STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clover Health Care	440 Minot Ave Auburn, ME 04210

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review and interviews, the facility failed to implement a resident's care for 1 of 3 residents reviewed for falls with injury (Resident #1).On 7/20/25 the Department of Licensing and Certification received notification of a facility reported incident which stated on 7/19/25 at 11:30 a.m., Resident #1 had sustained a fall from bed and was transferred to the Emergency Department.A review of the clinical record for Resident #1 revealed diagnoses that included Multiple Sclerosis (MS), Muscle Weakness, and Stage III Pressure Ulcer of the Sacral Region. The quarterly Minimum Data Set (MDS) 3.0., dated on 6/26/25, indicated Resident #1 had impairment of both lower extremities and one upper extremity. Resident #1 was dependent on staff for transfers and required substantial to maximum assistance by 2 staff for bed mobility and personal hygiene. The brief interview of mental status (BIMS) score was 13, indicating Resident #1 was cognitively intact. The comprehensive care plan, with a revision date of 6/20/25 stated the resident required total assistance by 2 staff to turn and reposition in bed, and use of a mechanical lift and total assistance by 2 staff to transfer between surfaces.On 8/5/25 at 12:30 p.m., in an interview with 2 surveyors, CNA#3 stated that on 7/19/25, CNA #1 had been assigned as a float to work on the [NAME] unit. CNA #3 was asked what information had been provided to CNA#1 for providing care to Resident #1. CNA#3 stated Resident #1 needed 2 people. I told him/her to coordinate with me when he/she was ready. CNA #3 stated that Resident #3 requires a lot of rolling and positioning. He/she has a lot of pain with turning and requires 2 staff to do it appropriately for better positioning. CNA#3 stated he/she has access to resident care plans and Kardexes.On 8/6/25 at 8:50 a.m., in a telephone interview with a surveyor, CNA#1 was asked how he/she obtains information about resident care needs. CNA #1 stated I ask the other CNAs for help and they explain it to me. The surveyor asked on 7/19/25, what type of information had CNA#1 received regarding Resident #1's care needs. CNA#1 stated I didn't know anything about MS (multiple sclerosis) or what it is or that he/she had it. The only mistake I made is I should've put the bed down before I left. The surveyor asked if CNA#1 had read Resident #1's care plan or Kardex. CNA#1 stated I've never looked at one. I don't think so (regarding the Kardex). Only the nurses have access. All the nurses tell me something different about how they want things done. The surveyor asked CNA#1 to describe the incident in which Resident #1 fell on 7/19/25. CNA #1 stated he/she had turned Resident #1 onto his/her right side, approximately half-way between the side and the middle of the bed. One knee was on top of the other one. CNA#1 stated Resident #1 said to go get help and he/she was ok lying on the right side and holding onto the edge of the air mattress. CNA #1 stated Resident #1 was unable to move his/her legs and required staff to move them. CNA#1 stated he/she went to get the nurse to provide wound care and had been out of the room for only 2 minutes. Upon the CNA's return with the nurse, Resident #1 was observed lying on the floor.On 8/5/25 at 10:30 a.m., in an interview with two surveyors, the Administrator discussed the facility's efforts to immediately address the situation after Resident #1's fall, and stated administration identified that staff were not following care plans.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide safety and supervision when a Certified Nursing Assistant (CNA#1) left a resident (#1) unattended in a bed with an air mattress, in the high position, and Resident #1 subsequently fell out of bed. This failure created an immediate jeopardy situation.On [DATE] the Department of Licensing and Certification received a facility reported incident indicating on [DATE] at 11:30 a. m., Resident #1 had sustained a fall from bed and was transferred to the Emergency Department. Review of the clinical record for Resident #1 revealed diagnoses which included Multiple Sclerosis, Muscle Weakness, and Stage III Pressure Ulcer of the Sacral region. The quarterly Minimum Data Set (MDS) 3.0., dated on [DATE], indicated Resident #1 had impairment of both lower extremities and one upper extremity. Resident #1 was dependent on staff for transfers and required substantial to maximum assistance by 2 staff for bed mobility and personal hygiene. The brief interview of mental status (BIMS) score was 13, indicating Resident #1 was cognitively intact. Resident #1's comprehensive care plan, last revised [DATE], stated the resident required total assistance by 2 staff to turn and reposition in bed, and use of a mechanical lift and total assistance by 2 staff to transfer between surfaces. Resident #1 required a low air loss mattress to help decrease pressure on areas prone to pressure ulcers. On [DATE] at 8:50 a.m., in a telephone interview with a surveyor, CNA #1 stated he/she had turned Resident #1 onto the resident's right side, approximately half-way between the side and the middle of the bed. Resident #1 was facing the doorway. There had been a pillow between his/her legs, but CNA #1 removed it. One knee was on top of the other one. The CNA stated Resident #1 told him/her that he/she was going to have to go get help and that Resident #1 was ok in the current position. Resident #1 was holding onto the edge of the air mattress with the left hand and Resident #1 told staff he/she was ok. CNA #1 stated Resident #1 was unable to move his/her legs and required staff to move them. The CNA stated he/she went to get the LPN (Licensed Practical Nurse) and had been out of the room for only 2 minutes. There was no type of bed rail on the bed. When the CNA returned, Resident #1 was observed lying on his/her back on the floor with his/her head against the wall and his/her legs in the frog-leg position. At that time, Resident #1 was alert, awake and answering questions, but in significant pain. CNA #1 stated the LPN arrived at the same time and after evaluating Resident #1, instructed staff to transfer Resident #1 back to bed using a hoyer lift. Another CNA had arrived and assisted with the transfer. Shortly thereafter, Resident #1 stated she was going to vomit. When Emergency Medical Services staff arrived, Resident #1 was transferred to a stretcher and suddenly turned ashen in color, eyes fixed in a stare, with gulping movements, and became nonresponsive. Resident #1 was transferred to the Emergency Department and died later that day. In the interview on [DATE] at 8:50 a.m. with a surveyor, CNA#1 stated he/she usually worked on the [NAME] unit, but on [DATE], was floated to the [NAME] unit. When asked what information CNA #1 had received concerning the assignment, CNA #1 stated I ask the other CNAs for help and they explain it to me. Regarding Resident #1, CNA #1 stated I didn't know anything about MS (multiple sclerosis) or what it is or that he/she had it. The only mistake I made is I should've put the bed down before I left. On [DATE] at 9:18 a.m., in a telephone interview with a surveyor, the LPN on duty at the time of the incident, stated he/she had instructed CNA#1 to come get the nurse when ready to perform perineal care and the nurse would complete Resident #1's wound care to the sacral area at that time. The LPN stated he/she heard Resident #1 yelling from the hallway and observed the resident lying on the floor. The LPN stated The first thing I noticed was the bed was in a high position. (The CNA) is shorter than me so it was at his/her working height, which was at least 3 and a half feet off the floor. The LPN completed a brief assessment and determined transport to the Emergency Department was indicated and called 911. The LPN stated Resident #1 had demonstrated no signs of illness or concerns prior to the fall, but had considerable pain afterwards, however, this was baseline for Resident #1. The resident had demanded to be put back to bed. On [DATE] at 2:50 p.m., in an interview with two surveyors, the Administrator confirmed the facility had no policy or procedure regarding bed safety or bed height. On [DATE] at 11:45 a.m., in a telephone interview with a surveyor, the Interim Director of Nursing confirmed Resident #1 did not have bed rails. At one time, Resident #1 had a halo assistive device, but it had been removed at the resident's request. Based on the above information, IJ was determined to exist on [DATE] at 3:25 p.m. for the facility's failure to provide adequate supervision to a dependent resident left alone in a side-lying position on an air mattress, without a side rail and with the bed left at an unsafe height, approximately 3 and a half feet from the floor, resulted in an

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on the facility assessment, record review, interviews, and the facility policy statement the facility failed to develop, implement, and maintain an effective training program for all new and existing staff that includes training to meet the resident's behavioral health care needs for 6 of 8 employee files reviewed, Certified Nursing Assistant (CNA) #3, #4, #5, #6, #7, and #8. A review of the Facility Assessment for 2025, stated its facility resident profile includes residents admitted with psychiatric/mood conditions which is 35-65% of the facility's' population. The Specific Care or Practices for mental health states to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (Post Traumatic Stress Disorder), other psychiatric diagnoses, intellectual or developmental disabilities, specialized program. 1. Review of Certified Nursing Assistances (CNA) #3 education files on 8/13/25 lacked evidence that training in behavioral health care needs had been provided. CNA #3 was hired on 7/14/25, and review of the education file on 8/13/25 lacked evidence of behavioral health training/trauma informed care education being completed. 2. Review of CNA #4 education files on 8/13/25 lacked evidence that training in behavioral health care needs had been provided. CNA #4 was hired on 7/28/25, and review of the education file on 8/13/25 lacked evidence of behavioral health training/trauma informed care education being completed. 3. Review of CNA #5 education files on 8/13/25 lacked evidence that training in behavioral health care needs had been provided. CNA #5 was hired on 7/28/25, and review of the education file on 8/13/25 lacked evidence of behavioral health training/trauma informed care education being completed. 4. Review of CNA #6 education files on 8/13/25 lacked evidence that training in behavioral health care needs had been provided. CNA #6 was hired on 3/31/25, and review of the education file on 8/13/25 lacked evidence of behavioral health training/trauma informed care education being completed. 5. Review of CNA #7 education files on 8/13/25 lacked evidence that training in behavioral health care needs had been provided. CNA #7 was hired on 4/28/25, and review of the education file on 8/13/25 lacked evidence of behavioral health training/trauma informed care education being completed. 6. Review of CNA #8 education files on 8/13/25 lacked evidence that training in behavioral health care needs had been provided. CNA #8 was hired on 5/12/25, and review of the education file on 8/13/25 lacked evidence of behavioral health training/trauma informed care education being completed. On 8/13/25 at 12:48 p.m. during an interview, the Interim Director of Nursing confirmed she could not find behavioral health training/trauma informed care for the staff above stating, the previous Social Worker, who left approximately in February 2025 would provide education during orientation. On 8/13/25 at 1:50 p.m. during an interview, the Administrator and the Director of Nursing confirmed the lack of the Behavioral Health Care training for existing staff and new staff has not been completed since February. The Administrator stated, she was unaware and figured out that the Behavioral Health Care training/ Trauma informed care training had dropped off the learning platform the facility utilizes and they, after surveyor intervention, have assigned it to everyone to complete by end of month. On 8/14/25 at 5:49 p.m. the surveyor received an email from the Area Director of Clinical Operations in reply to the surveyor's request for the Behavioral Health/Trauma informed care policy, stating they do not have access to the policy due to converting from one policy portal to another. On 8/15/25 at 11:21 a.m. the Executive Director sent a copy of the Behavioral Health services policy statement that had no initial or revision date listed. A review of the policy statement, #5 states: Staff training regarding behavioral health services includes, but is not limited to: recognizing changes in behavior that indicate psychological distress; implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs; monitoring care plan interventions and reporting changes in condition; and protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post-traumatic stress disorder and #6 states: Behavioral health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care.