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 _____	05/30/2024

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

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F 000	INITIAL COMMENTS From 5/28/24 through 5/30/24, on-site visits were conducted at Augusta Center for Health & Rehabilitation, Llc for the purpose of completing the Special Focus Long Term Care Survey Process for Federal Recertification, facility reported incidents #ME00045355, #ME00045254 and complaints #ME00046656, #ME00045435, #ME00045046, #ME00045010. It was determined that Augusta Center for Health & Rehabilitation, Llc was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 550 SS=E	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 provision of services under the State plan for all residents regardless of payment source.	F 550		

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

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F 550	Continued From page 1 §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 observations and interviews, the facility failed to promote care for residents in a manner that maintains each resident's dignity and respect when staff spoke and acted rudely to residents in their care for 2 of 2 residents reviewed (Resident #43 and Resident #33). Findings: 1. On 5/28/24 at 1:49 p.m., during an interview with Resident #43 he/she stated that there is one Certified Nursing Assistant (CNA) who is rude and on his/her case all the time. Resident #43 stated that this CNA does things just to get Resident #43 upset, the examples were that when the resident requests their door be closed due to the noise level this CNA (CNA #4) comes in the room and opens the window shades and turns on the roommates television. Resident #43 also stated that when he/she knows CNA #4 is	F 550		

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F 550	Continued From page 2	F 550		

on, they are in for it. Resident #43 told the surveyor to ask CNA #3 who this person was because she knows that they just don't get along. Resident #43 also stated there are other staff who know that CNA is rude and disrespectful.

At approximately 2:00 p.m., the Social Worker stopped by Resident #43's room and when Resident #43 asked the Social Worker to tell this surveyor who CNA #4 was the Social Worker stated that she is not a local person.

On 5/29/24 at 12:10 p.m., during an interview with an anonymous staff member, it was told that Resident #43 had told several staff members that CNA #4 is mean to him/her when she works and that CNA #4 always works with Resident #43.

On 5/29/24 at 12:23 p.m. during an interview with the acting Director of Nursing she found through a small investigation that Resident #43 had been verbalizing the interactions with CNA #4 to many staff and it was not addressed. The facility provided Resident #43 ear plugs to assist with the noise level and roommates television and they will address CNA #4's interactions with Resident #43.

2. Observation on 5/30/24 at 7:20 a.m., as surveyor was in the hallway near Room 6, this surveyor overheard a staff member (CNA #3) speaking to Resident #33. She was heard saying to the resident in a frustrated tone of voice "why are you ringing, I haven't even left the room yet. You need to give us time, you're not being fair to us. You need to be patient." The surveyor went to the doorway of the room and CNA #3 was standing at the foot of residents bed, facing the resident. Resident #33 was telling the CNA that

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F 550	Continued From page 3 he/she didn't know she was still there, and he/she wanted her to stay with them. The Regional Director of Clinical Operations (RDCO) and the Administrator were made aware of the conversation. The CNA was asked by the Administrator to go speak to them (Administrator and RDCO) and while in the hallway, CNA #3 stated in a frustrated tone "Resident #33's not being patient, he/she asked for ginger ale, and I told him/her that I would, just give me time to clean first." The Social Worker (SW) went in to see Resident #33, found that Resident #33 was not feeling well and wanted someone to reassure them and get them some ginger ale because, they were not feeling well. The SW did not address this incident (interaction with CNA #3) with Resident #33.	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. 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.	F 584		

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F 584	Continued From page 4 §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 provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable interior for the 3 of 3 units (Penobscot, Saco and Kennebec) and a nurse's station for 1 of 1 facility tours (5/30/24). Findings: 1. On 5/30/24 from 1:30 p.m. to 2:00 p.m., during a tour of the facility, a surveyor and the Maintenance Director, the Regional Housekeeping Manager, the Serene Health Services Laundry Manager, the Housekeeping/Laundry Manager, the Lead	F 584		

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F 584	Continued From page 5	F 584		

Maintenance Director/National the Administrator observed the following findings:

> The nurse's station had ripped/torn duct tape around the entire front edge of counter top creating an uncleanable surface.

Penobscot Unit
> Resident Room 17 - The caulking around the base of the toilet was dirty and stained.
> Resident Room 18 - The room entrance floor had 8 broken/cracked floor tiles and a buildup of dirt at the door entrance edges. The bathroom floor and the caulking around the base of the toilet were dirty.
> The utility room entrance floor had 2 broken floor tiles.
> Resident Room 20 - The room entrance floor had 4 broken/cracked floor tiles and had dried gray liquid residue spatter on it. The bathroom floor around the base of the toilet was dirty.
> Resident Room 21 - The room entrance floor had 4 broken/cracked floor tiles.
> Resident Room 23 - The room entrance floor had 10 broken/cracked floor tiles. The bathroom floor around the base of the toilet was dirty.

Saco Unit
> Resident Room 7 - Resident #43's wheelchair had a ripped/torn armrest.
> Resident Room 14 - The bathroom floor around the base of the toilet was dirty and the entire floor was dirty.

Kennebec Unit
> Resident Room 30 - The bathroom floor and the caulking around the base of the toilet were dirty.
> Resident Room 31 - There was a hole in wall

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F 584	Continued From page 6 near the outlet by the television. > Resident Room 34 - The room entrance door had dried gray liquid residue spatter on it. > Resident Room 35 - The room entrance door had dried gray liquid residue spatter on it. > Resident Room 38 - The room entrance door had dried gray liquid residue spatter on it. On 5/30/24 at 2:00 pm, in an interview, the Administrator, the Maintenance Director, the Regional Housekeeping Manager, the Serene Health Services Laundry Manager, the Housekeeping/Laundry Manager, and the Lead Maintenance Director/National confirmed the findings.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		

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discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to notify the resident and/or resident representative in writing for the reason of a transfer/discharge from the facility, for 1 of 2

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F 623	Continued From page 9 hospital transfers (2/22/24) for Resident #36. In addition, the facility failed to notify the Ombudsman of the February transfer/discharge for Resident #36. Finding: On 5/28/24, Resident #36's clinical record was reviewed and indicated that Resident #36 was transferred to the hospital on 2/22/24 and admitted. The clinical record lacked evidence of a written transfer/discharge notice being provided to the resident/resident representative. On 5/30/24 at 12:07 p.m., during an interview with a surveyor, the Administrator stated she was unable to find evidence that a written transfer/discharge notice had been given to the resident and/or representative. During this interview, the Administrator stated that the Director of Social Services is responsible for notifying the Ombudsman. On 5/30/24 at 12:16 p.m., the Administrator stated that the Ombudsman had not been notified of Resident #36's transfer/discharge by the Director of Social Services because she was out sick.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		

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any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of a bed hold notice after a transfer/admission to an acute care hospital, for 1 of 2 hospital transfers (2/22/24) for Resident #36.

Finding:

On 5/28/24, Resident #36's clinical record was reviewed and indicated that Resident #36 was transferred to the hospital on 2/22/24 and admitted. The clinical record lacked evidence of a written bed hold notice being provided to the resident/resident representative. On 5/30/24 at 12:07 p.m., during an interview with a surveyor, the Administrator stated she was unable to find evidence that a written bed hold had been given

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F 625	Continued From page 11 to the resident and/or representative.	F 625		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 645		

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paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that 2 of 3 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR)

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evaluation and determination (Resident #33 and Resident #35).

Finding:

1. Resident #31 was admitted to the facility on 10/11/23 with diagnosis of Panic Disorder, Major Depressive Disorder recurrent with Severe Psychotic Symptoms and Nightmare Disorder. Resident #31's clinical record contained a PASRR Level I determination letter dated 10/10/23 that stated further PASRR evaluation was not required due to Resident #31 met the criteria for a short-term convalescence admission. Resident #31 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #31's stay changed from short-term to long-term.

On 5/29/24 at 3:25 p.m., in an interview, the Director of Social Services confirmed the resident didn't receive a PASRR II evaluation after his/her stay went beyond 30 days and the resident stayed at the facility.

2. Resident #35 was admitted to the facility on 10/20/23 with diagnosis of Bipolar Disorder and Suicidal Ideations. Resident #31's clinical record contained a PASRR Level I determination letter dated 10/11/23 that stated further PASRR evaluation was not required due to Resident #35 met the criteria for a short-term convalescence admission. Resident #35 was not discharged after a short stay and was assessed to be

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F 645	Continued From page 14 Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #35's stay changed from short-term to long-term. On 5/29/24 at 12:46 p.m., in an interview, the Director of Social Services and the Regional Director of Clinical Operations confirmed the resident didn't receive a PASRR II evaluation after his/her stay went beyond 30 days and the resident stayed at the facility.	F 645		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		

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F 676	Continued From page 15 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide services to maintain and/or improve residents highest level of ambulation and Active Range of Motion (AROM), the facility failed to provide Restorative services as outlined in the resident's restorative therapy program care planned for 2 of 2 sampled residents (Resident #43 and Resident #21,). Findings: 1. On 5/28/24 at 1:38 p.m. during an interview with Resident #43 he/she stated "I think they should take extra care; I need the exercises and they don't have time to walk meand that makes me weaker. They do not walk with me every day. Resident #43's care plan documents interventions as follows: "Nursing Maintenance/Restorative: Ambulation - distance 50 feet or as resident tolerates with a 2 wheeled	F 676		

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walker (ww), 2 assist (A) and wheelchair (w/c) to follow. Resident #43's Kardex (identifies resident needs for care) documents a restorative plan for Nursing Maintenance/Restorative: Ambulation - distance 50 feet or as resident tolerates with 2 ww, 2A and w/c to follow.
Nursing Rehab: Patient to participate in daily exercise program to promote strength and activity tolerance during functional tasks. Use of cues, demonstration, and visual aide for carry over.
Nursing Rehab: Patient to participate in daily walking program up to 200 feet as tolerated with gait belt, 2 wheeled walker, and w/c following.

Upon review of the Nursing Rehab task documentation for ambulation, feet walked for previous 30 days 4/30/24 to 5/29/24, indicates that Resident #43 did not receive ambulation as directed.

2. On 5/29/24 at 9:20 a.m., during an interview with Resident #2, stated "I no longer get help, they don't walk me, I can't remember the last time I was assisted with walking so now I have a hard time walking now.

Resident #21's care plan documents care plan intervention as follows: Nursing Maintenance/Walking Program: ambulate 300 feet at least daily with 2 wheeled walker with wheelchair to follow. Resident #21's Kardex (identifies resident needs for care) documents that Resident #21 has a restorative plan for Nursing Maintenance/Restorative: Ambulation - Nursing Maintenance/Walking Program: ambulate 300 feet at least daily with 2 wheeled walker with wheelchair to follow
Nursing Rehab active Range of Motion: to participate in daily exercise program with red

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F 676	Continued From page 17 therapy band and visual aide to promote strength and activity tolerance. Nursing Rehab: Patient to participate in daily walking program with 2 wheeled walker, gait belt and wheelchair to follow up to 500 feet as tolerated in order to access facility level activities. Upon review of the Nursing Rehab task documentation for ambulation, feet walked for previous 30 days, 4/30/24 to 5/29/24, indicates that Resident #21 did not receive ambulation or Range of Motion as directed. On 5/30/24 at 10:20 a.m., during an interview with Regional Director of Clinical Operations and a review of the charting for Resident #43 and Resident #21's ambulation program, a surveyor confirmed that they had not been ambulated per their program.	F 676		
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 interview, the facility failed to ensure physician orders for sliding scale insulin were followed for 1 of 4 residents reviewed (Resident #155).	F 684		

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F 684	Continued From page 18 Finding: On 5/30/24, Resident #155's clinical record was reviewed and included a physician order for sliding scale insulin to administer Humalog 12 units but hold if not eating or blood sugar less than 150. On 10/22/23 Resident #155's morning blood sugar was documented as 109 and the treatment administration record for October 2023 indicated that insulin was given in the abdomen. On 5/30/24 at 8:09 a.m., a surveyor and the Regional Director of Clinical Operations reviewed Resident #155's documentation; the surveyor confirmed that the insulin was given even though the documented blood sugar was less than 150.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		

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provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure nutrition and hydration parameters were met to maintain sufficient hydration and health for 2 of 2 residents reviewed for nutrition and hydration (Resident #11 and Resident #18).

Findings:

1. On 05/28/24 at 12:11 p.m., a surveyor observed a lunch tray delivered to Resident #11's bed table, which was positioned over the resident's lap, then left the room. The lunch was observed to be spaghetti and sauce with garlic bread. After several minutes two staff returned and attempted to rouse Resident #11 for the meal, when Resident #11 did not wake, they removed the tray.

On 5/29/24 the clinical record indicated Resident #11's diagnosis included severe dementia and unspecified convulsions. The provider orders indicate Resident #11 needs a mechanical soft diet for dysphagia (difficulty swallowing). The care plan identified Resident #11's self-care performance deficit related to occasional syncope, seizures, and cognitive impairment. The intervention stated: "Eating: The resident requires extensive assist of 1, in the upright position alternate liquids and solids, covered cup. Requires lids on any hot liquids." The care plan also stated "[Resident #11] has actual nutritional problem: at risk for malnutrition aeb (as evidenced by) consuming (less than) 50% of needs, at risk for unplanned MD (moderate) weight loss related altered diet, needs assistance

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at meals."

On 05/29/24 at 12:01 p.m., a surveyor observed Resident #11 eating independently in bed, unsupervised, no lids on cups.

On 05/30/24 at 9:00 a.m., a surveyor observed Resident #11's breakfast which included broken pieces of a muffin, a bowl of cereal, and beverages including an uncovered cup of tea. No staff were present to assist Resident #11 with the meal. Resident #11 was observed to be non-verbal. At 9:03 a.m., Certified Nurse Assistant #1 (CNA1) entered the room and asked if Resident #11 was done eating. Resident #11 did not respond. CNA1 attempted to cue Resident #11 to eat, then removed the tray when cueing was not successful. A surveyor confirmed at this time that Resident #11 was ordered a mechanical soft diet. CNA1 stated "cornflakes could be mechanical soft if they were soaked in milk first."

On 5/30/24 at 9:23 a.m., in an interview with a surveyor, the Registered Nurse #1 (RN1) stated fluids should not be left on Resident #11's bedside table as Resident #11 is at risk for aspiration, Resident #11 needs to be monitored.

On 5/30/24 at 11:23 a.m., in an interview with a surveyor, CNA1 stated residents that need supervision should be in the dining room. CNA1 states Resident #11 can eat independently, depending on the day. CNA1 stated we watch them while we are up and down the halls. At this time the surveyor confirmed Resident #11 was not assisted with meals per care plan to ensure adequate nutrition and hydration.

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2. On 5/28/24 at 12:00 p.m., a surveyor observed Resident #18 eating lunch independently in bed. There was one small glass of milk on the tray which was removed with the tray when the resident had finished eating. No beverages were observed to be available to the resident from lunch service to the last observation of the day made at 3:23 p.m.

On 5/29/24, review of Resident #18's clinical record indicated a diagnosis of dementia and an order to encourage fluids daily.

On 5/30/24 at 9:05 a.m., a surveyor observed Resident #18 in bed, no beverages were available to the resident at the time of the observation. At 9:23 a.m., in an interview with a surveyor, RN1 stated Resident #18 should have beverages made available to him/her. The surveyor confirmed fluids were not readily available to the Resident #18 at that time.

On 5/30/24 at 11:23 a.m., in an interview with a surveyor, CNA1 she stated Resident #18 is not a big drinker, Resident #18 refuses a lot. At this time the surveyor confirmed fluids were not offered regularly to Resident #18.

On 5/30/24 at 12:28 p.m., a surveyor observed of Resident #18 resting in bed, with no fluids available to the resident. This finding was confirmed with CNA1 at the time of the observation.

On 5/30/24 at 12:32 p.m., in an interview with a surveyor, CNA2 stated she had a huge mess to clean up after Resident #18 spilt a beverage at breakfast. Resident #18 is not a big drinker, Resident #18 only takes sips with meals. CNA2

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F 692	Continued From page 22 stated the resident does not use the call bell system to make needs known related to Resident #18's dementia. At this time the surveyor confirmed that fluids were not made readily available to Resident #18 to maintain sufficient hydration.	F 692		
F 695 SS=E	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 observations, record reviews and interviews, the facility failed provide respiratory care consistent with professional standards of practice by failing to ensure that respiratory equipment was clean, failed to follow physician orders, and failed to date and label oxygen tubing for 5 of 5 sampled residents. (Resident #43, Resident #23, Resident #10, Resident #19, and Resident #160) Findings: 1.On 5/28/24 at 1:46 p.m. ,during a resident observation and interview Resident #43's nasal mask for his/her Continue positive airway pressure (CPAP) nasal mask was on the floor. During the interview Resident #43 stated that they do not wear their CPAP mask because staff do	F 695		

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not clean the nasal mask before attempting to put the nasal mask on him/her. On 5/29/24, several observations were made of Resident #43's nasal mask for the CPAP remains on the floor in his/her room.

On 5/30/24 at 10:20 a.m., Resident #43's nasal mask for their CPAP remains on the floor in the same spot as it was on 5/28. At this time the surveyor asked the Regional Director of Clinical Operations (RDCO) was asked to observe Resident #43's nasal mask. At this time the RDCO asked Resident #43 why they did not wear their nasal mask nightly, and Resident #43 stated "it's because staff are not cleaning it before putting it on him/her and was worried that was the reason he/she was getting congested.

On 5/30/24 at approximately 10:30 a.m. documentation for the cleaning of the nasal mask was reviewed, it showed that staff were marking it as a refusal from the resident or that it was worn. Further review shows that Resident #43 has physician orders that instruct staff with the following care instructions for the CPAP and nasal mask:

Physician orders are to Empty Chamber, wash with warm soapy water and rinse, then dry. Refill with distilled water daily.
Tubing Care - clean once weekly by soaking in 1 part vinegar and 2 parts water for 20 minutes. Rinse with water and air dry.
Nasal Mask Care - clean daily, wash with mild soap and water, rinse and dry.
CPAP: to be worn while resident is sleeping. Apply CPAP mask (Routine 1-at bedtime) and remove mask (Routine 2-in the morning)
Clean CPAP/Bi-PAP Head Gear weekly by

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washing with warm soap and water and rinsing

2.On 5/28/24 at 2:42 p.m., during a resident observation it was noted that Resident #23 was using oxygen concentrator with a setting of 2 liters using a nasal canula. Upon review of Resident #23's clinical record he/she had an order for the use of oxygen to keep saturation level above 92%. Resident #23's treatment administration record was reviewed and there are no orders for changing oxygen tubing or cleaning of the concentrator filters.

On 5/30/24 at 10:20 a.m. during an interview with the RDCO a surveyor confirmed that Resident #23 did not have orders for changing oxygen tubing or cleaning of the concentrator filters.

3. R10's clinical record was reviewed on 5/28/24 and indicated that R10 was admitted to the facility on 4/25/24. R10's physician orders included an order, dated 4/25/24, to administer oxygen (O2) at 1-2 liters per minute (LPM) via nasal cannula to keep O2 sats greater than 92% as needed for shortness of breath. The orders/treatments lacked evidence of care/use of the O2 tubing and humidifier bottle.

On 5/28/24 at 1:11 p.m., a surveyor observed an O2 concentrator with a humidifer bottle attached. The surveyor did not observe either the tubing or the humidifer bottle dated to indicate when either was last changed.

On 5/30/24 at 11:24 a.m., a surveyor confirmed with the RDCO that there were no treatments to change the oxygen tubing or orders for the use and care of the humidifer bottle.

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4. R19's physician orders included an order, dated 5/15/23, to administer O2 at 2 LPM continuously.

On 5/29/24 at 8:22 a.m., a surveyor observed R19 wear O2 via face mask with the O2 concentrator set at 3 LPM.

On 5/29/24 at 7:14 a.m., a surveyor observed R19 wear O2 via face mask with the O2 concentrator set at 3 LPM.

On 5/30/24 at 11:45 a.m., a surveyor and the RDCO observed R19's wearing oxygen via face mask and the concentrator was set on 3L per minute.

5. The manufacturer's directions for ResMed Aircurve 10 CPAP machine indicated that it is important that you regularly clean your AirCurve 10 device to make sure you receive optimal therapy and that you should clean the device weekly, including the mask.

On 5/29/24, R160's clinical record was reviewed and indicated that R160 was admitted to the facility on 5/21/24. On 5/22/24, a physician order was added to administer O2 at 1-4 LPM continuous to maintain O2 sats greater than 92% via nasal cannula. There were no treatments for the care of the O2 tubing and the O2 tubing was not dated to indicate when it had last been changed.

On 5/29/24 at 10:23 a.m., a surveyor observed R160 wearing O2 via nasal cannula with the concentrator set at 5 LPM. The surveyor also observed a CPAP machine on the night stand and R160 stated he/she wore this at night.

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 _____	05/30/2024

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 695	Continued From page 26 On 5/30/24 at 7:16 a.m., a surveyor observed R160 wearing O2 via nasal cannula with the concentrator set between 4.5 - 5 LPM. On 5/30/24 at 11:05 a.m., a surveyor and the RDCO observed R160's O2 concentrator set at 5 LPM. The surveyor also confirmed that there was no evidence that the O2 tubing was changed weekly and no treatments for the weekly care of the CPAP machine, noting that R160 had been at the facility 9 days. On 5/30/24 at approximately 11:15 a.m., a surveyor asked the RDCO for an oxygen policy. She stated that the faciilty does not have one but the practice was that all respiratory equipment care are cleaned and tubings are changed on Fridays.	F 695		
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.	F 812		

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 _____	05/30/2024

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

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F 812	Continued From page 27 §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 by: Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a ceiling vent, a food disposal unit, the dish machine, and a food mixer; failed to ensure facial hair protection was worn; and failed to ensure glasses were not wet stacked for 1 of 1 kitchen tour. Findings: On 5/28/24 from 11:15 a.m. to 11:35 a.m., an initial kitchen tour was conducted with a Food Service Director in which the following findings were observed: > The ceiling vent in the dish room was heavily soiled with dust. > The food disposal unit had dried food particles and dried liquid residue on it. > There was a large amount of chemical residue buildup on top of the dish machine. > The large standing food mixer had dried food particles on the bowl, the protective cage and the base. > A male kitchen worker had a mustache and beard and did not have facial hair protector over his mustache. > There were 20 clear tumblers that were wet stacked on a tray after washing. On 5/28/24 at 11:35 a.m., in an interview, a Food Service Director confirmed the findings.	F 812		