STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Center	27 Cool St Waterville, ME 04901

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and clinical record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all the resident's pre- and post-discharge medications for 1 of 2 residents reviewed for discharge to the community (Resident #98).Finding: On review of Resident #98's clinical record, a surveyor noted an admission date of 12/13/25. The record indicated that on 1/14/26, Resident #98's managed care insurance denied coverage after 1/21/26, and Resident #98 was discharged home on 1/22/26. The surveyor located an incomplete recapitulation of stay in the electronic record dated 1/22/26. The record lacked evidence that the provider had completed a final summary of Resident #98's status, or a summary of the resident's pre- and post-discharge medications in the hard or electronic clinical record. On 6/2/26 at 3:55 p.m., in an interview with a surveyor, the Market Lead Clinical Specialist confirmed that the provider had not completed a discharge summary prior to Resident #98's discharge.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on interviews, document review, the facility's Suicide Precautions policy and the facility's Person Centered Care Plan policy review, the facility failed to ensure that a resident who had signs of self-harm and suicidal ideation received the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning for 1 of 1 residents reviewed for mood/behavior (Resident #92).Findings:Review of the facility's Suicide Precautions revised 3/20/26, notedProcedure:1. Evaluate patients with suicidal behavior or ideation.2. Notify physician/advanced practice provider (APP) if assessment indicates patient is at risk for suicide. Collaborate with care team to determine risk level for suicide.2.1 Discuss Suicide safety plan with patient slash family slash representative.2.1.1 warning signs and triggers.3.1 Obtain order for suicide preventions from the physician slash app. Implementation of suicide precautions should not be delayed while awaiting physicians order. 3.2 evaluate immediate safety needs3.10 document: 1. Risk for suicide. 2. Actual/potential suicidal behavior observed. 3. Expression of wish to die, using patients own words, if possible. 4. Notification of physician (APP) including time notified and time of response. 5. Notification of family representative. 6. Safety plan information shared by patients representative/family. 7. Time of initiation of suicide precautions. 8. Notification of consultants archivists including time notified and time of response. Review of the facility's Person Centered Care Plan policy, revision date 9/15/25 notedPolicy: The center must develop and implement a person centered care plan for each patient slash resident consistent with patient rights measurable objectives and time frames to meet a patient's medical, nursing and mental and psychosocial needs and all services that meet professional standards of quality.Care plan Includes the measurable objectives and timetables to meet the patient's medical, nursing, nutrition and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will be prepared by the interdisciplinary team. 3. A comprehensive person centered care plan must be developed for each patient and must describe the following: 3.1 Services that are to be furnished.5.1 The care plan must be customized to each individual's patients preferences and needs. 6. Care plans will be: 6.2 reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. Review of Resident #92's clinical record revealed Care Plan Meeting note dated 4/30/26 stating Resident #92 made a comment that he/she might as well commit suicide. Review of Resident #92's clinical record lacked evidence that the resident was assessed for self-harm/suicide ideation, or that the provider was made aware of this statement. Further review of Resident #92's clinical record revealed Provider communication note dated 5/10/26 stating: [.Describe behavioral changes: increasing confusion threatening to commit suicide tonight.]. Review of Resident #92's care plan most recently updated 5/12/26 lacked evidence that goals and interventions were put into place for suicidal ideation. On 6/2/26 at 2:20 p.m., in an interview with a surveyor, the Market Clinical Lead stated she reviewed Resident 92's clinical record and there is no evidence that the doctor was notified, that the resident was assessed for self-harm/suicidal ideation and no evidence that the current care plan was updated to include triggers, goals and interventions for threat of self-harm/suicide. On 6/2/26 at 3:30 p.m., in an interview with a surveyor, the current Social Service Director stated that if a resident said they wanted to commit self-harm or suicide in front of him in a meeting that he would get a team together(nursing) and assess the resident, the DON and the Administrator would be involved and they would notify the doctor. Depending what the doctor stated, they may send the resident out to the emergency room for an evaluation. He then stated that he would document it in notes with follow-up as to what was done. On 6/3/26 at 3:55 p.m., in an interview with a surveyor, the Market Clinical Advisor, the Director of Nursing and the Market Clinical Lead (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that the resident's care plan had been reviewed by them and that there was no evidence that the current care plan was updated to include triggers, goals and interventions for threat of self-harm and suicide ideation.

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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. Based on observations, record reviews, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for Activities of Daily Living (Resident #14).Findings:1. Resident #14 has diagnoses including dementia.On 6/2/26 at 8:52 a.m. during an interview, Resident #14's son stated that he has observed Resident #14 in the same soiled clothes, sometimes for days.On 6/3/26 at 11:17 a.m. a surveyor observed Resident #14 dressed in a light blue t-shirt with a logo and dark blue pants. The surveyor observed Resident #14 in this clothing multiple times throughout the day.On 6/4/26 at 8:25 a.m. during a repeat observation, Resident #14 was dressed in the same light blue t-shirt and dark blue pants as the previous day.A review of Resident #14's clinical record revealed an Interdisciplinary Team (IDT) meeting note dated 4/8/26 that states, .[son] expressed concerns with the resident having the same pair of clothes on for several days in a row A review of Resident #14's care plan states, .Provide resident/patient with partial assist of 1 for dressing.On 6/4/26 at 11:40 a.m. during an interview, Certified Nursing Assistant (CNA) #4 stated that Resident #14 does not dress himself/herself and cannot select his/her own clothing and that he/she would wear the same clothing every day if staff let him/her. CNA #4 then stated that she did not provide Resident #14 dressing assistance today, and that the off-going night shift CNA told her that Resident #14 was already dressed for the day when she arrived for her shift this morning.A review of Resident #14's task documentation for Task: GG-dressing.Did you obtain clothing from the closet or drawers for resident? indicated No on 6/3/26 at 4:55 p.m. and Not applicable on 6/4/25 at 1:08 a.m. (night shift) and lacked evidence that the night CNA provided Resident #14 dressing assistance this morning, as stated by CNA #4 .On 6/4/26 at 1:13 p.m., the surveyor and the Market Clinical Lead observed Resident #14 in the hallway wearing the blue outfit. The surveyor discussed the above concerns and reviewed Resident #14's dressing task documentation with the Market Clinical Lead.On 6/4/26 at 2:10 p.m. during a follow-up Interview, the Market Clinical Lead stated that after speaking with the night CNA, Resident #14 was provided dressing assistance and changed into sleepwear last night and that this morning, Resident #14 requested to wear same clothing as yesterday. The Market Clinical Lead then confirmed that Resident #14's task documentation does not accurately reflect the care provided.