STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205106	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastside Center for Health & Rehabilitation, LLC	516 MT Hope Avenue Bangor, ME 04401

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews, observations, and record reviews, the facility failed to develop and/or implement policy and procedures for residents to file grievances to ensure timely resolution to resident concerns. This has the potential to affect all residents. Findings: 1. The facility's Grievance Policy, revised 11/16, indicated the following: The resident/responsible party can bring forward their concerns verbally and or by the writing grievance process. Grievance/concerns forms are available on the nursing units and in the front lobby where applicable. Facility staff Is encouraged to attempt to resolve the verbal grievance/concern at the time it is brought forward whenever possible. in the case that a concern cannot be resolved promptly the staff member will complete the grievance form or give it to the person with the concern to complete. Upon receive of the completed form, the social worker will follow up with the person who filed the grievance/concern and discuss the resolution and have the complainant sign and or verbally acknowledge that they agree that the issue has been resolved. The complainant will then be offered a signed copy of the grievance form. During a group interview on 3/31/26 at 9:25 a.m., 7 residents were asked if they knew how to file a grievance or complaint with one resident responding that they would go to the social worker or Activities Director but that there hasn't been a social worker for a while here, but they have a new one coming. Surveyor asked if the group knew how to file anonymously and the response was no. On 3/31/26 at 9:40 a.m., during an interview with a surveyor, the Activities Director (AD) explained that Resident Council is a safe place for residents to vent and if there was a complaint or grievance, the process was that she would complete the grievance form and give it to the Administrator. The surveyor reviewed the form and asked the AD what would you put on the Grievance/Concern Form where it says resident involved if they wanted to be anonymous. The AD stated that she would put the room number and bed number if they didn't want to give their name. She would then give the form to the Administrator when completed. On 3/31/2026 at 10:17 a.m., during an interview with a surveyor, the Administrator stated the facility has a website that anonymous complaints can be submitted and that a name is not required. Surveyor explained not every resident has access to or capability to use a computer. The Administrator stated that staff do not have to complete the resident name on the Grievance/concern form, they could just leave it blank. The surveyor stated that some residents and staff are unaware of this process. On 3/31/26 at 3:20 p.m., during an interview with the Administrator, a surveyor reviewed the facility's (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policy and confirmed that the policy does not mention a way to complete a grievance anonymously. 2. On 3/29/26 at 10:53 a.m., during an interview with a surveyor, R3 stated that his/her glasses have been missing for 3 or more weeks, and he/she can't see well without them. No glasses were observed in use or within the room at the time of the interview. On 3/30/26 at 2:15 p.m., during an interview with a surveyor, R3 stated his/her glasses are still missing. R3's roommate stated that they have been missing for more than 3 weeks now. No glasses were observed in use or within the resident's room at the time of the interview. On 3/30/26, R3's clinical record was reviewed and indicated R3's cognition is moderately impaired. The Care Plan indicated R3 has impaired visual function, interventions included Ensure glasses are clean and available. Remind resident to wear glasses when up. Ensure resident is wearing glasses which are clean free from scratches and in good repair. Report any damage to nurse/family. Certified Nursing Assistant documentation indicated R3 wore glasses each morning and removed them each night (See F842). The clinical record lacked evidence that the glasses were missing or that the facility took steps to locate them. On 3/30/26 at 2:56 p.m., during an interview with a surveyor and the Administrator, R3's clinical record and the grievance book were reviewed. The Administrator confirmed that the glasses were reported missing on 2/6/26, that the facility does not know if the glasses were lost in the facility or at dialysis, and that the facility did not call dialysis to assist R3 in locating the glasses when they were reported missing. The Administrator stated he believed R3 would look for them at the next dialysis appointment on 2/9/26. At this time, the surveyor confirmed that the facility did not assist the resident to locate his/her missing glasses to prevent permanent loss and did not follow up with R3 to assist in locating or replacing his/her glasses.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to recognize a potential significant weight loss and a potential significant weight gain for 1 of 6 residents reviewed for nutrition. (Resident #12 [R12])On 3/30/26, a review of R12's clinical record was complete. R12 was care planned for diabetes with an intervention to monitor, document/report any signs or symptoms of weight loss . R12 also had a care plan problem for overweight/obesity/risk of malnutrition related to chronic disease (diabetes mellitus Type II) with an intervention to monitor/evaluate weight/weight changes.Documentation indicated that on 3/5/26, R12 weighed 294 pounds (#). Then on 3/12/26, R12 weighed 263 #'s, indicating a potential for a significant weight loss of 30.6 #.On 3/16/26, R12 weighed 266.1 #'s. Then on 3/26/26, R12 weighed 310.2 #'s, indicating a potential for a significant weight gain of 44.1 #'s.There was no evidence that the care plan interventions were followed, that potential significant weight changes were assessed for accuracy and/or evaluated for potential medical intervention.On 3/31/26 at 7:00 a.m., in an interview with the Director of Nursing Services, the surveyor discussed this finding.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record reviews and interviews, the facility failed to ensure the attending Provider signed the medication Order Review History Report (Physician block orders) that is required during a visit at least every 60 days plus a 10 day grace period for 3 of 5 sampled residents reviewed for unnecessary medications. (Resident #2 [R2] R9, R46) and 2 of 3 reviewed for Activities of Daily Living (R6 and R14) In addition, the facility failed to ensure the attending Provider signed the medication Order Review History Report (Physician block orders) that is required during a visit for a new admission at least every 30 days plus a 10 day grace period for 1 of 1 sampled resident reviewed for hospitalization (Resident #58 [R58]). Finding: 1. On 3/31/26, a review of R2's clinical record was completed. Documentation indicated a required regulatory visit was completed on 1/15/26. A provider progress note was completed on 1/15/26, but there was no evidence that the physician block orders were signed. The facility was unable to provide evidence that the physician block orders were signed on the day of the required recertification visit. On 3/31/26 at 9:45 a.m., the surveyor discussed this finding with the Regional Director of Clinical Operations. 2. On 3/31/26, a review of R6's clinical record was completed. Documentation indicated a required regulatory visit and signing of physician block orders was completed on 2/4/26. R6's physician block orders were signed on 2/4/26, but there was no evidence that the provider progress note (visit) was completed and signed until 6 days after the physician block orders were signed. The facility was unable to provide evidence that the providers progress note (visit) was completed on the day the physician block orders were signed for the required recertification visit which instructs the provider to review the residents' total care to include medications and treatments with each visit. 3. On 3/31/26, a review of R9's clinical record was completed. Documentation indicated a required regulatory visit and signing of physician block orders was completed on 1/13/26. R9's physician block orders were signed on 1/13/26, but there was no evidence that the providers progress note (visit) was completed and signed the following day after the physician block orders were signed. The facility was unable to provide evidence that the providers progress note (visit) was completed on the day the physician block orders were signed for the required recertification visit which instructs the provider to review the residents' total care to include medications and treatments with each visit. 4. On 3/31/26, a review of R14's clinical record was completed. Documentation indicated a required regulatory visit and signing of physician block orders was completed on 1/28/26. R14's physician block orders were signed on 1/28/26, but there was no evidence that the providers progress note (visit) was completed and signed until 5 days after the physician block orders were signed. The facility was unable to provide evidence that the providers progress note (visit) was completed on the day the physician block orders were signed for the required recertification visit which instructs the provider to review the residents' total care to include medications and treatments with each visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 3/31/26, a review of R46's clinical record was completed. Documentation indicated a required regulatory visit and signing of physician block orders was completed on 1/28/26. R46's physician block orders were signed on 1/28/26, but there was no evidence that the providers progress note (visit) was completed and signed until 5 days after the physician block orders were signed. The facility was unable to provide evidence that the providers progress note (visit) was completed on the day the physician block orders were signed for the required recertification visit which instructs the providers to review the residents' total care to include medications and treatments with each visit. On 3/31/26 at 9:45 a.m., surveyors discussed this finding with the Regional Director of Clinical Operations. 6. On 3/31/26, R58's clinical record was reviewed and indicated that R58 was readmitted to the facility as a skilled resident the first week of December 2025. The Medical Provider visited R58 and signed the medication Order Review History Report (physician block orders) on 12/10/25 with the next required provider visit and signing of physician block orders due by 1/19/26 (30 days plus 10 day grace). Providers made multiple visits between 12/10/26 - 1/19/26, but the next time physician block orders were signed was 1/7/26, but that provider did not have a documented visit on that day. On 3/31/26 at 10:42 a.m., the Regional Director of Clinical Operations and a surveyor reviewed R58's clinical record. The next time a Medical Provider visited R58 and signed the physician block orders was on 2/5/26, 17 days late. The surveyor confirmed a provider signed the physician block orders with no physician visit, thus making them late when a provider actually visits the resident, reviews the resident's total care, and signs the physician block orders.

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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. Based on observations and interviews, the facility failed to ensure that plastic scoops were not left in the flour and sugar bins, in the walk in refrigerator the facility failed to prevent cross contamination when they had a plastic container with lettuce leaves, bag of carrots, unpeeled cucumber and an onion wrapped in plastic wrap all in the same container on 1 of 4 days of survey (3/29/26) in addition the facility failed to ensure all kitchen staff were wearing facial hair restraints on 2 of 4 days of survey (3/29/26 and 3/30/26). Findings: On 3/29/26 at 10:55 a.m. during the initial tour of the kitchen an observation of the flour and sugar bins showed the scoops were left in the flour and sugar bins. On 3/29/26 at 10:57 a.m. during the initial tour of the kitchen, the surveyor observed that the cook did not have his facial hair restraint on completely leaving his mustache uncovered while performing food preparation tasks. This observation was confirmed with the cook at the time of the observation.On 3/29/26 during lunch meal tray service the dietary aide was observed preparing the lunch trays with desserts and the plated food without having his facial hair covered. On 3/30/26 during lunch preparation observation the cook was observed having his facial hair restraint that was not on completely leaving his mustache uncovered. The dietary aide did not have a facial hair restraint on leaving his beard and mustache uncovered. On 3/30/26 at 10:49 the surveyor confirmed with the Food Service Director (FSD) that the cook and the dietary aide did not have a facial hair restraint on while performing food handling tasks.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-admission Screening and Resident Review (PASRR) was notified after a resident was admitted with a diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 1 sampled residents reviewed for PASRR (Resident #8 [R8]).Finding:On 3/31/26, R8's clinical record was reviewed. Documentation indicated that R8 was admitted with a PASRR Level I screening that did not include R8's active diagnoses of Post Traumatic Stress Disorder (PTSD) or anxiety disorder. The clinical record lacked evidence that the resident was referred to the State mental health authority for a new PASRR determination.On 3/31/26 at 11:44 a.m., during an interview with a surveyor and the Director of Nursing Services (DNS), R8's medical record and PASRR were reviewed. At this time the surveyor confirmed with the DNS that the clinical record lacked evidence that R8 was resubmitted for a PASRR determination to include R8's active diagnoses of PTSD and anxiety.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a care plan was developed and implemented to address the needs of a resident to minimize triggers that may cause re-traumatization for 1 of 1 resident(s) reviewed for Pre-admission Screening and Resident Review (Resident #8 [R8]).Finding:On 3/31/26, R8's clinical record was reviewed and indicated that R8 was admitted with an active diagnosis of Chronic Post Traumatic Stress Disorder (PTSD). R8's Initial assessment indicated R8 had experienced physical/emotional trauma that is triggered by certain sounds. The clinical record lacked evidence that interventions were put in place to prevent re-traumatization.On 3/31/26 at 11:44 a.m., during an interview with the surveyor and the Director of Nursing Services (DNS), R8's medical record was reviewed. The DNS confirmed with the surveyor that the care plan does not address PTSD to include goals, or interventions to prevent re-traumatization.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interviews, and record reviews, the facility failed to assist a resident with scheduling a follow-up appointment for Eye Care or assist the resident to obtain new eyeglasses when they were lost for 1 of 1 resident(s) reviewed for vision and hearing (Resident #3 [R3]).Findings:On 3/29/26 at 10:53 a.m., during an interview with a surveyor, R3 stated he/she cannot see without his/her glasses, and they have been missing for approximately 3 weeks. R3 stated that nursing staff and the Administrator looked for them, but R3 does not know if there is a plan to find or replace them.On 3/30/26 at 2:21 p.m., during an interview with a surveyor, a Certified Nursing Assistant (CNA) stated R3's glasses have been missing for a while. She stated there was a screw that had come out of one of the hinges and would not go back in. The CNA stated she thought R3 went to the eye doctor recently. The appointment book was reviewed with the CNA. On 2/3/26, R3's Eye Care appointment was crossed off with a note stating Will need to reschedule. Call to reschedule when glasses are found. The book was reviewed for the year ahead and no future appointments were scheduled. The CNA stated that when an item goes missing such as glasses, staff will do a search for the item, then they report it to the charge nurse, and staff will notify family of the missing item.On 3/30/26 at 2:46 p.m., during an interview with a surveyor, the Regional Director of Clinical Operations and the Director of Nursing Services (DNS), R3's medical record and the appointment book were reviewed. At this time a surveyor confirmed the clinical record lacked evidence that the glasses were missing or that R3's family was notified (see F842).On 3/30/26 at 2:56 p.m., during an interview with a surveyor, the Regional Director of Clinical Operations and the Administrator, the grievance book was reviewed. The Administrator stated the glasses went missing on 2/3/26, that they were found at dialysis on 2/5/26, and were reported missing again on 2/6/26. The Administrator stated R3 was going to ask about them at dialysis on 2/9/26. The Administrator confirmed that the facility did not assist the resident in locating the lost eyeglasses (See F585) and did not know if they were missing from the facility or from the dialysis center. At this time the surveyor confirmed that R3's Eye Care appointment was not rescheduled, and the facility did not follow up with the resident to assist with obtaining new eyeglasses after they were lost.

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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, facility policy review, and interview, the facility failed to ensure that staff followed Enhanced Barrier Precautions during a pressure ulcer dressing change for 1 of 1 resident (Resident #32 [R32]).Finding: The facility's policy, Precautions to Prevent Infection, revised 6/24, indicated that Enhanced Barrier Precautions requires gown and glove use for certain residents during specific high-contact resident care activities that included those with indwelling medical devices and/or wounds, even if the resident is not known to be infected or colonized with a Multi-Drug Resistant Organism (MDRO). The high contact care activities list included wound care and dressing change for pressure injuries On 3/29/26, R32's clinical record was reviewed, and indicated on 3/25/26, a Medical Provider observed and documented that R32 had an unstageable pressure ulcer on the spine. On 3/31/26, R32's care plan for the care area of the resident has a pressure injuries mid back was updated to include Enhanced Barrier Precautions and to don (apply) gloves and gown when performing high contact activities which included wound care. On 3/31/26 at 10:46 a.m., a surveyor observed Registered Nurse #1 (RN1) complete a dressing change to R32's spine pressure ulcer. RN1 completed the dressing change but did not wear a gown during the procedure. On 3/31/26 at 11:25 a.m., during an interview with RN1, a surveyor confirmed this finding.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to notify the Ombudsman of transfers/discharge to a hospital for 2 of 3 residents reviewed (Resident #48 [R48] and R58).Findings: 1. On 3/30/26, R48's clinical record was reviewed an indicated that the resident was transferred and admitted to the hospital on [DATE]. 2. On 3/30/26, R58's clinical record was reviewed and indicated that the resident was transferred and admitted to the hospital on [DATE]. On 3/30/26 at 12:22 p.m., during an interview with a surveyor, the Regional Director of Clinical Services stated Ombudsman notifications were not sent for the months of November thru January.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 a resident record contained accurate, complete, and/or readily accessible information for 2 of 22 residents reviewed on survey (Resident #3 [R3], and R10).Findings: 1. On 3/29/26 at 10:53 a.m., during an interview with a surveyor, R3 stated that his/her glasses have been missing for 3 or more weeks, and he/she can't see well without them. No glasses were observed in use or within the room at the time of the interview. On 3/30/26 at 2:15 p.m., during an interview with a surveyor, R3 stated his/her glasses are still missing. R3's roommate stated that they have been missing for more than 3 weeks now. No glasses were observed in use or within the resident's room at the time of the interview. On 3/30/26, review of R3's Certified Nursing Assistants (CNA) documentation indicated that R3's glasses were put on each morning and removed every evening. The clinical record lacked evidence that the glasses were missing. On 3/30/26 at 2:46 p.m., during an interview with a surveyor, the Regional Director of Clinical Operations and the Director of Nursing, R3's medical record was reviewed. At this time, a surveyor confirmed R3's clinical record lacked evidence that the glasses were missing, that the resident representative was notified, and CNA documentation had inaccurate information regarding the R3's glasses. On 3/30/26 at 2:56 p.m., during an interview with the surveyor, the Regional Director of Clinical Operations, and the Administrator, the grievance book was reviewed. The Administrator stated that the glasses were reported missing on 2/6/26. At this time the surveyor confirmed that the clinical record lacked evidence that the glasses were missing, or that the resident representative was notified. 2. On 3/31/26, a clinical record review was completed for R10. In the clinical record a monthly pharmacist recommendation dated 9/28/25 for the diagnosis for the medication Olanzapine (Zyprexa) to be more specific than agitation/increased behaviors The nurse updated the diagnosis on 12/7/25 to behaviors of hitting, punching, kicking, agitation and screaming which are not a diagnosis but rather behaviors. On 3/31/26 at 8:50 a.m. during an interview with the Director of Nursing the surveyor confirmed the above finding. On 3/31/26 at 10:15 a.m. during an interview with the Regional Director of Clinical Operations, she stated the diagnosis for the use of Olanzapine (Zyprexa) was updated to vascular dementia with behaviors by the in-house provider.