

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Augusta Center for Health & Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 188 Eastern Ave 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33639</p> <p>Based on record review and interviews, the facility failed to ensure that physician's orders were followed for 1 of 5 sampled residents (Resident #2).</p> <p>Finding:</p> <p>Resident #2's Physician Order Summary sheet, dated 12/15/23, indicated the resident was to be weighed weekly for Congestive Heart Failure. There was no evidence in the resident's clinical record to indicate the resident was weighed on 1/26/24, 2/2/24 and 2/23/24.</p> <p>The surveyor confirmed this finding in an interview with the Administrator on 3/18/24 at 2:30 p.m.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639</p> <p>Based on observation and interview, the facility failed to transport soiled linens in a sanitary manner on 1 of 3 units. ([NAME] unit)</p> <p>Finding:</p> <p>On 3/18/24 at 10:15 a.m., a surveyor observed a Certified Nursing Assistant #1 (CNA) carry unbagged bed linens against her body in the [NAME] unit corridor. During an interview with a surveyor, CNA #1 confirmed the bed linens were soiled and acknowledged that she was holding soiled bed linens close to her body.</p> <p>The facilities Handling Soiled Linen Policy & Procedure dated 1/2020 instructs staff to place soiled linen directly into a soiled linen hamper or a plain plastic bag.</p> <p>On 3/18/24 at 11:19 a.m., the surveyor confirmed the above finding in an interview with the Director of Nursing.</p>