STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205077	A. BUILDING _____ B. WING _____	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE AUGUSTA, ME 04330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 11/17/24 through 11/20/24, on-site visits were conducted at Augusta Center for Health and Rehabilitation for the purpose of completing a Special Focus Facility Long Term Care Survey Process for Federal Recertification, facility reported incidents #ME00049548, #ME00049486, #ME00049385, #ME00049324, #ME00049323, #ME00049289, #ME00048761, #ME00047723, and complaints #ME00049478, #ME00048965, #ME00048745, and #ME00048741. It was determined that Augusta Center for Health and Rehabilitation was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley [illegible] | TITLE: Administrator | (X6) DATE: 12-12-24

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.

Augusta
Center for Health & Rehabilitation, LLC

December 5th, 2024

Plan of Correction for State Survey Conducted November 20th, 2024

F550

Residents affected by the deficient practice received reassurance that the practice has been amended.

Nursing department received two-fold in-service education regarding dignity. First in-service provided education that resident incontinence care takes priority over mealtime routines. Second education demonstrated effective rounding practices to help ensure that resident needs are met proactively. In addition, education regarding proactive care and care provisions during mealtimes has been added to general orientation for staff.

Nursing leadership will randomly audit provision of incontinence care during mealtimes to ensure dignity until 100% compliance has been met for a period of 3 months. Updates will be provided to the QAPI committee monthly.

Compliance by 01/02/2025

F584

Dust and debris were cleared from hallway and resident room/bathroom vents immediately upon discovery. A complete audit of vents was completed by Administrator and Director of Maintenance to ensure that no other vents were affected.

Resident #8's wheelchair armrests were repaired immediately upon discovery. A complete audit of wheelchair armrests was completed to ensure that no other residents were affected.

Bathroom floors and toilets throughout the facility were inspected to ensure that no others were affected. The urine collection cup was disposed of immediately upon discovery. The stained ceiling tile was repaired.

Toilet arm rails were found to be inhibiting the ability to thoroughly clean under and around the rails. Rails will be audited and removed where appropriate. Needed rails will be replaced with an alternative that allows for more thorough cleaning in the bathroom.

Soiled bathrooms floors were cleaned immediately upon discovery. Caulking around toilets and doors will be replaced or removed by the maintenance team.

Ceiling vents with rust will be repaired by the maintenance team.

Housekeeping is completing a deep clean for "room of the day" each day, and supervisor is conducting random audits for cleanliness of bathroom floors, doors, trim, toilets, and debris on bathroom floors. Maintenance team is completing "room of the day" inspections for physical plant compliance and is conducting random audits for cleanliness of vents, rust, and caulking and is randomly auditing wheelchair arm rests for breakdown and replacing/repairing as necessary. Maintenance Director and Housekeeping Supervisor will report their findings to QAPI committee monthly until 100% compliance has been achieved for a period of 3 months. Environmental Rounds Committee will complete monthly environmental rounds ongoing to ensure continued compliance.

Compliance by 01/02/2025

F684

Resident 27 was immediately reviewed for any adverse effects related to not receiving neuro checks with no discernible deviation from baseline noted.

House-wide audits began immediately to ensure that residents that fall receive timely neuro checks, per policy.

Nurses across 3 shifts received education regarding fall protocol and procedure. A new binder and checklist was created with the procedure for witnessed and unwitnessed falls, as well as documentation related to neuro checks.

Nursing leadership will continue to randomly audit to ensure neuro check completion and report findings to the QAPI committee until 100% compliance has been met for a period of three months.

Compliance by 01/02/2025

F689

Administrator immediately apologized to Resident 35 for interrupting her meal and removed the non-adherent cup from her.

Resident was immediately provided her drink in the correct cup to prevent/mitigate spills.

Therapy and Nursing Departments completed a house-wide audit to ensure that no other residents were affected. Nursing Department revised adaptive equipment procedure in collaboration with the Therapy and Dietary Departments.

A list of updated adaptive equipment is now available on each of the three units and the dining room. Nursing Department received in-service education on how to find and utilize this equipment.

Nursing Leadership is randomly auditing provision of adaptive equipment and will report findings monthly at QAPI committee until 100% compliance has been reached for a period of 3 months.

Compliance by 01/02/2025

F695

Resident #7 was immediately connected to a concentrator when it was discovered that his oxygen tank was empty.

Provider was immediately contacted regarding Resident #7's oxygen parameters following the discovery, to maintain his O2 saturation baseline.

Nurses received education on following medical parameters ordered for oxygen and acknowledged understanding that the physician must be contacted if the O2 parameters are insufficient or there is clinical indication of a change in patient condition. Nursing staff also received education regarding frequency of monitoring O2 tanks for sufficient supply of oxygen.

The Director of Nursing completed an immediate audit of individuals on oxygen, to ensure that anyone utilizing oxygen was within the prescribed parameters and that the tanks they were utilizing had sufficient oxygen supply in them.

Nursing Leadership team is randomly auditing to ensure that respiratory services are provided according to physician orders and will report monthly at QAPI until 100% compliance is reached for a period of three months.

Compliance by 01/02/2024

F 761

The expired inhalers were immediately removed from the medication carts upon discovery.

Inhalers were audited throughout the facility to ensure no others were affected.

Nurses and Certified Med-Techs received education regarding expiration timelines for inhalers. Education regarding inhaler expiry will be added to the night-shift check-list to be available while they are completing the medication cart audits, to ensure sustained compliance.

Nursing leadership is completing random audits on the three medication carts within the facility and will report findings monthly to the QAPI committee until 100% compliance has been reached for a period of three months.

Compliance by 01/02/2025

F812

Following the discovery of the rust on the grease trap, the Maintenance Director immediately completed reparations to resolve the issue.

The baseboard heater register was immediately inspected and cleaned to ensure hygienic premises.

The donuts and waffles identified were discarded, and items identified in the refrigerator were covered, labeled, and dated.

The floor under the sink across from the steam table will be deep cleaned by environmental services.

The Food Service Director provided educational in-service to food service staff on the storage and labeling of food. Kitchen checklist was reviewed to ensure that areas cited were added to cleaning schedule.

The Food Service Director is completing random cleanliness audits of the floor and register, as well as random audits of the food in the kitchen to ensure that all food that is open is labeled, covered, dated, and stored appropriately. The Food Service Director will report his findings monthly at QAPI until 100% compliance has been maintained for a period of 3 months.

Compliance by 01/02/2025

F842

An immediate audit was completed to ensure that recent fall documentation by providers (including Third Eye, the after-hours provider) matched the facility's documentation.

Education was provided to the licensed nurses regarding the importance of giving a comprehensive and accurate report to the providers and ensuring that the documentation received from providers matches the facility's account of events.

The Nursing Department is randomly auditing fall documentation to ensure that the facility's account of events is consistent with the provider's documentation. The results of these audits will be reported monthly to the QAPI committee until 100% compliance has been reached for a period of 3 months.

Compliance by 01/02/2025.

Respectfully submitted,

Ashley Nichols

Administrator

Augusta Center for Health & Rehabilitation

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