:36 p.m., the LPN #1 confirmed she did not follow the physician orders by using water to clean R12's legs and should have applied clobetasol to the legs not the open wounds. 33242 2. On 8/7/24, R47's clinical record was review and included a physician order, dated 6/4/24, to administer Novolog Insulin based on blood sugar results as follows: Instructions: 0-150: 0 units 151-200: 2 units, 201-250: 4 units, 251-300: 6 units, 301-350: 8 units, 351-400: 10 units, equal to or greater than 401: 12, units Alert provider if BG is less than 70 or greater than 400. On 8/2/24, R47's blood sugar results was 330. Documentation indicated that R47 received 10 units and should have received 8 units. R47's clinical record was further reviewed for physician notification for high blood sugars for July 2024, for the 7:30 a.m. blood sugar results with the following documented but lacked evidence that the Medical Provider was notified: On 7/18/24, the blood sugar was not documented but R47 received 12 units which indicated that the blood sugar was grater than 401; On 7/20/24, the blood sugar was 531; On 7/23/24, the blood sugar was 531; On 7/24/24, the blood sugar was 411; On 7/25/24, the blood sugar was 421; and On 7/30/24, the blood sugar was 418. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 11:38 a.m., during an interview with the Pines Nurse Manager, a surveyor confirmed these findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 51331 Based on observations, record reviews, facility policy, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 5 of 6 residents reviewed for respiratory care (Resident #9 [R9]), Resident #60 [R60], Resident #221 [R221]), Resident #15 [R15], Resident #49 [R49]). Findings: The facilities policy on Obtaining and Use of Oxygen Devises, last revised on 7/23/24. Under section 4 procedures, subsection C Cleaning/changing of oxygen equipment states the particle filter on the concentrators should be removed and cleaned weekly. 1. On 8/5/24 at 3:56 p.m., observation of R9's oxygen (O2) nasal cannula tubing stored over the O2 concentrator handle. On 8/6/24 at 8:00 a.m., and on 8/7/24 at 7:12 a.m., additional observation of R9's O2 nasal cannula tubing wrapped up and hanging over the cylinder on the back of his/her wheelchair. 37648 2. On 8/5/24 at 12:41 p.m., observation of R221's O2 nasal cannula tubing wrapped up and stored under the handle of the oxygen concentrator. On 8/6/24 at 7:43 a.m., and 8/7/24 at 7:11 a.m., additional observations of his/her O2 nasal cannula tubing wrapped and hanging over oxygen concentrator. On 8/7/24 at 7:20 a.m., both the surveyor and Director of Nursing observed the above finding. 3. On 8/5/24 at 12:32 p.m., observation of R60's O2 tubing wrapped up and stored under the handle of the concentrator and on 8/6/24 at 7:35 a.m., additional observation of the oxygen nasal cannula being stored by lying across his/her bed. On 8/7/24 at 10:35 a.m., during an interview, the DON stated the O2 tubings are expected to be stored in the provided bags for when the tubing is not in use. 49635 4. On 8/5/24 at 1:31 p.m., a surveyor observed R15's oxygen concentrator filter to be heavily soiled. On 8/7/24 at 11:13 a.m., a surveyor and the Director of Nursing (DON) observed R15's concentrator to be set to 3 liters of oxygen flow and the filter was heavily soiled. Review of the clinical record indicated the oxygen is to be used during hours of sleep at 2 liters per minute. The surveyor confirmed these findings at the time of the observations with the DON. 5. On 8/6/24 at 12:19 p.m., a surveyor observed R49 connected to a portable oxygen tank set to 3 liters of oxygen flow; the tank was observed to be empty. R49's oxygen saturation was observed to be 88% on room air. At 2:36 p.m., review of the care plan indicated, To ease breathing, oxygen is used at 2 liters via nasal cannula, to maintain an oxygen saturation of 92% or greater. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/24 at 1:27 p.m., in an interview with the DON, a surveyor confirmed respiratory care was not implemented as directed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on interviews and record review, the facility failed to ensure that the clinical record contained information necessary to meet the professional standards of practice for monitoring a dialysis catheter site for 1 of 1 residents reviewed for dialysis (Resident #56 [R56]). Finding: On 8/6/24, R56's clinical record was reviewed it stated R56 was admitted to the facility on [DATE]. The clinical record indicated that R56 had received dialysis prior to admission and currently was using a right chest dialysis catheter for treatments. The surveyor was unable to find in the physician orders, an order to monitor the dressing that covered the right chest dialysis catheter or daily documentation that it was being monitored. On 8/06/24 at 02:35 p.m., during an interview with a surveyor, the Pines Unit Manager stated that they monitor the clear dressing that covers the catheter site, but not sure if there was an order to do so. The surveyor also asked about instructions on what to do in case of an emergency related to R56's dialysis catheter site as the surveyor could not find instructions in the physician orders or the care plan. The Pines Unit Manager stated she would check on it. On 8/7/24 at 8:09 a.m., during an interview with a surveyor, the Pines Unit Manager stated she was unable to find an order for the monitoring of the catheter dressing or what to do in case of an emergency related to R56's dialysis catheter site at the time of yesterday's interview with the surveyor.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing dishes and food in a sanitary manner, not maintaining a clean kitchen floor, and not ensuring that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 days of survey (8/5/24 and 8/6/24). This has the potential to effect all residents. Findings: On 8/05/24 at 11:10 a.m., during the initial kitchen tour, a surveyor observed with the Food Service Director (FSD), the floors to be heavily soiled with crumbs, grease, fruit, and unidentifiable debris. A container full of measuring cups used for food preparation was observed with the lid ajar and covered in crumbs. The measuring cups within the container had visible food debris inside them. A large bin containing oats was observed with the lid partially open to the environment. The air gap for the left kitchen sink was less than 1 inch, in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). Observation of the walk-in refrigerator revealed the floor was heavily soiled with food debris including shredded pieces of chicken. Observation of dry food storage revealed on the shelf and available for use: 3 cans - 6 pounds (lbs) 10 ounces (oz) [NAME] Creek Diced Beets, 1 had a dented in side, 2 had dented bottom seals. 1 can - 6lbs 12 0z Magellan Pineapple Slices with a dented top seal. 2 cans - 7lbs [NAME] Creek Banana Pudding both dented on the top seal. Observation of the walk-in freezer revealed on the shelf and available for use: 1 box - 10.25lbs [NAME] Breaded chicken breasts open and undated, open to the environment. 1 box - 10lbs Pork Sausage 2oz patties (fully cooked heat & serve), open to the environment. These findings were observed and confirmed with the FSD at the time of the observation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 9:57a.m., observation of the dry food storage revealed on the shelf and available for use, 2 cans of 6lbs 10oz [NAME] Creek Diced Beets, both dented on the bottom seal. Observation of the walk-in refrigerator revealed soiled flooring including plastic tape, food debris and a potato on the floor. Observation of the kitchen revealed the air gap for the left kitchen sink and the air gap for the steamer were less than 1. These findings were observed and confirmed with the FSD at the time of the observation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37648 Based on observations, interviews, and record reviews the facility failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection related to wound management for 1 of 2 residents sampled for wound care. (Resident #12 [R12]). Finding: On 8/5/24 from 12:49 p.m. through 1:36 p.m. 2 surveyors observed the Licensed Practical Nurse (LPN 1) perform R12's bilateral leg dressing change. During the observation the following was observed: LPN1 gowned and gloved, entered the room and closed curtain with her gloved hand. With the same gloved hands, she began removing the xeroform from the wound bed, removed her gloves then exited the room and returned with a handful of facecloths. Next, she donned a new gown and gloves and cleansed both legs using the face cloths with faucet water. With the same gloved hands, she applied clobetasol ointment to several wounds using her gloved fingers. She then stopped, removed gown and gloves, performed hand hygiene and exited the room returning with Q-tips. She washed her hands and applied new gown and gloves. The following care was all completed with the same gloved hands and without performing hand hygiene. With her gloved hand she tucked her hair behind her ear, lifted up her gown and removed the packages of Q-tips from her scrub pocket. She opened the Q-tips and continued to apply the ointment to the wound beds. Then she again lifted her gown and removed more Q-tips from her scrub pocket and continued to apply the ointment. She then took a package of xeroform off the windowsill, reached under her gown again to her name badge which had an attached black marker and dated the package of xeroform. She then obtained scissors off the windowsill and cut a piece of the xeroform off, placing each piece of xeroform on an open wound beds, during this process she placed the scissors into the basin filled with the residents personal belongings 6 times. Next, she obtained the abdominal pads off the windowsill, opened and placed them on the legs, again reached under her gown to obtain the marker and dated the ABD pads. Finally, she applied the netting to bilateral legs, all with the same gloved hands and without performing hand hygiene. On 8/5/24 at 1:36 p.m., during an interview, LPN1 confirmed she failed to provide an environment to prevent development and transmission of disease and infection during the dressing change. On 8/6/24 at 9:38 a.m., the above concerns were discussed with the Director of Nursing.

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	08/07/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record reviews and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Resident #54 [R54] and R66). Findings: 1. R54 was admitted to the facility on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. 2. R66 was admitted to the facility on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. On 8/7/24 1:22 p.m., during an interview with a surveyor, the Infection Preventionist stated that the Medical Provider follows the CDC recommendations for vaccinations. The surveyor confirmed these findings.