DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205063	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER HEALTH CARE	440 MINOT AVE , AUBURN, Maine, 04210

(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
F0000	INITIAL COMMENTS On 8/5/25, the Division of Licensing and Certification conducted an on-site visits at Clover Health Care for the purpose of investigations of facility reported incidents and complaint #2566597, #2568681, #2567906, and #2575463. It was determined that Clover Health Care was not in compliance with 42 Code of Federal Regulation (CFR) Part 483, Subpart B, Requirements for Long Term Care Facilities. At 42 Code of Federal Regulations (CFR) Part 483, Subpart §483.25(d)(2), - F689; the facility failed to provide supervision safety and supervision when a Certified Nursing Assistant (CNA#1) left a resident (#1) unattended in a bed with an air mattress, in the high position, and Resident #1 subsequently falling out of bed. Noncompliance with this requirement constituted a determination of immediate jeopardy (IJ), beginning on 7/19/25. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. See §483.25(d)(2), also known as F689, for details. On 8/6/25 at 3:25 p.m., the Administrator was provided written notification (IJ template for F689) related to the IJ situation, and a removal plan was requested. On 8/7/25 at 7:39 a.m., the facility submitted a removal plan, which was reviewed and approved by the State Agency. This removal plan indicated the following: Immediate Steps taken: · C.N.A. 1 and L.P.N were suspended pending investigation · Initiated education on 7/20/2025 related to safe bed mobility this was for C.N.A's and Licensed Nurses. · Licensed Nurses were educated on 7/20/2025 Post-Fall Management/Safety Plan.On 7/20/2025 all residents in facility had their current mobility status ascertained and any Kardex and Care Plan updates were made.Starting	F0000	Please see attached	

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Stern	Administrator	08/28/2025

F656

Corrective action for residents identified in the deficiency.

Resident #1 has been discharged from the facility.

Identifying other residents with potential for being affected and corrective action taken:

All current residents have the potential to be affected.

Corrective Action

All current care plans were reviewed and updated as needed to ensure positioning and lifting status is current and reflected on the CNA Kardex

All care plans will be reviewed after admission and change of condition to ensure they reflect accurate positioning and lifting status.

Current CNA's will be educated on accessing the Kardex/Care Tasks and following care plans.

All new nursing hires will receive education during orientation on how to access the Kardex and the importance of following care plans.

Any staff that did not receive education prior to the compliance date will be completed upon their return to work.

How corrective action will be monitored:

Audits will be conducted weekly for a period of one month, then monthly for two months or until substantial compliance is maintained. Any discrepancies of audit will be reported to the Administrator.

Systemic changes to reasonably assure deficiency does not recur.

Results will be submitted to the facility's QA Committee for review and recommendations.

Date of Compliance: 09/02/2025

F689

Corrective action for residents identified in the deficiency.

- C.N.A. #1 and L.P.N #1 were suspended pending investigation.
- Education on safe bed mobility for Licensed Nurses and CNA's was initiated on 7/20/2025.
- Licensed nurse education on Post-Fall Management was initiated on 7/20/2025
- On 7/20/2025 through 07/21/2025 current residents in the facility had their current mobility status ascertained, and corresponding updates were made to their Kardex and Care Plan
- Additional bed safety education was provided for nursing staff on 7/22/2025 through 7/28/2025.
- Staff observation audits were initiated on 7/24/2025 to ensure adherence to care plans and proper bed height safety. The audits are ongoing.
- Upon conclusion of investigation, C.N.A#1 and L.P.N #1 were terminated.

Identifying other residents with potential for being affected and corrective action

All residents of the facility have the potential to be affected by this practice.

Education was provided to nursing staff regarding resident safety, bed mobility and bed height.

Any staff that did not receive education prior to the compliance date will be completed upon their return to work.

How corrective action will be monitored.

Director of Nursing or their designee will conduct an audit for safe bed height, on all units, on each shift, two resident care observations per core, 5 days per week for a period of 2 weeks, then 3 days a week for a period of 2 weeks, then random audits of care observations, per unit per week for a period of 3 months or until substantial compliance is achieved. Any discrepancies noted will be reported to the Administrator.

Results of the audits will be presented to the facilities' QA Committee for review and recommendation.

Completion Date: 09/02/2025

F949

Corrective action for residents identified in the deficiency.

No residents were identified or harmed.

Identifying other residents with potential for being affected and corrective action

All residents of the facility have the potential to be affected.

Corrective Action

Current staff will receive re-education on behavioral health starting on 8/28/2025 by the Director of Nursing, or their designee(s).

All nursing new hires will receive behavioral health education during the new-hire orientation.

Any staff that did not receive education prior to the compliance date will complete upon their return.

How corrective action will be monitored.

The Director of Nursing, or their designee, will conduct an audit of new hire education to ensure that Behavioral Health/Trauma informed care training has been completed every two weeks for two months, then monthly for three months until compliance is achieved. Any discrepancies noted will be reported to the Administrator.

Systemic changes to reasonably assure deficiency does not recur.

Results of audits will be submitted to QAPI for review and recommendation.

Date of Completion: 09/02/2025