STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205139	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainegeneral Rehab & Long Term Care - Glenridge	40 Glenridge Drive 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, observations, interviews, and facility policy, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and failed to ensure that two people who are authorized to administer medications signed the Shift Count page of the Bound Book [a logbook used to record controlled medications], indicating that they counted all controlled substances at the change of shift for multiple shifts, for 3 of 3 units observed (Cove Unit, Gardens Unit, and Valley Unit).Findings:1. Facility Policy Controlled Medication Storage and Administration, revised 07/2024 states, .The count of Schedule II, III, IV, and V substances shall be recorded and signed at the change of each shift. All counting of narcotics/controlled medications will be driven by first verifying what is documented in the bound book. The actual supply of medication on hand will be checked against this written documentation for accuracy and verified by both nursing personnel.On 3/24/26 at 8:15 a.m., during a medication storage observation, the Bound Book and Shift Counts for the Cove Unit medication tech med cart were reviewed and revealed the following:- The person authorized to administer medications coming on duty failed to sign the Shift Count page of the Bound Book that indicated the controlled substances count was done on 3/2/26 at 2:00 p.m. (pg. 292)- The person authorized to administer medications going off duty failed to sign the Shift Count page of the Bound Book that indicated the controlled substances count was done on 3/2/26 at 10:00 p.m.2. On 3/24/26 at 9:00 a.m., during a medication storage observation, the Bound Book and Shift Counts for the Cove unit Long Hall med cart were reviewed and revealed an undated and untimed entry, located on the line below the 3/24/26 6:00 a.m. entry (pg. 299). The Nurse Going Off Duty column was signed by Registered Nurse (RN) # 2, prior to completing the count at the end of her shift with the oncoming nurse.On 3/24/26 at 9:06 a.m., the above findings were discussed with the Cove Unit Manager during an interview. At this time, the Unit Manager stated that it is her expectation that the nurse coming on duty and the nurse going off duty sign the shift count at the time the count is completed, not ahead of time.3. On 3/24/26 at 10:56 a.m., during a medication storage observation, the Bound Book and Shift Counts for the Garden Unit Short Hall med cart were reviewed and revealed the following:- The person authorized to administer medications coming on duty failed to sign the Shift Count page of the Bound Book that indicated the controlled substances count was done on 3/1/26 at 7:00 a.m. (pg. 282)- The person authorized to administer medications going off duty failed to sign the Shift Count page of the Bound Book that indicated the controlled substances count was done on 12/28/25 at 7:00 a.m. (pg. 278) and on 3/1/26 at 7:00 p.m. (pg. 282)- On 12/20/25, 12/21/25, 12/22/25, 12/23/25, 12/24/25, 12/25/25, 12/27/25, 12/28/25, 12/30/25,12/31/25, 2/22/26, 2/25/26, 2/26/26, 2/27/26, 3/1/26, 3/3/26, 3/5/26, and 3/23/26 there are incomplete entries that lack the time and/or the status of count.- An entry dated 3/24/26 and timed for 7:00 p.m. (pg. 284) indicated yes for status of count exact, and the Nurse Going Off Duty column was signed by RN #3. During an interview at this time, RN #3 confirmed that she already signed and indicated that the count was exact, even though she will not perform the count until the end of her shift with the nurse coming on duty. RN #3 then stated that she usually signs the book before the shift count is done because she does not want to get a reminder note saying that she (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	forgot to sign the book.On 3/24/26 at 11:07 a.m. the above findings were discussed with the Gardens Unit Manager.4. On 3/24/26 at 11:30 a.m., during a medication storage observation, the Bound Book and Shift Counts for the Valley Unit medication tech med cart were reviewed and revealed the following:- The person authorized to administer medications coming on duty failed to sign the Shift Count page of the Bound Book that indicated the controlled substances count was done on 2/18/26 at 2:00 p.m. (pg. 273). Additionally, the status of the count was not indicated.- The person authorized to administer medications going off duty failed to sign the Shift Count page of the Bound Book that indicated the controlled substances count was done on 2/18/26 at 8:40 p.m. (pg. 273)Additionally, 3 of 3 shift count books (Long Hall, Short Hall, and Medication Tech) for the Valley Unit revealed that the nurses on duty for 3/24/26 had already signed the Nurse Going Off Duty column prior to completing the count at the end of their shift with the oncoming nurse.On 3/24/26 at 11:51 a.m., the findings were discussed with the Valley Unit Manager. On 3/24/26 at 1:45 p.m., the surveyor discussed the above findings with the Director of Nursing.

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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** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 1 of 3 Units (Cove Unit), a common area and the laundry room for 2 of 2 facility tours. (3/23/26 and 3/26/26) Findings:1. Laundry Room:On 3/23/26 at 8:07 a.m., the surveyor and Environmental Services Manager observed the walls to be missing cove base on many areas around the room. At this time, in an interview with a surveyor, the Environmental Services Manager confirmed the finding. 2. On 3/26/26 from 8:30 a.m. to 9:10 a.m., a surveyor conducted an Environmental tour with the Maintenance Assistant in which the following findings were observed:Common Area:-The bathroom in main entrance lobby area had chipped/missing paint exposing sheetrock above the baseboard heater. The baseboard heater had chipped/missing paint. This created uncleanable surfaces on both areas. 3. Cove Unit:- Resident room [ROOM NUMBER] - The bathroom door frames and walls had chipped/missing paint creating uncleanable surfaces. - Resident room [ROOM NUMBER] - The floor fan was visibly dusty/dirty. The privacy curtain was missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER]- The floor heating unit was visibly dusty/dirty in the bottom grill area. The bathroom ceiling vent was visibly dusty/dirty. - Resident room [ROOM NUMBER] - The bathroom door frames and walls had chipped/missing paint creating uncleanable surfaces.- Resident room [ROOM NUMBER] - The caulking around the base of the toilet was visibly stained and dirty. The bathroom and room doorframes had chipped/missing paint creating uncleanable surfaces. The fall matt had ripped/torn edges creating uncleanable surfaces. The baseboard heater had chipped/missing paint.- Resident room [ROOM NUMBER] - Two fall mats had ripped/torn edges and sides. The caulking around the toilet was visibly stained and dirty. The bathroom doorframes had chipped/missing paint.- Resident room [ROOM NUMBER] - The caulking around the base of the toilet was visibly stained and dirty. The bathroom doorframes had chipped/missing paint.-Resident room [ROOM NUMBER] - There was an unlabeled bed pan and unlabeled graduated cylinder on the back of the toilet which is shared by two rooms. The caulking around the base of the toilet was visibly stained and dirty. - Resident room [ROOM NUMBER] - The bathroom light was not working. The bathroom door frame and walls had chipped/missing paint creating uncleanable surfaces. The caulking around the base of the toilet was visibly stained and dirty. On 3/26/26 at 9:10 a.m., in an interview with a surveyor, the Maintenance Assistant confirmed the findings.

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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 observation and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for an air conditioner, food disposal units, shelving, ceiling vents, a grease trap cover, a fan, and an exit door; failed to ensure foods were labeled and/or dated in the kitchen and walk-in refrigerator; and failed to ensure that kitchen staff members with facial hair wore facial hair protection for 1 of 1 kitchen tour. Findings:The facility's Food Storage policy and procedure, dated 3-22, noted Procedure: 7. B. Food should be dated as it is placed on the shelves . 8. Plastic containers with tight fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated. 13. Refrigerated food storage: f. All foods should be covered, labeled, and dated.On 3/23/26 from 8:15 a.m. to 9:10 a.m., a surveyor and the Food Service Director completed an initial kitchen tour in which the following findings were observed:- Dish room: The wall mounted air conditioning unit was heavily soiled with dust/dirt on the top air intake grill. The wall fan was dusty/dirty. The food disposal unit(#1) had dried food particles and dried liquid residue on it.- The food disposal unit(#2) near a shelving unit had dried food particles and dried liquid residue on it and was rusty on the body and the legs. - The shelving unit, next to food disposal unit(#2), was dirty and had dried liquid residue on it.- Three ceiling vents, over food preparation areas, were dusty/dirty. - The grease trap cover had chipped/missing paint creating an uncleanable surface. - A wall fan was dusty/dirty. - The service entrance/exit door had chipped/missing paint creating an uncleanable surface. - There was a large plastic container of a brown powder type substance that was not labeled and dated.- The walk-in refrigerator had a large bag of a diced product that was not labeled. - There were two kitchen workers with facial hair that were not wearing facial hair protection. On 3/23/26 at 9:10 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interviews, the facility failed to provide residents/representatives with written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 2 of 10 residents reviewed for advanced directives (Resident #12, #72). Findings: 1.Resident 72 was admitted to the facility in 2023. Review of the clinical record lacked evidence that resident's representative had been asked/offered the opportunity to formulate an Advanced Directive. 2 Resident 12 was admitted to the facility in 2024. Review of the clinical record lacked evidence that the resident's representative had been asked/offered the opportunity to formulate an Advanced Directive. During an interview with 4 surveyors on 3/24/26 at 2:45 p.m., Licensed Social Worker (LSW) confirmed the clinical record's did not include evidence that Resident representative's were asked/offered the opportunity to formulate an Advanced Directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record reviews, interviews, and facility policy, the facility failed to notify the physician when a resident received an antibiotic to which the resident had a known allergy, resulting in the need for increased monitoring for 1 of 5 residents reviewed for unnecessary medications (Resident #40).Finding:Facility policy, Clinical Variance Reporting, revised 10/2024 states, A variance report is required when a variance occurs with medication, documentation, or other circumstances considered variances.The nurse manager or designee on the neighborhood/community will ensure that the following are completed.Physician notification.Resident #40 was admitted with diagnoses to include, but not limited to, otitis media.A review of Resident #40's clinical record revealed a physician progress note dated 3/23/26 that states, . [Resident #40] is seen. regarding ear pain . [he/she] has an allergy to amoxicillin so will use cefdinir 300mg BID x 10 days for otitis media .Further review of Resident #40's clinical record revealed the following physician orders:An order for Amoxicillin 875 mg-potassium clavulanate (Augmentin) 125 mg tablet (1) TABLET Oral Two Times Daily for Ten Days Starting 03/23/26.An order for Cefdinir 300 mg capsule (1) CAPSULE Oral Two Times Daily for Ten Days Starting 3/23/26.A review of Resident #40's Medication Administration Record (MAR) indicated that the Augmentin was administered 3/23/26 during the afternoon pass and that the medication was discontinued 3/23/26. A nursing progress note dated 3/23/26 states, Resident seen by PCP [primary care physician] for (L) ear pain. 2 different ABT [antibiotic therapy] orders placed by PCP with verbal to start immediately. Cefdinir not available in Pixis [Pyxis-an automated machine that dispenses medications] but Augmentin was and initial dose given at 1400 [2:00 p.m.]. Just after 1500 [3:00 p.m.], [Pharmacy] called to verify order for Augmentin as resident has an Amoxicillin allergy in history. Resident not presenting with any s/s [signs/symptoms] of allergic reaction. Will continue to monitor for any s/s of a reaction.On 3/25/26 at approximately 3:45 p.m., in the presence of the Director of Nursing (DON), the surveyor conducted a telephone interview with Licensed Practical Nurse (LPN) #1, the nurse on duty at the time of the medication error. LPN #1 stated that an hour after the Medication Tech gave the Augmentin, the pharmacy called her for clarification due to Resident #40's amoxicillin allergy. LPN #1 stated that she then called the physician, and that the physician stated that she had already caught the allergy and had prescribed Cefdinir instead and discontinued the Augmentin. LPN #1 then stated that at the time she spoke to the physician, she was unaware that the Medication Tech had administered the Augmentin, so she did not notify the physician that Resident #40 had received the Augmentin. The surveyor then asked if LPN #1 if she had notified the physician once she became aware that Resident #40 had received the Augmentin, and LPN #1 stated that she did not notify the physician, but that she notified the Cove Unit Manager.On 3/25/26 at approximately 4:00 p.m., after the above interview with LPN #1, the surveyor asked the DON if the physician is now aware that Resident #40 had received Augmentin, and the DON stated that she would reach out to the physician to find out if she was notified. At 4:18 p.m., during a follow-up interview in the presence of 3 surveyors, the DON stated that she contacted the physician and confirmed that the physician was not notified that Resident #40 had received a dose of Augmentin.

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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 reviews, interviews, facility policy, and the facility assessment, the facility failed to ensure a resident's comprehensive care plan was developed and implemented to reflect the current needs of the resident for 2 of 27 residents reviewed for care planning (Residents #9, #40). The facility's Medication Management Policy #LTCMM-11, revised 7/24 noted IV: Procedure: A. Psychopharmacological Medication use: 9. The care plan will be developed/updated as appropriate including goals of therapy and evaluation of progress towards goals. The Facility assessment dated 2025 noted: Part 3:Services and Care Based on Residents Needs:1 Types of care that resident populations require and types of care that are provided at Glen Ridge. General care: medications - Specific Care or Practices: Awareness of any limitations of administering medications, administration of medications that residents need by route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc., assessment/management of polypharmacy 1. Resident #9 was admitted in August 2025 with diagnoses to include Alzheimer's disease, Suicidal ideations, Delusional disorders, Adjustment disorder with mixed anxiety and depressed mood, Unspecified mood [affective] disorder and Bipolar disorder. Review of Resident #9 's clinical record revealed a doctor's orders that stated – 9/3/2025 Active (Current) QUEtiapine 25 mg(milligram) tablet 1 Time Daily 25 mg Route: Oral BIPOLAR DISORDER, CURRENT EPISODE MIXED, UNSPECIFIED Start Date: 09/03/2025 2:33 pm(evening) No Specific # 1 X Daily Scheduled First scheduled time is 9/3/2025 on the Night Pass time period. X's 90 days. Further review of Resident #9's clinical record reveals that Resident #9's current care plan was not developed and initiated for the use of an antipsychotic medication. On 3/26/26 at 10:08 a.m., in an interview with a surveyor, the Cove Unit Nurse Manager confirmed that Resident #9's current care plan was not developed and initiated for the use of an antipsychotic medication. 2. Resident #40 was admitted with diagnoses to include, but not limited to chronic pain and adjustment disorder with mixed anxiety and depressed mood. A review of Resident #40's clinical record revealed the following active physician orders: An order for Sertraline 50 MG (milligram) tablet 1 Time Daily for depression An order for methadone 5 MG tablet, 0.5 tablet 1 Time Daily for chronic pain An order for oxycodone 5 MG tablet PRN [as needed] 2 Times Daily for chronic pain An order for Renew Narcotics Every 30 Days A review of Resident #40's care plan lacked evidence that goals and interventions were developed and implemented for chronic pain and for the use of the antidepressant, including side effect monitoring. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/26 at 10:59 a.m. during an interview, the surveyor discussed the above finding with the Director of Nursing (DON) and the Gardens Unit Manager. At this time, the DON and the Gardens Unit Manager reviewed Resident #40's care plan and confirmed that it had not been developed and implemented for chronic pain or for the use of the antidepressant.

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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. Based on observations and interviews, the facility failed to ensure that the resident's environment was free of accident hazards by ensuring doors had wood and/or protective covering that was not gouged/splintered and/or broken creating sharp edges on 1 of 3 units(Cove Unit) and a common area for 2 of 2 environmental observations on 1 of 4 days of survey. (3/23/26)Findings:Cove Unit:1. On 3/23/26 at 10:15 a.m., a surveyor observed the small sitting room door that had a broken door protector covering that was sticking out and sharp, creating a hazardous and unsafe environment.On 3/23/26 at 10:17 a.m., in an observation and interview with a surveyor, a Licensed Practical Nurse confirmed the finding. On 3/23/26 10:27 a.m., in an interview, a surveyor discussed the finding with the Administrator. 2. On 3/23/26 10:27 a.m., a surveyor and the Administrator observed the left wooden double door in the lobby area headed to the units had a gouge/chunk missing exposing untreated wood and sharp edges, creating a hazardous and unsafe environment. At this time, in an interview with a surveyor, the Administrator confirmed the finding.

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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. Based on observations, record review, interviews, and facility policy, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 2 residents reviewed for respiratory care (Residents #11, #82).Findings:Facility policy Obtaining and Use of Oxygen Devices, revised 7/2025 states, .Cleaning/changing of oxygen equipment. nasal cannula (nosepiece) should be detached and discarded once per week.Concentrator-particle filter on concentrator should be removed and cleaned weekly.1.On 3/23/26 at 10:43 a.m. and 3/24/26 at 2:01 p.m., a surveyor observed Resident #27's undated nasal cannula oxygen tubing connected to an oxygen concentrator next to his/her bed. The tubing was stored unbagged on top of the concentrator.On 3/25/26 at 8:29 a.m., a surveyor observed Resident #11 sleeping in bed, wearing oxygen via nasal cannula tubing.A review of Resident #11's clinical record revealed the following active physician orders:An order with a start date of 1/26/26 for Oxygen (O2) at 2L/min [liters per minute] per nasal cannula PRN [as needed]. For dyspnea [shortness of breath] or respiratory distress and comfort.An order with a start date of 1/26/26 for Change Oxygen Tubing PRN 1 Time Weekly. when in use.Review of Resident #11's March 20206 Treatment Administration Record indicated that Resident #11 received oxygen on 3/14/26 and lacked evidence that the oxygen tubing is being changed, or that the concentrator particle filter is being cleaned. On 3/25/26 at 9:09 a.m. during an interview, Registered Nurse (RN) #1 stated that oxygen tubing is stored in a plastic drawstring bag when not in use and that tubing is dated and labeled when it is changed, but that she is not sure how often it is changed. At this time, the surveyor discussed the above observations with RN #1.2. On 3/25/26 at 9:40 a.m. a surveyor and RN #1 observed Resident #82's unbagged nasal cannula tubing, dated 3/24/26, connected to a portable oxygen tank secured to the back of his/her wheelchair, and the nasal cannula prongs were in direct contact with the wheelchair seat cushion. Additional nasal cannula oxygen tubing was connected to Resident #82's oxygen concentrator, located next to his/her bed, and the unbagged oxygen tubing was tucked under the blankets on his/her bed. During an interview this time, RN #1 stated that Resident #82 wears oxygen intermittently throughout the day.On 3/25/26 at 10:00 a.m. the surveyor discussed the above findings with the Director of Nursing (DON) during an interview. At this time, the DON stated that oxygen tubing is changed weekly and is stored in plastic bags when not in use.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record reviews and interviews, the facility failed to ensure a resident was free from a significant medication error when an antibiotic to which the resident had a known allergy was prescribed and administered for 1 of 5 residents reviewed for unnecessary medications (Resident #40).Finding:Resident #40 was admitted with diagnoses to include, but not limited to, otitis media.A review of Resident #40's clinical record revealed a physician progress note dated 3/23/26 that states, . [Resident #40] is seen. regarding ear pain - on exam [he/she] says [his/her] left ear hurts. [he/she] also had a fever over the weekend. [he/she] has an allergy to amoxicillin so will use cefdinir 300mg BID x 10 days for otitis media .Further review of Resident #40's clinical record revealed the following physician orders:An order for Amoxicillin 875 mg-potassium clavulanate [Augmentin] 125 mg tablet (1) TABLET Oral Two Times Daily for Ten Days Starting 03/23/26.An order for Cefdinir 300 mg capsule (1) CAPSULE Oral Two Times Daily for Ten Days Starting 3/23/26.A review of Resident #40's Medication Administration Record (MAR) indicated that the Augmentin was administered 3/23/26 during the afternoon pass and that the medication was discontinued 3/23/26. Further review of the MAR revealed that the Cefdinir was administered starting 3/23/26 during the night pass. A nursing progress note dated 3/23/26 states, Resident seen by PCP [primary care physician] for (L) ear pain. 2 different ABT [antibiotic therapy] orders placed by PCP with verbal to start immediately. Cefdinir not available in Pixis [Pyxis-an automated machine that dispenses medications] but Augmentin was and initial dose given at 1400 [2:00 p.m.]. Just after 1500 [3:00 p.m.], [Pharmacy] called to verify order for Augmentin as resident has an Amoxicillin allergy in history. Resident not presenting with any s/s [signs/symptoms] of allergic reaction. Will continue to monitor for any s/s of a reaction.On 3/25/26 at 3:13 p.m. during an interview, the surveyor discussed the above finding with the Cove Unit Manager. At this time, the Cove Unit Manager stated that she thinks the physician initially ordered Augmentin and then realized that Resident #40 has an amoxicillin allergy, so she ordered Cefdinir instead. The Cove Unit Manager then stated that the Pyxis does not alert if a resident has an allergy to a medication, so the nurse can pull any medication for any resident and that this has been identified as an issue by the facility previously.On 3/25/26 at 3:27 p.m. during an interview, the surveyor discussed the above finding with the Director of Nursing (DON). At this time, the Director of Nursing reviewed Resident #40's entire clinical record and confirmed that he/she received the Augmentin on 3/23/26 at 2:40 p.m. At approximately 3:45 p.m., the surveyor conducted a telephone interview with Licensed Practical Nurse (LPN) #1 in the presence of the DON. LPN #1 stated that when she saw the orders for two different antibiotics, she was surprised but that she did not think to clarify the orders and thought that Resident #40 must have had a bad infection. LPN #1 then stated that an hour after the Medication Tech had given the Augmentin, the pharmacy called her for clarification due to Resident #40's amoxicillin allergy. LPN #1 stated that she then called the physician, and that the physician stated that she had already caught the allergy and had prescribed Cefdinir instead and discontinued the Augmentin. LPN #1 then stated that at the time she spoke to the physician, the Augmentin order had not actually been discontinued, and that she notified the pharmacy of the clarified order and notified the Cove Unit Manager that Resident #40 received the Augmentin, and that Resident #40 was placed on close monitoring and a medication variance was entered in his/her clinical record.On 3/25/26 at approximately 4:00 p.m. during a follow-up interview, the DON stated that LPN #1 should have clarified the antibiotic order when she noticed two antibiotics had been ordered. The DON then stated that there are no individual resident profiles in the Pyxis system, so there is no way to alert nursing staff of a medication allergy, and that the facility has discussed this with the pharmacy before but there has been no resolution to the identified issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205139	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainegeneral Rehab & Long Term Care - Glenridge	40 Glenridge Drive 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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain a garbage storage area and in a sanitary condition to prevent the harborage and feeding of pests for 1 of 2 trash dumpsters for 2 of 4 days of survey. (3/23/26 and 3/24/26)Findings:1. On 3/23/26 at 8:15 a.m., a surveyor observed the small garbage/refuse dumpster to have the left-side slide door open and the right-side slide door missing, exposing garbage/refuse.2. On 3/24/26 at 8:07 a.m., the surveyor and a laundry staff observed the small garbage/refuse dumpster to have the left side slide door open and the right-side slide door missing, exposing garbage/refuse. At this time, the laundry staff confirmed the findings. On 3/24/2026 at 8:10 a.m., in an interview, the surveyor discussed the two findings with the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 interviews, the facility failed to ensure written bed hold and transfer/discharge notices were provided in writing to the resident and/or their legal representative for a facility-initiated transfer/discharge for 4 of 4 sampled residents transferred/discharged to an acute care facility (Residents #5, #17, #56, #86). Findings: 1.Documentation in Resident #5's clinical record indicated that he/she was transferred to an acute hospital on [DATE]. The clinical record lacked evidence that the facility issued a written transfer/discharge and bed hold notices to the resident's representative. 2. Documentation in Resident #56's clinical record indicated that he/she was transferred to an acute hospital on [DATE]. The clinical record lacked evidence that the facility issued a written transfer/discharge notice and bed hold notice to the resident's representative. 3. Documentation in Resident 86's clinical record revealed he/she was transferred to and acute care hospital and subsequently admitted o 2/21/26. The clinical record revealed Notice of Transfer or Discharge/Bed Hold Policy dated 2/21/26. The clinical record lacks evidence the notice with provided to the resident representative in writing. 4. Documentation in Resident 17's clinical record indicated that he/she was transferred to an acute hospital on [DATE]. The clinical record lacked evidence that the facility issued a written transfer/discharge notice and bed hold notice to the resident's representative. On 3/25/26 at 10:25 a.m., in an interview with a surveyor, the Social Service Manager confirmed the facility does not send transfer/discharge notices and bed hold notices in writing to the resident representatives. On 3/25/26 at 11:40 a.m., with four surveyors present, a Licensed Social Worker(LSW) confirmed that a packet containing a transfer/discharge notice and bed hold notice goes with the resident and the Ombudsman is notified. A transfer/discharge notice and bed hold notice are not sent in writing to the resident representatives.