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AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE AUGUSTA, ME 04330

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F 000	INITIAL COMMENTS From 7/31/23 through 8/3/23, on-site visits were conducted at Augusta Center for Health & Rehabilitation for the purpose of conducting the annual Long Term Care Survey Process. It was determined that Augusta Center for Health & Rehabilitation was not in substantial compliance with 42 CFR 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/24/2023

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of facility policy, the facility staff failed to notify Resident (R)22's physician when the resident continued to need an oral antihistamine medication for itching for one of one sampled residents reviewed for notification of change. Findings include: Review of R22's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 01/27/22. Review of R22's Significant Change in status "Minimum Data Set (MDS)," located in the "MDS"	F 580		

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tab of the EMR with an Assessment Reference Date (ARD) of 06/06/23, revealed R22's "Brief Interview for Mental Status (BIMS)" score was 12 out of 15 indicating moderate cognitive impairment.

Review of the "Progress Notes" under the "Progress Notes" tab in the EMR revealed the following entry:

06/02/23 at 4:22 PM: "Heat rash like scattered red bumps noted to extend up throughout pt's [R22's] mid to upper back. Notified NP [Nurse Practitioner] to see if cream can be ordered. Rec'd [received] VO's [verbal order] stating to apply barrier cream BID [two times per day] and NP will see first thing Mon [Monday] AM."

Review of the June 2023 "Medication Administration Record (MAR)" located under the "Orders" tab in the EMR revealed the resident had an order dated 06/04/23 for Benadryl Allergy Oral Tablet 25 milligrams (mg), by mouth every six hours as needed [PRN] for rash related to itchy skin. Further review of the "MAR" revealed that the resident received Benadryl PRN from 06/04/23 through 06/14/23. After 06/14/23, Benadryl was not administered for the remainder of June 2023.

Review of the "Progress Notes" under the "Progress Notes" tab of the EMR revealed the following entries:

06/21/23 at 12:00 PM: "Weekly Skin Check. Note Text: No new notable skin issues observed."

06/28/23 at 1:21 PM: "Weekly Skin Check. Note Text: No new notable skin issues observed."

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F 580	Continued From page 3 07/05/23 at 8:44 AM: "Weekly Skin Check. Late Entry: Note Text: Yes a new notable skin issue was observed rash in between thighs." 07/10/23 at 11:36 PM: "Resident noted to have red rash on left chest and left torso. C/O [complained of] it itching. Received PRN Benadryl 25 mg with good effect." Review of the July 2023 "MAR" located under the "Orders" tab of the EMR revealed that between 07/04/23 through 07/31/23, R22 received 16 doses of Benadryl. There was no evidence the resident's physician was made aware of the resident's new rash between her thighs, left chest and left torso. During an interview with R22 on 07/31/23 at 2:06 PM, the resident revealed she had itchy skin and believed it may have been attributed to antibiotics she received during and after a hospitalization for sepsis. On 08/02/23 at 3:32 PM Registered Nurse (RN)1 was interviewed. RN1 stated that R22 complained of itching mostly on her back and under her arms, and the itching had been a new complaint for about the last two to three weeks. RN1 stated she had mentioned R22's complaint of itching to the provider, and that she was going to mention it again. RN1 stated R22 had been taking Benadryl almost every night. RN1 stated that "it was on my to do list" and "I was going to write up a Situation, Background, Assessment, and Recommendation (SBAR) today." Interview of the Regional Nurse Consultant (RNC) on 08/03/23 at 10:45 AM revealed that she	F 580		

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F 580	Continued From page 4 would rather there have been a duration for the administration of Benadryl for R22, followed up by a reassessment of the resident's skin condition. RNC further stated that the on-call provider had prescribed Benadryl and there should have been communication with R22's provider for the ongoing use of Benadryl and there was not. Review of the facility's "Clinical Services" policy and procedure for "Change of Condition Notification" dated 04/2001 and revised 04/2023 revealed, "The facility must inform the resident, consult with the resident's healthcare provider, and if known, notify the resident's legal representative or family member when there is: A need to alter treatment significantly (i.e., discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)."	F 580		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to transfer a resident timely to the hospital after the resident experienced a significant change in condition for one resident (Resident (R)22) of six sampled	F 684		

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residents reviewed for hospitalization. This resulted in harm when R22 was admitted to the hospital's Critical Care Unit (CCU) with a diagnosis of acute metabolic encephalopathy likely secondary to sepsis and urinary tract infection (UTI) and acute kidney injury likely prerenal in the setting of septic shock.

Findings include:

Review of R22's electronic "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 01/27/22 with diagnoses including hypothyroidism, hypertension (high blood pressure), chronic atrial fibrillation and hyperlipidemia.

Review of R22's Significant Change in status "Minimum Data Set (MDS)," located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 06/06/23, revealed R22's "Brief Interview for Mental Status (BIMS)" score was 12 out of 15 indicating moderate cognitive impairment.

Review of the May 2023 Certified Nursing Assistant (CNA) documentation located in the EMR under "Clinical - Reports - Documentation Survey Report" revealed that R22 had refused breakfast, lunch, and dinner on 05/20/23.

Review of R22's "Progress Notes" located under the "Progress Notes" tab in the EMR revealed the following entries were documented by Licensed Practical Nurse (LPN) 2:

05/20/23 at 11:23 PM: "Received report from evening nurse that resident was not feeling good

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all day and was unable to eat or drink all day. This reporter went to assess resident after shift report. I observed resident to have pallor, dry mucous membranes, and was unable to get resident to respond. Resident's pupils were reactive to light but was unable to squeeze my hands. Resident's right side warm to touch, left side is cold to touch. V/S (vital signs) = 100.0 [degrees Fahrenheit (F)]-106 [pulse]-36 [respirations]-107/69 [blood pressure]-87% O2 [oxygen saturation] on RA [room air]. Mouth care given to resident to stimulate thirst reflex. Tylenol supp [suppository] 650 mg [milligrams] given due to resident not being able to take P.O. [by mouth] Tylenol."

05/20/23 at 11:36 PM: "Addendum to last note: Call place to (name of provider) Answering Service."

05/21/23 at 1:41 AM: "Assessed resident again, v/s= 98.6 [degrees F]-108 [pulse]-28-[respirations] 81/50 [B/P], 93% 02. Resident now showing facial droop to right side, with tongue also deviating to right side. 2nd call placed to (name of provider) answering service to update latest assessment data."

05/21/23 at 3:08 AM: "Spoke with resident's son [name], updated him about resident. Son wants resident transferred to ER [emergency room] to be evaluated."

05/21/23 at 3:26 AM: "resident picked up by [name of ambulance service] at 0327 [3:27 AM]."

05/21/23 at 8:58 AM: "Spoke with [name of hospital] ED [emergency department]. Admitted to CCU [Critical Care Unit] with ? urosepsis [when

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a UTI becomes a life-threatening response to an infection requiring prompt treatment]. Family is present in the ED."

Review of R22's hospital "History and Physical" located under the "Miscellaneous" tab in the EMR, revealed on 05/21/23, R22 presented to the hospital emergency room unresponsive with a low-grade temperature of 100.2 F, was tachycardic with a heart rate of 135, and hypotensive (low blood pressure). The resident was admitted to the CCU with acute metabolic encephalopathy likely secondary to sepsis and urinary tract infection and acute kidney injury likely prerenal in the setting of septic shock. R22 was treated in the hospital with intravenous (IV) fluids and IV antibiotics. The resident was readmitted to the facility on 05/31/23.

Interview with Licensed Practical Nurse (LPN)1 on 08/02/23 at 12:52 PM confirmed she was assigned to the care of R22 on 05/20/23 on the evening shift. LPN1 revealed R22 "was more tired than usual." When asked if she performed a nursing assessment, LPN1 stated she was not allowed to do an assessment because she is an LPN, not a Registered Nurse (RN). LPN1 did not recall giving report to the oncoming nurse, LPN2.

Interview with LPN2 on 08/02/23 at 3:43 PM confirmed he was the nurse assigned to the care of R22 during the night shift of 05/21/23 and he was nervous about transferring R22 to the hospital without having a physician's order. LPN2 stated that the resident's son was called after a second attempt to contact the provider was unsuccessful. LPN2 stated he felt like the resident needed to be sent to the hospital sooner rather than later. LPN2 stated that in an urgent

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situation he would call the supervisor for guidance but could not recall if he had called the on-call supervisor, and that his gut was telling him to send the resident out sooner, but he was trying to follow the chain of command.

Interview with the Regional Nurse Consultant (RNC) on 08/03/23 at 10:45 AM confirmed that two telephone calls were placed to the provider answering service one on 05/20/23 at 11:23 PM and on 05/21/23 at 1:41 AM. R22's son was notified of the resident's change in condition on 05/21/23 at 3:08 AM and the resident was transferred to the hospital at 3:27 AM. The RNC confirmed that the on-call physician did not respond to the notification because it was texted to her. The RNC stated that the expectation would be for the nurse to reach out to the on-call nursing supervisor for further direction and as a last resort, the Medical Director.

Review of the facility's "Clinical Services" policy and procedure for "Change of Condition Notification" dated 04/2001 and revised 04/2023 revealed that "if the attending physician does not return the phone call in a timely manner, the Nurse Manager/Supervisor/Designee will contact the Medical Director; repeated attempts will be made to reach the attending physician and/or Medical Director and family until successful; and, in the event of an emergency, the licensed nurse can transfer the resident to the hospital via 911."

Review of the infectious disease consult dated 05/24/23, located under the "Miscellaneous" tab of the EMR revealed "Impression: 1. Complicated urinary tract infection with septic shock: Blood cultures growing out E coli, Proteus mirabilis and Enterococcus faecalis (ampicillin

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F 684	Continued From page 9 susceptible) in multiple bottles and urine culture also growing out greater than 100,000 colonies gram-negative rods x2. Repeat blood cultures May 23rd currently are pending. TTE [transthoracic echocardiogram] shows no evidence of vegetation. Currently, the patient is on broad-spectrum coverage with IV vancomycin and meropenem. 2. Polymicrobial bacteremia. 3. Acute toxic metabolic encephalopathy. 4. Acute kidney injury. 5. Lactic acidosis. 6. Atrial fibrillation. 7. Hypercalcemia. 8. Leukocytosis. 9. Thrombocytopenia. 10. Hypokalemia. 11. Hypertension. 12. Hypothyroidism."	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and review of facility policy, the facility failed to ensure respiratory equipment was cleaned, stored appropriately, and failed to administer oxygen as ordered by the physician for three residents (Resident (R) 51, R270 and R40) of three sampled residents reviewed for respiratory care. Findings include:	F 695		

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1. Review of R51's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 04/19/21.

Review of R51's annual "Minimum Data Set (MDS)," located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 06/01/23, revealed R51's "Brief Interview for Mental Status (BIMS)" was not conducted due to R51 had moderate cognitive impairment and was rarely/never understood. The "MDS" revealed R51 had diagnoses that included chronic obstructive pulmonary disease (COPD) and heart failure.

Review of R51's "Care Plan" dated 04/26/21 and revised on 07/06/22 located in the "Care Plan" tab of the EMR revealed R51 had a "Care Plan" for altered respiratory status/difficulty breathing related to a history of COPD, acute respiratory failure, and congestive heart failure. Interventions include administering medications/puffers as ordered.

Review of R51's "Physicians Orders," located in the "Orders" tab of the EMR revealed R51 had an order dated, 06/05/23 for Albuterol Sulfate Nebulizer Solution (2.5 mg/3ml) 0.083%, 1 vial inhale orally via nebulizer every 4 hours as need (PRN) for shortness of breath (SOB), cough, or wheezing lung sounds.

Review of R51's July 2023 "Treatment Administration Record (TAR)" located under the "Orders" tab of the EMR revealed an entry for oxygen tubing change as needed every Sunday when O2 (oxygen) in use. There was not an entry for nebulizer equipment change, cleaning or

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storage.

During observation of R51's room on 07/31/23 at 11:23 AM an uncovered nebulizer mask and medication container were on the nightstand with a hair accessory with hair on it inside of the nebulizer mask.

During observation of R51's room on 08/01/23 at 9:00 AM and 1:14 PM, an uncovered nebulizer mask and medication container were observed on the nightstand on a paper towel.

During an interview with the Assistant Director of Nursing (ADON) on 08/01/23 at 2:00 PM, the ADON stated that nebulizer equipment should be stored in a bag after cleaning and drying. The ADON accompanied the surveyor to R51's room and confirmed that R51's nebulizer equipment was not properly stored.

2.Review of R270's "Admission Record," located in the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 05/19/23.

Review of R270's electronic annual "MDS," located in the "MDS" tab of the EMR with an ARD of 06/01/23, revealed R270's "BIMS" score was 11 out of 15 indicating moderate cognitive impairment. The "MDS" revealed R270 had diagnoses that included acute and chronic respiratory failure, oxygen dependence and heart failure.

Review of R270's "Physician Orders," located in the "Orders" tab of the EMR, revealed R51 had an order dated 07/25/23 for Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/ml) 0.083% 3 ml inhale orally via nebulizer 4 times a

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day for COPD and oxygen 2 liters per minute (lpm) continuously via nasal cannula every shift for shortness of breath.

Review of R270's July 2023 "TAR" located in the "Orders" tab of the EMR revealed an entry to clean the concentrator filter every night shift every Sunday for prophylaxis infection control. There was no entry for the care and maintenance of nebulizer equipment.

During observation and interview on 07/31/23 at 9:35 AM, R270 was sitting in a wheelchair in her room. R270 was receiving 1.5 lpm of oxygen via nasal canula. An uncovered nebulizer equipment was observed on the resident's dresser. The resident revealed that she was supposed to receive 2 lpm of oxygen.

During observation on 07/31/23 at 3:00 PM, R270 was sitting in the wheelchair in her room and was receiving 1.5 lpm of oxygen via nasal canula. An uncovered nebulizer equipment was observed on the resident's dresser.

During observation on 08/01/23 at 9:26 AM, R270 was sitting in the wheelchair in her room and was receiving 1.0 lpm of oxygen via nasal canula. An uncovered nebulizer equipment was observed on the resident's dresser.

During an interview with Registered Nurse (RN) 2 on 08/01/23 at 1:49 PM revealed that after nebulizer treatments are administered, nebulizer equipment is cleaned with soap and water and put on a paper towel to dry. RN2 stated that she believed tubing was changed on Saturday or Sunday. RN2 was asked about R270's physician's order for oxygen administration. RN2

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	205077	A. BUILDING _____ B. WING _____	08/03/2023

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F 695	Continued From page 13	F 695		

confirmed that R270 had an order for oxygen 2 lpm. RN2 accompanied surveyor to R270's room and confirmed that resident was not receiving oxygen at 2 lpm as ordered.

3. Review of R40's "Admission Record," located in the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 12/09/17.

Review of R40's admission "MDS," located in the "MDS" tab of the EMR with an ARD of 05/16/23, revealed R40 has a BIMS score of 12 out of 15 indicating moderate cognitive impairment. The "MDS" revealed R40 had diagnoses that include COPD and heart failure.

Review of R40's "Physician Orders," located in the "Orders" tab of the EMR, revealed R40 had an order dated 5/15/23 for oxygen 2 lpm, continuously.

During observation of R40 in the resident's room on 07/31/23 at 11:19 AM and 08/01/23 at 9:24 AM, revealed the resident was receiving oxygen via nasal cannula. The filter located on the back of the oxygen concentrator was coated with a thick layer of dust.

Review of R40's July 2023 "TAR" located under the "Orders" tab of the EMR revealed that there is not an entry to change oxygen tubing or clean the oxygen concentrator filter.

On 08/01/23 at 2:04 PM, the ADON accompanied the surveyor to R40's room and after observation, confirmed that the oxygen concentrator filter was soiled and in need of cleaning.

During interview with the Regional Nurse

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F 695	Continued From page 14 Consultant (RNC) and the ADON on 08/01/23 at 2:00 PM, the RNC stated that "facility staff change oxygen and nebulizer tubing and equipment weekly, and documentation is placed on the "TAR" to prompt staff to change oxygen tubing and nebulizer equipment. The RNC further stated staff are expected to document in the "TAR." The ADON stated, "oxygen filters should be cleaned weekly and nebulizer equipment should be stored in a plastic bag after washing and drying." Review of the Clinical Services policy titled, "Oxygen Concentrator Maintenance" dated 08/2014 and revised on 04/2023 revealed, the "Procedure" included: "External filters are to be either cleaned or replaced weekly with the oxygen tubing change."	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

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F 812	Continued From page 15 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to keep the kitchen's ovens, knife rack, food preparation pans, and insulated plate holders clean and/or dry, and failed to keep a scoop from being stored in direct contact with flour that was in a storage container. This had the potential to affect all 71 residents who resided in the facility and consumed food prepared from the facility's kitchen. Findings include: Review of the facility's policy entitled, "Sanitation of Kitchen, Food Service Equipment & Work Surfaces," revised on 02/22, revealed, "Foodservice equipment and surfaces (stationary and mobile) are cleaned. Food contact surfaces of stationary foodservice equipment and work surfaces are cleaned and sanitized to minimize the risk of pathogen and chemical food contamination." Review of the facility's policy entitled, "Storage of Food & Supplies," revised on 02/22, revealed, "Policy Food, non-food, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption as outlined in the Federal Drug Administration Food Code, state regulations, and city/county health codes" . . . 9) Scoops should not be stored in ingredient bins or containers. Store in a clean space where the scoop (food contact surface) cannot be contaminated by touch."	F 812		

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F 812	Continued From page 16	F 812		

Review of the facility's policy entitled, "Dishwashing- Dish machine," revised on 01/22, revealed, "Clean Dishes" . . . "25. Stack like items together, e.g., plates, bowls, trays, etc., in the appropriate storage location. Dishes should be dry when stored or stored in a manner that allows air to circulate and air drying to continue."

1. Observation on 07/31/23 from 9:00 AM to 9:20 AM during the initial kitchen inspection, with the Dietary Manager (DM) present, revealed the following:

a. The kitchen's two convection ovens were unclean with heavy accumulated blackened and dried food spills on their interior cooking compartment and on the inside of their doors.

b. The kitchen's wall mounted knife rack, with knives stored inside, had dust and loose food debris on the top where knives were inserted into the rack.

c. Observation of food preparation pans, stored as clean, revealed one pan had food debris and moisture on its inner surface, two pans had moisture on their inner and outer surfaces, and one pan had a heavy greasy residue on its outer surface.

d. Observation of a large storage container revealed flour and a scoop were stored inside. The scoop was in direct contact with the flour and the scoop's handle was embedded in the flour.

e. Observation of 10 insulated plate holders, stored as clean on the kitchen's tray line area, revealed they were stacked directly on top of

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F 812	Continued From page 17 each other and all 10 were stored wet with accumulated moisture on the inner and outer surfaces. Interview with the DM, during the initial kitchen inspection on 07/31/23 from 9:00 AM to 9:20 AM, the DM confirmed the kitchen's ovens, knife rack, food preparation pans and insulated plate holders were unclean and/or stored wet and a scoop was stored in direct contact with flour stored in a bin. The DM stated food preparation and service equipment should be kept clean and dry, and a scoop should not be stored in direct contact with flour in a storage container.	F 812		