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	02/05/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 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 3 of 3 units ([NAME], Penobscot and Kennebec Units) and a common area for 1 of 1 environmental tour (2/5/26).Findings: On 2/5/26 from 8:55 a.m. to 9:25 a.m., a surveyor conducted an Environmental Tour with the Maintenance Director and the Administrator in which the following findings were discussed and observed: Common Area:- A hallway ceiling tile, by the main entrance door, had a large brown stain on it. Penobscot Unit:- Resident room [ROOM NUMBER] - There was a full cup of liquid, with a straw in it, on floor next to bed B. There was an unbagged bed pan on the bathroom floor.- Resident room [ROOM NUMBER] - There was a medium size bottle of powder lying on floor behind the head of bed A. The oxygen concentrator, located between the beds, had dirt/debris and dried liquid residue on it.- Resident room [ROOM NUMBER] - The over the bed table, for bed B, had dried food particles and dried liquid residue on it. Kennebec Unit:- Resident room [ROOM NUMBER] - The window blind was broken in many places, hanging down and in disrepair. The bathroom had a container of purple wipes on a rollator walker with a wipe sticking out. [NAME] unit- Resident room [ROOM NUMBER] - The baseboard heating unit had chipped/missing paint creating an uncleanable surface.- Resident room [ROOM NUMBER] - The baseboard heating unit had chipped/missing paint creating an uncleanable surface.- Resident room [ROOM NUMBER] - The window blind was broken in many places, hanging down and in disrepair. On 2/05/2026 at 9:25 a.m., in an interview with a surveyor, the Maintenance Director and the Administrator confirmed the discussed and observed findings.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 5 of 7 residents reviewed for care planning (Residents #3, #6, #7, #9, and #24).Findings:1. Review of Resident #3's clinical record revealed an MDS Quarterly Assessment was completed on 11/27/25. Further review of Resident #3's clinical record revealed that an IDT meeting was held 12/10/25 (13 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment.Additional review of Resident #3's clinical record indicated that he/she sustained an unwitnessed fall at the facility on 12/17/25 and was subsequently admitted to an acute care hospital on [DATE], was diagnosed with a left hip fracture, and underwent left hip surgery on 12/18/25. Resident #3 returned to the facility on 1/3/26. The clinical record revealed an MDS Significant Change Assessment was completed on 1/13/26 but lacked evidence that an IDT meeting was held within 7 days following the assessment.A review of Resident #3's provider History & Physical dated 1/5/26 states, .seen today for readmission following hospitalization for a mechanical fall resulting in left proximal femoral fracture. maintain post-op dressing precautions and monitor for bleeding, erythema, warmth, purulent drainage, wound dehiscence, or fever; reinforce to staff close supervision given attempts to remove Steri-Strips.A review of Resident #3's physician orders revealed the following:An order with a start date of 1/27/26 for Monitor L [left] hip incision, leave OTA [open to air] every day and evening shift for 7 Days.An order with a start date of 1/20/26 for Monitor dressing on L hip. Change dressing every 3 days and PRN [as needed] every day and evening shift for 7 days.A review of Resident #3's care plan lacked evidence that goals and interventions were put into place for the left hip incision.On 2/5/26 at 8:30 a.m., the above finding was discussed during an interview with the Administrator and Regional Director of Clinical Operations. At this time, the Administrator reviewed Resident #3's care plan and stated that she would expect to see goals and interventions for the care of the left hip incision and confirmed the care plan was not revised to reflect Resident #3's current needs.2. Review of Resident #6's clinical record revealed an MDS Annual Assessment was completed on 10/30/25 and an MDS Quarterly Assessment was completed on 1/22/26. Further review of Resident #6's clinical record lacked evidence that an IDT meeting was held within 7 days following the above assessments.3. Review of Resident #7's clinical record revealed an MDS Quarterly Assessment was completed on 1/7/26. Further review of Resident #7's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment.4. Review of Resident #9's clinical record revealed an MDS Quarterly Assessment was completed on 11/18/25 and an MDS Significant Change Assessment was completed on 12/22/25 and that Resident #9 was admitted to hospice services. Further review of Resident #9's clinical record revealed that an IDT meeting was held 1/28/26 and lacked evidence that an IDT meeting was held within 7 days following the above assessments.5. Review of Resident #24's clinical record revealed an MDS Annual Assessment was completed on 8/18/25 and that an IDT meeting was held on 9/10/25. Further review of Resident #24's clinical record revealed an MDS Quarterly Assessment was completed on 11/11/25 and that an IDT meeting was held on 12/11/25. Resident #24's clinical record lacked evidence that an IDT meeting was held within 7 days following the above assessments.On 2/5/26 at 8:05 a.m., during an interview, the MDS Coordinator stated that the facility does not schedule IDT meetings based off of MDS Assessment dates and that IDT meetings are scheduled based off of the date that the last IDT meeting was held. On 2/5/26 at 8:18 a.m. during an interview, the Licensed Social Worker (LSW) stated that she schedules IDT meetings based off of a report she receives, and that it is her understanding that IDT meetings for Long Term Care residents should be (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled within 7 days of the review date indicated on the report and within 14 days of the review date for Skilled residents.On 2/5/26 at 8:30 a.m., the above findings were discussed with the Administrator and Regional Director of Clinical Operations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, interviews and record reviews, the facility failed to ensure medications, including treatments, were stored properly by failing to obtain physician orders for medications located at a resident's bedside for 2 of 20 sampled residents (Residents #64, #9). In addition, the facility lacked evidence of consistent monitoring of medication storage room refrigerator temperatures to ensure proper medication and vaccine storage temperatures for 5 of 7 months reviewed. Findings: 1. On 2/1/26 at 9:45 a.m., during an observation of Resident #64's room, a 43 g bottle of miconazole topical 2% powder with a pharmacy label for Resident #64 and a medicine cup containing an unknown white substance was located on the counter next to the shared sink. During an interview at this time, Resident #64 stated that he/she cannot apply the medications himself/herself because he/she is disabled and that staff apply his/her medications. 2. On 2/1/26 at 10:24 a.m., during an observation of Resident #9's room, a 6 fluid ounce bottle of Calamine lotion with a pharmacy label for Resident #9 was located on the counter next to the shared sink. A review of Resident #9's clinical record lacked evidence of a physician order for Resident #9 to self-administer medications. On 2/1/26 at 2:51 p.m., the above findings were discussed during an interview with the Director of Nursing (DON). At this time, the DON stated that topical medications are stored in a separate bag for each resident in the treatment cart and should not be stored at the resident's bedside. 3. On 2/5/26 at 11:46 a.m., the surveyor observed the medication storage room refrigerator, which contained insulin, vaccinations and other medications requiring refrigeration. Review of the facility policy titled Medication Storage - Storage of Medication (Section 4.1, revised 01/25 directed that refrigerators storing vaccines be monitored. And recorded twice daily and maintained within 36 F – 46 F. The policy further indicates insulin products are to be stored in the refrigerator until opened and must not be frozen. Review of the Refrigerator Temperature Log, which instructs staff to record temperatures twice daily, revealed missing documentation as follows: August 2025 4 of 31 days missing AM documentation 2 of 31 days missing documentation September 2025: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 of 30 days missing AM documentation 1 of 30 days missing PM documentation October 2025: 4 of 31 days missing AM documentation November 2025: 1 of 30 days missing AM documentation December 3 of 31 days missing AM documentation 3 of 31 days missing PM documentation On 2/5/26 at 1:30 p.m., the above findings were discussed with the Administrator and Regional Director of Clinical Operations.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure the confidentiality of protected health information when resident identifiable assignment sheets and a monthly weight documentation sheet were left unattended in the solarium, an area accessible to residents and visitors, on 1 of 4 days of survey. Finding:On 2/1/26 at 11:00 a.m., a surveyor observed copies of multiple resident care assignment sheets and a document titled December Monthly Weights left unattended on a table in the solarium, an area accessible to residents and visitors. At the time of the observation, two residents and one visitor were present in the solarium. The assignment sheets contained resident identifiable information including resident names, room numbers, diagnosis, continence status, required assistance with activities of daily living (ADL's), transfer needs (including Hoyer use), fall risk status and other personal care instructions. The monthly weight sheet contained resident names and recorded weights. The documents were left unattended in a publicly accessible area without safeguards to maintain confidentiality of resident information.On 2/1/26 at approximately 11:20 a.m., the surveyor confirmed this finding with the Human Resources Assistant, who acknowledged the assignment sheets contained sensitive and private protected health information and stated the documents should not have been left unattended in the solarium.

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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. Based on observations, interviews, and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice in the area of nutrition and wound care for 2 of 20 sampled residents (Residents #6, #9).Findings:1. Resident #6 was admitted in May 2023 with diagnoses to include Parkinson's Disease and dysphagia.On 2/5/26 at 8:05 a.m., a surveyor observed Resident #6 in bed with his/her over-the-bed table set up with his/her breakfast meal, including a spoon in the bowl of oatmeal and a fork by the entree plate. No staff were in the room at the time of the observation.On 2/5/26 at 9:45 a.m. during an interview, the Director of Nursing (DON) stated that there have been concerns with aspiration and an overall functional decline and that staff have been assisting Resident #6 more with feeding recently. A review of Resident #6's clinical record revealed an active physician order with a start date of 5/14/25 for Full supervision with all meals.Further review of Resident #6's clinical record revealed a quarterly nutrition evaluation dated 1/21/26 that states, .holding food in mouth/cheeks or having residual food in mouth after meals. needing supervision all meals . and a physician progress note dated 1/27/26 that states, .requires supervision with meals.On 2/5/26 at 12:53 p.m., during an interview, CNA #1 stated that Resident #6 feeds himself/herself about 50% of the time, and that when he/she can eat on his/her own, the staff will set him/her up and then leave the room to get trays for the other residents. She then stated that the staff periodically check in on Resident #6.On 2/5/26 at 1:15 p.m., during a follow-up interview with 2 surveyors, the above finding was discussed with the DON. At this time, the DON stated that sometimes Resident #6 feeds himself/herself and sometimes he/she needs assistance and that she was unaware that an order for full supervision with meals has been in place since May.2. Resident #9 was admitted in August 2025 with diagnoses to include chronic ulcer of the left leg.A review of Resident #9's clinical record revealed an active physician order with a start date of 1/23/26 for Wound care for LLE [left lower extremity] wound: cleanse LLE wound with sterile water (on days that we change collagen), apply a light dusting of collagen. to entire wound bed. apply oil emulsion over the collagen dusting, then apply barrier cream to wound edges (only outside wound edges) cover with large Abd pads [an absorbent, multi-layer dressing], and wrap with kerlix [a type of gauze bandage].On 2/1/26 from 12:14 p.m. to 12:43 p.m., a surveyor observed Registered Nurse (RN) #1 perform Resident #9's wound care. RN #1 removed the existing dressing and cleansed the wound with sterile water. RN #1 then applied the collagen to the wound bed, then applied oil emulsion, then covered the wound with the Abd pads, and wrapped Resident #9's lower leg with Kerlix.On 2/1/26 at 12:45 p.m., during an interview, the surveyor and RN #1 discussed Resident #9's wound care orders. At this time, RN #1 stated that Resident #9 often refuses barrier cream, but that she should have offered the treatment to him/her and missed that. Additional review of Resident #9's clinical record revealed a late-entry nursing progress note dated 2/1/26 that states, This RN inadvertently did not apply barrier cream to wound edges during dressing change to left lower extremity. Reapproached resident and asked if [he/she] would like me to apply it. [He/She] states [he/she] did and I applied the barrier cream to wound edges.On 2/1/26 at 1:10 p.m., the surveyor discussed the finding with the DON, the Administrator, and the Regional Director of Clinical Operations.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observations, record review, and interviews, the facility failed to provide adaptive utensils for 1 of 3 residents reviewed for nutrition (Resident #6).Finding:Resident #6 was admitted in May 2023 with diagnoses to include Parkinson's Disease and dysphagia.On 2/5/26 at 8:05 a.m., a surveyor observed Resident #6's breakfast meal set up on his/her over-the-bed table. A standard spoon was resting in the bowl of oatmeal and a standard fork was set up next to Resident #6's entree, served on a lip plate. There were no adaptive utensils or cups.Review of Resident #6's care plan revealed the following: .ADL [Activities of Daily Living] self-care performance deficit.Lip plate with meals.L [left] and R [right] angled spoons.adaptive dining equipment: lip plate at meals. Blue insulated mug. Left and right angled spoon.On 2/5/26 at 12:53 p.m., during a repeat observation, Resident #6 received his/her lunch tray in his/her room. The meal ticket indicated .Blue insulated mug Left and right-angled spoon . There were no adaptive utensils or specialized mug. During an interview at this time, Certified Nursing Assistant (CNA) #1 stated that the kitchen sends the specialized eating and drinking utensils on the resident's tray and confirmed that the specialized mug and spoon were not on Resident #6's meal tray. CNA #1 then stated that Resident #6 feeds himself/herself about 50% of the time and when he/she can eat on his/her own, the staff will set him/her up and then leave the room to get trays for the other residents.On 2/5/26 at 1:10 p.m., during an interview, the Food Service Director stated that all resident specialized eating and drinking equipment is listed on the meal ticket and put on the resident's meal tray when it is sent to them.On 2/5/26 at 1:15 p.m. during an interview with 2 surveyors, the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated that sometimes Resident #6 feeds himself/herself and sometimes he/she needs assistance and that he/she does not require adaptive utensils if staff is feeding him/her. The surveyors discussed that the kitchen does not know whether Resident #6 is feeding himself/herself that meal or if he/she will need assistance, so the kitchen has no way of knowing which meals Resident #6 will require adaptive utensils or which meals he/she will have staff assistance.

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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. Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall and the floor; failed to ensure foods were labeled and dated in a reach-in freezer; and failed to ensure kitchen staff with facial hair wore facial protection for 1 of 1 kitchen tour for 1 of 1 day of survey (2/1/26). Findings: On 2/1/26 from 9:05 a.m. to 9:35 a.m., a surveyor conducted an Initial Kitchen Tour in which the following findings were observed: - Two male kitchen workers with facial hair (beards and moustaches) were not wearing facial hair protection. - The wall behind the toaster had chipped/missing paint creating an uncleanable surface. - The kitchen floor had food debris and trash throughout the kitchen, under equipment and under shelving. - The Reach-in freezer, nearest the walk-in refrigerator, had a previously opened package of strips/tenders that was not labeled and dated. On 2/1/26 at 9:38 a.m., in an interview, a surveyor discussed the findings with the Dietary Aide. On 2/1/26 at 11:25 a.m., in an interview, a surveyor discussed the findings with the Acting Administrator.

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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. Based on observation, interviews, and Centers for Disease Control and Prevention (CDC) guidance, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to transporting soiled linens and disinfecting a soiled surface during a wound dressing observation for 1 of 3 residents reviewed for wounds (Resident #9). Findings: On 2/1/26 from 12:14 to 12:43 PM, during an observation of Resident #9's left leg wound dressing change, Registered Nurse (RN) #1 sanitized her hands and donned (put on) Personal Protective Equipment (PPE) per the Contact precautions sign hanging outside Resident #9's door. RN #1 then placed Resident #9's left leg on a towel located on top of his/her bed and proceeded to remove Resident #9's existing dressing, provide wound care, and apply a new dressing. Resident #9's open wounds were in direct contact with the towel during the wound care and dressing change. After the dressing change, RN #1 discarded the soiled dressing and then removed the soiled towel from under Resident #9's leg. RN #1 then placed the unbagged, soiled towel on the counter of the sink that Resident #9 and Resident #61 share. RN #1 then placed her bandage scissors in the sink basin and proceeded to wash her hands, reposition Resident #9, and cover him/her with blankets. RN #1 then doffed (took off) her PPE and then picked up the unbagged, soiled towel with her ungloved hands and carried it out of the room and across the hall to the soiled utility room (Whirlpool room), where she discarded the towel. RN #1 then returned to Resident #9's room, sanitized her hands, donned new PPE, and cleaned the bandage scissors in the sink with disinfectant wipes. RN #1 then doffed her PPE, sanitized her hands, and without cleaning the sink counter, proceeded to leave the room. On 2/1/26 at 12:43 p.m. during an interview, Resident #61 stated that he/she and Resident #9 share the sink, and stated that he/she uses the sink to wash his/her face and bathe. On 2/1/26 at 12:45 p.m. during an interview, RN #1 stated that Resident #9 is on Contact precautions for Shingles. At this time, the surveyor discussed the above observation, and RN #1 stated that she does not like carrying soiled linens with her bare hands, but that she is not supposed to wear gloves in the hall. The surveyor also discussed the placement of the soiled towel on the shared sink counter, and that the counter was not cleaned after RN #1 removed the soiled towel. At this time, RN #1 stated she was going to go get disinfectant wipes to clean the sink and counter and proceeded to do so. On 2/1/26 at 1:10 p.m., the above finding was discussed during an interview with the Director of Nursing, the Administrator, and the Regional Director of Clinical Operations. At this time the Administrator stated that the facility's procedure is that staff do not wear gloves when transporting soiled linens in the hall. Centers for Disease Control and Prevention (CDC) Best Practices for Environmental Cleaning in Global Healthcare Settings, Appendix D- Linen and laundry management, dated 3/19/24 states, Always wear reusable rubber gloves before handling soiled linen.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to ensure that the resident's medical record included documentation that indicated that the resident or resident representative accepted a COVID-19 vaccine that the resident received for 1 of 5 residents reviewed for immunizations (Resident #24).Finding:Review of Resident #24's clinical record revealed a signed Immunization Consent Form dated 6/6/25, indicating Resident #24 declined the COVID-19 vaccine. Further review of the clinical record revealed that Resident #24 received the COVID-19 immunization on 11/5/25. On 2/5/26 at 1:08 p.m. during an interview, the Director of Nursing and the Administrator stated that they were looking for evidence that Resident #24 had consented to receive the COVID-19 vaccine administered on 11/5/25. At this time, the Regional Director of Clinical Operations stated that Resident #24 had refused the 2024-2025 COVID-19 vaccine but consented to receiving the 2025-2026 vaccine.The facility failed to provide evidence that Resident #24 consented to receiving the vaccine by the end of the survey.