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	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Center for Health & Rehabilitation, LLC	188 Eastern Ave Augusta, ME 04330

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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. 32540 Based on interviews and record review, the facility failed to ensure residents were treated in a dignified manner when staff failed to respond and attend to a resident's request for incontinence care during meal service. (Resident #40 [R40] and R41) Finding: On 11/17/24 at 1:10 p.m. during resident interviews with R40 and R41 they stated they make me wait. I get very anxious, and I get a bad headache, and that they are not changing him/her as frequently as he/she should be. R41 stated they just don't have enough staff, and they tell me I have to wait to use my urinal, and I don't want to wet my brief, and they make me wait. I want to use my urinal. I want to keep it going so I don't wet myself. On 11/18/24, during a record review a Health Status Note for Behavior dated 11/12/24, was documented in R40's clinical record stating It's policy that staff does not interrupt passing trays until they are all passed during mealtime. R40 has been informed of this policy many times. The nurse documented that R40 was informed again of the above policy, yet he/she continues to ring and holler out when staff walk by. On 11/19/24 at 10:00 a.m., during an interview with the Administrator and the Regional Directors, the surveyor asked about the above-mentioned policy for resident assistance during mealtimes. At this time the surveyor shared the Health Status note, dated 11/12/24, documented by a charge nurse. They stated that the facility does not have that policy. On 11/19/24 at 3:30 p.m., during an interview with a Certified Nursing Assistant, she stated that the process they are following during mealtime is that they pass out all the trays then they will change the residents. They have not been told not to help the residents, but they have to finish passing the meal trays first. She has heard a nurse tell the residents about the policy that staff does not interrupt the meal service.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 2 of 3 units ([NAME] Unit, and Kennebec Unit) for 1 of 1 environmental tour (11/19/24). Findings: On 11/19/24, from 10:05 a.m. to 10:30 a.m., an environmental tour was conducted with the Administrator and the Maintenance Director in which the following findings were observed: [NAME] Unit: > 3 hallway ceiling vents by resident rooms [ROOM NUMBER] were rusty and had dust on them. > Resident room [ROOM NUMBER] - The toilet surface and behind the seat were dirty with dried liquid residue. The bathroom exhaust vent was dusty/dirty. The caulking on floor around the bathroom door frame was dirty and stained. There was a urine collection cup on the floor by the toilet. > Resident room [ROOM NUMBER] - The bathroom floor was dirty. There was a yellow/brown stain on a ceiling tile near the vent above the toilet. The caulking at base of the room and bathroom door trim was dirty and stained. > Resident room [ROOM NUMBER] - The bathroom floor was dirty. The caulking around the base of the toilet was dirty/stained. The caulking at base of the room and bathroom door trim was dirty and stained. The bathroom exhaust vent was dusty/dirty. Kennebec Unit: > Resident room [ROOM NUMBER] - Resident #8's wheelchair had both left and right armrests that were cracked/broken. The caulking around the base of the toilet was dirty/stained. The bathroom exhaust vent was dusty/dirty. On 11/20/24 at 9:42 a.m. in an interview with a surveyor, the Administrator and the Maintenance Director confirmed the above findings.

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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. 33242 Based on record review and interviews, the facility failed to complete neurological assessments for 1 of 1 resident reviewed for fall with major injury (Resident #27 [R27]). Finding: The facility's paper form for a neurological (neuro) assessment indicated the following: Vital signs/Neuros to be done initially then every (q) 15 minutes x 2, q 30 minutes x 4, q 2 (hrs) x 4, then q shift x 3 (24 hours). The columns on the form to be completed included nurse's initials, date, time, vital signs (temperature, pulse, respirations, blood pressure) and neurological check (pupils, level of consciousness, motor function, speech, and facility symmetry). On 11/20/24, R27's clinical record was reviewed. On 9/10/24 at 4:06 a.m., a health status note was documented that indicated at approximately 3:30 a.m., a staff member went into R27's room to find the resident face down on the floor with a puddle of blood under his/her face. Emergency Medical Services (EMS) was called and when EMS got resident into the stretcher for transport, R27 had visible facial swelling, a laceration to the forehead, cheek, and chin. R27 returned to the facility after a Computed Tomography (CT) scan was completed which indicated no immediate head bleed, sustained a nasal fracture, and returned to the facility later that morning. On 11/20/24 at 11:00 a.m., during an interview with a surveyor, the Director of Nursing Services (DNS) stated that neuro assessments were not initiated upon return from the emergency room . At 11:56 a.m., during an interview with the Physician Assistant - Certified (PAC) with the DNS present, a surveyor asked what the expectation of neuro assessments would be for a resident with a fall with head injury and a negative CT scan. PAC stated if a resident had a negative CT scan and returned to the facility within 2 days, that he would expect neuros to be completed. A surveyor confirmed this finding with the DNS at the time of this interview.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32540 Based on record review, observation and interviews, the facility failed to provide the proper adaptive equipment to a resident during a meal service for 1 of 6 observed meals for Resident #35 [R35] who was involved in an incident on 11/6/24. Finding: On 11/7/24, the Division of Licensing and Certification received from the facility a reportable incident form which indicated that on 11/6/24 R35 had spilled hot chocolate on his/her lap which caused burns which later in the day developed into blistered areas on both his/her thighs. On 11/18/24, during resident observations it was noted that R35 was sitting in the dining room with a Kennedy cup (spillproof cup). During interviews it was noted that R35 was evaluated by Occupational Therapy (OT) on 11/12/24 with recommendation for use of covered mug for hot liquids secondary to decreased fine motor coordination. On 11/20/24 at 8:30 a.m., R35 was observed in the dining room for breakfast, he/she had a plate of pureed food and a bowl of oatmeal in front of him/her on the table. R35 was observed by the surveyor drinking using a regular coffee cup with no cover. It was then confirmed that the cup contained hot chocolate, R35 was observed taking 2 additional sips from the uncovered cup. The surveyor brought it to the attention of the Administrator and the Regional Director of Clinical Operations. R35 was then given a cup with a cover. At this time, the surveyor confirmed that R35 was not using a spillproof cup (adaptive equipment) with his/her hot chocolate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51669 Based on observation, interviews, and record review, the facility failed to provide respiratory care according to physician orders for 1 of 1 sampled residents (Resident #7 [R7]). Findings: Resident R7 was admitted on [DATE] and has diagnoses to include chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and congestive heart failure (CHF). A review of R7's active orders revealed a physician order, dated 5/30/24, for Oxygen therapy 1-2Lpm [liters per minute] titration to keep O2 sat (oxygen saturation) at 90-92%. every shift for SOB (shortness of breath)/cough. During an observation of R7 in the [NAME] unit dayroom, on 11/20/24 at 10:48 a.m., R7 was seated in a wheelchair at a table, working on a puzzle. R7 was wearing a nasal cannula, and the oxygen tubing was connected to a portable oxygen tank that was secured on the back of the wheelchair. The oxygen flow rate was set to 3Lpm, and the needle on the oxygen tank gauge was observed in the red area of the gauge marked, empty. During an interview on 11/20/24 at 10:53 a.m. with a surveyor, Registered Nurse (RN) 1 confirmed that R7 utilizes continuous oxygen therapy and that she interpreted the physician order to mean the oxygen was to be titrated to keep R7's oxygen saturation (O2 sat) between 90-92%. RN1 stated she had given R7 a nebulizer treatment approximately 15 minutes ago after his/her O2 sat was measured at 85-86% and then increased the oxygen flow rate from 2Lpm to 3Lpm and that she intended to re-check the O2 sat but got busy. At this time, a surveyor pointed out that the gauge on the portable oxygen tank indicated, empty. RN1 stated the gauge on the portable tank was in the full range when she had connected the oxygen tubing to the tank 15 minutes prior and proceeded to disconnect the oxygen tubing from the portable tank and connected it to an oxygen concentrator located by the table. During an interview on 11/20/24 at 11:04 a.m. with a surveyor, the Regional Director of Clinical Operations (RDCO) reviewed R7's oxygen order and stated she interpreted the order to mean that titration would occur within the 1-2Lpm, not above a 2Lpm flow rate, but that the facility may have standing oxygen orders. During an interview on 11/20/24 at 11:05 a.m. with a surveyor, the Director of Nursing Services (DNS) confirmed that the facility does not have standing oxygen orders, and stated the physician is in building, so RN1 may have titrated beyond order with intention of discussing with the physician. At this time, a surveyor reviewed the above findings with the DNS. On 11/20/24 at 11:40 a.m., in an interview with a surveyor, the Assistant Director of Nursing Services (ADNS) and RN1 requested to speak with a surveyor. At this time, with 2 surveyors present, ADNS and RN1 again confirmed the above findings and stated that R7's oxygen saturation is now improved to 89%, and that R7's oxygen saturation is usually 89% at baseline, and the physician has been notified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51669 Based on observation and interview, the facility failed to adequately date open medications and properly dispose of expired medications, according to manufacturer specifications for two inhalers in 2 of 3 medication carts ([NAME] Unit, and Penobscot Unit) observed. Findings: On 11/19/24 at 8:50 a.m., two surveyors and Certified Nurse Med Tech (CNA-M) 1 observed, in the medication cart on the [NAME] unit, a Trelegy Ellipta Inhalation Aerosol device, labeled for Resident (R) 314, with a pharmacy label stating, came in on 10/4/24. The manufacturer box states, Discard 6 weeks after opening or when the counter reads '0'. The box and the device itself were not labeled with a date indicating when the device was opened. On 11/19/24 at 8:55 a.m., during an interview with CNA-M1, two surveyors confirmed that the Trelegy Ellipta device was not labeled with an opened date to ensure use and disposal according to manufacturer specifications. On 11/19/24 at 9:43 a.m., two surveyors and CNA-M2 observed, in the medication cart on the Penobscot unit, a Fluticasone Salmeterol 250-50 mcg (microgram) inhalation device, labeled for R22, with opened date of 9/20/24 marked on the box, with the device itself not dated. The manufacturer packaging stated, Discard the inhaler 1 month after opening the foil pouch or when the counter reads '0' (after all blisters have been used), whichever comes first. On 11/19/24 at 9:49 a.m., during an interview with CNA-M2 and Licensed Practical Nurse (LPN) 1, two surveyors confirmed that the Fluticasone Salmeterol device was not labeled with an opened date and a discard date to ensure use and disposal according to manufacturer specifications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37440 Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a grease trap, a baseboard heater register and the floor. Additionally, the facility failed to ensure foods were sealed, labeled and dated in a reach-in freezer and in a walk-in refrigerator for 1 of 1 kitchen tour for 1 of 1 day of survey (11/17/24). Findings: On 11/17/24 from 11:30 a.m. to 11:58 a.m., two surveyors conducted a kitchen tour in which the following findings were observed: > The grease trap exterior had rust on the lid and the base. Additionally, the caulking around the base was dirty and stained with a black substance. > The baseboard heater register, located between the grease trap and a sink, was dusty/dirty and had dried liquid residue and food splatter on it. > The floor, under the sink across from the steam table, was heavily soiled with food debris and dried liquid residue. > The reach-in freezer had a 10.2 ounce box of cinnamon donuts and an 18 ounce box of waffles that were not sealed and open to the air. > The walk-in refrigerator had a metal tray containing 3 custard-type pies that were uncovered, unlabeled, and undated. Additionally, there were 6 cakes that were unlabeled. On 11/17/24 at 11:58 a.m. in an interview with two surveyors, confirmed the findings with the Head Cook.

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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. 33242 Based on record review and interviews, the facility failed to ensure a clinical record contained complete and accurate information for 1 of 1 residents reviewed for falls (Resident #27 [R27]). Finding: On 11/20/24, R27's clinical record was reviewed and the surveyor requested to review the facility's fall report for R27 that occurred on 9/29/24. Documentation on the fall report, completed 9/29/24 at 2:48 p.m. by Registered Nurse #2 (RN2) indicated that R27 was transferring self, fell forward towards the wall, and a staff member was able to grab R27 and sit back down on the bed. R27 sustained a nosebleed. The fall report indicated that the physician (Third Eye) was notified at 2:57 p.m. Review of the Third Eye health note documented in R27's progress notes, completed by Third Eye, on 9/29/24 at 10:44 p.m., indicated that on 9/29/24 at 1:53 p.m. (central time) which is 2:53 p.m. (eastern time), it was reported by RN2 that R27 had an unwitnessed fall, likely slid onto floor in bedroom, found on buttocks, with no head strike or trauma reported. On 11/20/24 at 2:07 p.m., during an interview with the Director of Nursing Services (DNS), the surveyor confirmed that RN2 documented that R27 had a nose bleed after falling towards the wall and that Third Eye documentation does not match the fall report (which was the only fall report found for R27). At 2:59 p.m., during an interview with a surveyor, DNS stated that she spoke with RN2 who did not recall if a neurological monitoring sheet was started or not after R27 sustained a nosebleed after falling into the wall.