STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205077	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Center for Health & Rehabilitation, LLC	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews, the facility failed to ensure that a resident was free of accidents/hazards for a resident who had rolled out of bed during personal care resulting in a fracture for 1 of 3 residents reviewed for falls. (Resident #1).Findings:On 4/19/26 Division of Licensing and Certification received an incident report indicating the following: On Thursday 4/15, staff member (Certified Nursing Assistant CNA #1) was giving care to [Resident #1]. [Resident #1] began to fall out of bed. The [CNA#1] called out for help. Two other staff arrived and helped lower [Resident #1] to the floor. [Resident #1] had persistent pain. X-ray results today show bilateral fractures above the knee. Facility investigation, dated 4/21/26, indicated the following: [CNA #1] attempted to provide care to [Resident#1] alone with bed in the high position. Kardex and care plan reflect that resident is a 2-assist for bed mobility. CNA#1 entered the room alone and helped resident roll onto her side so that she could begin washing her up for the day. After rolling resident onto her side, CNA#1 saw that resident began gaining momentum and sliding off the side of the bed. Due to resident's size, CNA#1 was unable to stop resident descent. CNA#1 called out for assistance. An LPN came to assist. LPN also attempted to stop residents' descent and called out to Medication Tech for further assistance. Resident was lowered to ground. LPN completed evaluation of resident.Care plan, revision date 4/2/26 for ADL self-care deficit, related to Parkinsons, obesity -PERSONAL HYGIENE/ORAL CARE: DependentOn 5/14/26 at 8:46 a.m., during an interview with a surveyor, the Assistant Director of Nursing (ADON) stated that Resident #1 was a 2-person assist and there was only one staff assisting the resident at the time of the incident.On 5/14/26 at 12:17 p.m., in an interview with Licensed Practical Nurse (LPN) #1, they stated that they never perform care for Resident #1 alone, he/she is too big, I always get help.On 5/14/26 at 9:05 a.m., review of the emergency room visit documentation dated 4/19/26 states: You have been evaluated in the Emergency Department today for pain. your evaluation, including physical evaluation and Computed Tomography scan, suggests that your symptoms are related to bilateral femur fractures that are comminuted and extensive.On 5/14/26 around 12:30 p.m., in an interview with a surveyor, the Administrator confirmed the above findings.As a result of the facility's investigations of this fall incident, the following corrective actions were initiated:On 4/19/26, CNA #1 was suspended from working at the facility during the investigation.On 4/19/26, per the family's request, they met with the Administrator to address their concerns and questions and to incorporate their suggestions into future safety and risk planning.On 4/20/26, the remaining staff did a reenactment of the incident to create a sequence of events for analysis.On 4/20/26, the facility provided staff education on reading the Kardex and reportable incidents.On 4/22/26 CNA #1 was terminated.On 4/23/26 at 2:07 p.m., the facility notified the CNA registry via email regarding CNA #1's termination following a serious incident.Audits for falls were completed from 4/22/26 to 5/3/26.Audits for bed mobility to ensure that it is accurately listed in the Kardex for each resident were done from 4/24/26 to 5/5/26.On 5/14/26 during observation of the resident, resident was in a newly ordered wheelchair to ensure their comfort and participation in any activities as they heal.At the time of the onsite investigation, the facility presented corrective actions taken to address the incident to the surveyor including conducting a root cause analysis The facility was (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	determined to be in past non-compliance after the review and verification of the implemented corrective actions.