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

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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 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 | TITLE | (X6) DATE

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure residents were treated in a dignified manner when staff failed to respond and attend to a resident's request for incontinence care during meal service. (Resident #40 [R40] and R41) Finding: On 11/17/24 at 1:10 p.m. during resident interviews with R40 and R41 they stated "they make me wait. I get very anxious, and I get a bad headache, and that they are not changing him/her as frequently as he/she should be". R41 stated "they just don't have enough staff, and they tell me I have to wait to use my urinal, and I don't want to wet my brief, and they make me wait. I want to use my urinal. I want to keep it going so I	F 550		

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F 550	Continued From page 2 don't wet myself". On 11/18/24, during a record review a Health Status Note for Behavior dated 11/12/24, was documented in R40's clinical record stating "It's policy that staff does not interrupt passing trays until they are all passed during mealtime. R40 has been informed of this policy many times. The nurse documented that R40 was informed again of the above policy, yet he/she continues to ring and holler out when staff walk by. On 11/19/24 at 10:00 a.m., during an interview with the Administrator and the Regional Directors, the surveyor asked about the above-mentioned policy for resident assistance during mealtimes. At this time the surveyor shared the Health Status note, dated 11/12/24, documented by a charge nurse. They stated that the facility does not have that policy. On 11/19/24 at 3:30 p.m., during an interview with a Certified Nursing Assistant, she stated that the process they are following during mealtime is that they pass out all the trays then they will change the residents. They have not been told not to help the residents, but they have to finish passing the meal trays first. She has heard a nurse tell the residents about the policy that staff does not interrupt the meal service.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		

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F 584	Continued From page 3 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the	F 584		

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F 584	Continued From page 4	F 584		

facility in good repair and sanitary conditions for 2 of 3 units (Saco Unit, and Kennebec Unit) for 1 of 1 environmental tour (11/19/24).

Findings:

On 11/19/24, from 10:05 a.m. to 10:30 a.m., an environmental tour was conducted with the Administrator and the Maintenance Director in which the following findings were observed:

Saco Unit:
> 3 hallway ceiling vents by resident rooms 3, 5, and 7 were rusty and had dust on them.
> Resident Room 4 - The toilet surface and behind the seat were dirty with dried liquid residue. The bathroom exhaust vent was dusty/dirty. The caulking on floor around the bathroom door frame was dirty and stained. There was a urine collection cup on the floor by the toilet.
> Resident Room 8 - The bathroom floor was dirty. There was a yellow/brown stain on a ceiling tile near the vent above the toilet. The caulking at base of the room and bathroom door trim was dirty and stained.
> Resident Room 14 - The bathroom floor was dirty. The caulking around the base of the toilet was dirty/stained. The caulking at base of the room and bathroom door trim was dirty and stained. The bathroom exhaust vent was dusty/dirty.

Kennebec Unit:
> Resident Room 37 - Resident #8's wheelchair had both left and right armrests that were cracked/broken. The caulking around the base of the toilet was dirty/stained. The bathroom exhaust vent was dusty/dirty.

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F 584	Continued From page 5 On 11/20/24 at 9:42 a.m. in an interview with a surveyor, the Administrator and the Maintenance Director confirmed the above findings.	F 584		
F 684 SS=D	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 and interviews, the facility failed to complete neurological assessments for 1 of 1 resident reviewed for fall with major injury (Resident #27 [R27]). Finding: The facility's paper form for a neurological (neuro) assessment indicated the following: Vital signs/Neuros to be done initially then every (q) 15 minutes x 2, q 30 minutes x 4, q 2 (hrs) x 4, then q shift x 3 (24 hours). The columns on the form to be completed included nurse's initials, date, time, vital signs (temperature, pulse, respirations, blood pressure) and neurological check (pupils, level of consciousness, motor function, speech, and facility symmetry). On 11/20/24, R27's clinical record was reviewed.	F 684		

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F 684	Continued From page 6 On 9/10/24 at 4:06 a.m., a health status note was documented that indicated at approximately 3:30 a.m., a staff member went into R27's room to find the resident face down on the floor with a puddle of blood under his/her face. Emergency Medical Services (EMS) was called and when EMS got resident into the stretcher for transport, R27 had visible facial swelling, a laceration to the forehead, cheek, and chin. R27 returned to the facility after a Computed Tomography (CT) scan was completed which indicated no immediate head bleed, sustained a nasal fracture, and returned to the facility later that morning. On 11/20/24 at 11:00 a.m., during an interview with a surveyor, the Director of Nursing Services (DNS) stated that neuro assessments were not initiated upon return from the Emergency Room. At 11:56 a.m., during an interview with the Physician Assistant - Certified (PAC) with the DNS present, a surveyor asked what the expectation of neuro assessments would be for a resident with a fall with head injury and a negative CT scan. PAC stated if a resident had a negative CT scan and returned to the facility within 2 days, that he would expect neuros to be completed. A surveyor confirmed this finding with the DNS at the time of this interview.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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F 689	Continued From page 7	F 689		

supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interviews, the facility failed to provide the proper adaptive equipment to a resident during a meal service for 1 of 6 observed meals for Resident #35 [R35] who was involved in an incident on 11/6/24.

Finding:

On 11/7/24, the Division of Licensing and Certification received from the facility a reportable incident form which indicated that on 11/6/24 R35 had spilled hot chocolate on his/her lap which caused burns which later in the day developed into blistered areas on both his/her thighs.

On 11/18/24, during resident observations it was noted that R35 was sitting in the dining room with a Kennedy cup (spillproof cup). During interviews it was noted that R35 was evaluated by Occupational Therapy (OT) on 11/12/24 with recommendation for use of covered mug for hot liquids secondary to decreased fine motor coordination.

On 11/20/24 at 8:30 a.m., R35 was observed in the dining room for breakfast, he/she had a plate of pureed food and a bowl of oatmeal in front of him/her on the table. R35 was observed by the surveyor drinking using a regular coffee cup with no cover. It was then confirmed that the cup contained hot chocolate, R35 was observed taking 2 additional sips from the uncovered cup. The surveyor brought it to the attention of the Administrator and the Regional Director of

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F 689	Continued From page 8 Clinical Operations. R35 was then given a cup with a cover. At this time, the surveyor confirmed that R35 was not using a spillproof cup (adaptive equipment) with his/her hot chocolate.	F 689		
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, interviews, and record review, the facility failed to provide respiratory care according to physician orders for 1 of 1 sampled residents (Resident #7 [R7]). Findings: Resident R7 was admitted on 9/6/23 and has diagnoses to include chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and congestive heart failure (CHF). A review of R7's active orders revealed a physician order, dated 5/30/24, for "Oxygen therapy 1-2Lpm [liters per minute] titration to keep O2 sat (oxygen saturation) at 90-92%. every shift for SOB (shortness of breath)/cough."	F 695		

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F 695	Continued From page 9	F 695		

During an observation of R7 in the Saco unit dayroom, on 11/20/24 at 10:48 a.m., R7 was seated in a wheelchair at a table, working on a puzzle. R7 was wearing a nasal cannula, and the oxygen tubing was connected to a portable oxygen tank that was secured on the back of the wheelchair. The oxygen flow rate was set to 3Lpm, and the needle on the oxygen tank gauge was observed in the red area of the gauge marked, "empty."

During an interview on 11/20/24 at 10:53 a.m. with a surveyor, Registered Nurse (RN) 1 confirmed that R7 utilizes continuous oxygen therapy and that she interpreted the physician order to mean the oxygen was to be titrated to keep R7's oxygen saturation (O2 sat) between 90-92%. RN1 stated she had given R7 a nebulizer treatment approximately 15 minutes ago after his/her O2 sat was measured at 85-86% and then increased the oxygen flow rate from 2Lpm to 3Lpm and that she intended to re-check the O2 sat but got busy. At this time, a surveyor pointed out that the gauge on the portable oxygen tank indicated, "empty." RN1 stated the gauge on the portable tank was in the "full" range when she had connected the oxygen tubing to the tank 15 minutes prior and proceeded to disconnect the oxygen tubing from the portable tank and connected it to an oxygen concentrator located by the table.

During an interview on 11/20/24 at 11:04 a.m. with a surveyor, the Regional Director of Clinical Operations (RDCO) reviewed R7's oxygen order and stated she interpreted the order to mean that titration would occur within the 1-2Lpm, not above a 2Lpm flow rate, but that the facility may have

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F 695	Continued From page 10 standing oxygen orders. During an interview on 11/20/24 at 11:05 a.m. with a surveyor, the Director of Nursing Services (DNS) confirmed that the facility does not have standing oxygen orders, and stated the physician is in building, so RN1 may have titrated beyond order with intention of discussing with the physician. At this time, a surveyor reviewed the above findings with the DNS. On 11/20/24 at 11:40 a.m., in an interview with a surveyor, the Assistant Director of Nursing Services (ADNS) and RN1 requested to speak with a surveyor. At this time, with 2 surveyors present, ADNS and RN1 again confirmed the above findings and stated that R7's oxygen saturation is now improved to 89%, and that R7's oxygen saturation is usually 89% at baseline, and the physician has been notified.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

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§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to adequately date open medications and properly dispose of expired medications, according to manufacturer specifications for two inhalers in 2 of 3 medication carts (Saco Unit, and Penobscot Unit) observed.

Findings:

On 11/19/24 at 8:50 a.m., two surveyors and Certified Nurse Med Tech (CNA-M) 1 observed, in the medication cart on the Saco unit, a Trelegy Ellipta Inhalation Aerosol device, labeled for Resident (R) 314, with a pharmacy label stating, "came in on 10/4/24." The manufacturer box states, "Discard 6 weeks after opening or when the counter reads '0'." The box and the device itself were not labeled with a date indicating when the device was opened. On 11/19/24 at 8:55 a.m., during an interview with CNA-M1, two surveyors confirmed that the Trelegy Ellipta device was not labeled with an opened date to ensure use and disposal according to manufacturer specifications.

On 11/19/24 at 9:43 a.m., two surveyors and CNA-M2 observed, in the medication cart on the

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F 761	Continued From page 12 Penobscot unit, a Fluticasone Salmeterol 250-50 mcg (microgram) inhalation device, labeled for R22, with opened date of 9/20/24 marked on the box, with the device itself not dated. The manufacturer packaging stated, "Discard the inhaler 1 month after opening the foil pouch or when the counter reads '0' (after all blisters have been used), whichever comes first." On 11/19/24 at 9:49 a.m., during an interview with CNA-M2 and Licensed Practical Nurse (LPN) 1, two surveyors confirmed that the Fluticasone Salmeterol device was not labeled with an opened date and a discard date to ensure use and disposal according to manufacturer specifications.	F 761		
F 812 SS=E	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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		

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	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 812	Continued From page 13	F 812		

by:
Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a grease trap, a baseboard heater register and the floor. Additionally, the facility failed to ensure foods were sealed, labeled and dated in a reach-in freezer and in a walk-in refrigerator for 1 of 1 kitchen tour for 1 of 1 day of survey (11/17/24).

Findings:

On 11/17/24 from 11:30 a.m. to 11:58 a.m., two surveyors conducted a kitchen tour in which the following findings were observed:

> The grease trap exterior had rust on the lid and the base. Additionally, the caulking around the base was dirty and stained with a black substance.
> The baseboard heater register, located between the grease trap and a sink, was dusty/dirty and had dried liquid residue and food splatter on it.
> The floor, under the sink across from the steam table, was heavily soiled with food debris and dried liquid residue.
> The reach-in freezer had a 10.2 ounce box of cinnamon donuts and an 18 ounce box of waffles that were not sealed and open to the air.
> The walk-in refrigerator had a metal tray containing 3 custard-type pies that were uncovered, unlabeled, and undated. Additionally, there were 6 cakes that were unlabeled.

On 11/17/24 at 11:58 a.m. in an interview with two surveyors, confirmed the findings with the Head Cook.

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F 842	Continued From page 14	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		

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F 842	Continued From page 15 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a clinical record contained complete and accurate information for 1 of 1 residents reviewed for falls (Resident #27 [R27]). Finding: On 11/20/24, R27's clinical record was reviewed and the surveyor requested to review the facility's	F 842		

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F 842	Continued From page 16	F 842		

fall report for R27 that occurred on 9/29/24.

Documentation on the fall report, completed 9/29/24 at 2:48 p.m. by Registered Nurse #2 (RN2) indicated that R27 was transferring self, fell forward towards the wall, and a staff member was able to grab R27 and sit back down on the bed. R27 sustained a nosebleed. The fall report indicated that the physician (Third Eye) was notified at 2:57 p.m.

Review of the Third Eye health note documented in R27's progress notes, completed by Third Eye, on 9/29/24 at 10:44 p.m., indicated that on 9/29/24 at 1:53 p.m. (central time) which is 2:53 p.m. (eastern time), it was reported by RN2 that R27 had an unwitnessed fall, likely slid onto floor in bedroom, found on buttocks, with no head strike or trauma reported.

On 11/20/24 at 2:07 p.m., during an interview with the Director of Nursing Services (DNS), the surveyor confirmed that RN2 documented that R27 had a nose bleed after falling towards the wall and that Third Eye documentation does not match the fall report (which was the only fall report found for R27). At 2:59 p.m., during an interview with a surveyor, DNS stated that she spoke with RN2 who did not recall if a neurological monitoring sheet was started or not after R27 sustained a nosebleed after falling into the wall.