STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0000	INITIAL COMMENTS From 2/1/26, 2/2/26, 2/4/26, and 2/5/26, on-site visits were conducted at Augusta Center for Health & Rehabilitation for the purpose of conducting the annual Long Term Care Survey Process and investigating complaints #218281, #218306, #218309, #218317, and #2610151. 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.	F0000		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state	F0583		

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
[signature]	Administrator	2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0583 SS = D	Continued from page 1 laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the confidentiality of protected health information when resident identifiable assignment sheets and a monthly weight documentation sheet were left unattended in the solarium, an area accessible to residents and visitors, on 1 of 4 days of survey. Finding: On 2/1/26 at 11:00 a.m., a surveyor observed copies of multiple resident care assignment sheets and a document titled "December Monthly Weights" left unattended on a table in the solarium, an area accessible to residents and visitors. At the time of the observation, two residents and one visitor were present in the solarium. The assignment sheets contained resident identifiable information including resident names, room numbers, diagnosis, continence status, required assistance with activities of daily living (ADL's), transfer needs (including Hoyer use), fall risk status and other personal care instructions. The monthly weight sheet contained resident names and recorded weights. The documents were left unattended in a publicly accessible area without safeguards to maintain confidentiality of resident information. On 2/1/26 at approximately 11:20 a.m., the surveyor confirmed this finding with the Human Resources Assistant, who acknowledged the assignment sheets contained sensitive and private protected health information and stated the documents should not have been left unattended in the solarium.	F0583		
F0584 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.	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0584 SS = E	Continued from page 2 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 facility in good repair and sanitary conditions for 3 of 3 units (Saco, Penobscot and Kennebec Units) and a common area for 1 of 1 environmental tour (2/5/26). Findings:	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0584 SS = E	Continued from page 3 On 2/5/26 from 8:55 a.m. to 9:25 a.m., a surveyor conducted an Environmental Tour with the Maintenance Director and the Administrator in which the following findings were discussed and observed: Common Area: - A hallway ceiling tile, by the main entrance door, had a large brown stain on it. Penobscot Unit: - Resident Room 21 – There was a full cup of liquid, with a straw in it, on floor next to bed B. There was an unbagged bed pan on the bathroom floor. - Resident Room 22 – There was a medium size bottle of powder lying on floor behind the head of bed A. The oxygen concentrator, located between the beds, had dirt/debris and dried liquid residue on it. - Resident room 25 – The over the bed table, for bed B, had dried food particles and dried liquid residue on it. Kennebec Unit: - Resident Room 29 - The window blind was broken in many places, hanging down and in disrepair. The bathroom had a container of purple wipes on a rollator walker with a wipe sticking out. Saco unit - Resident Room 1 – The baseboard heating unit had chipped/missing paint creating an uncleanable surface. - Resident Room 3 - The baseboard heating unit had chipped/missing paint creating an uncleanable surface. - Resident Room 6 – The window blind was broken in many places, hanging down and in disrepair. On 2/05/2026 at 9:25 a.m., in an interview with a surveyor, the Maintenance Director and the Administrator confirmed the discussed and observed findings.	F0584		
F0657 SS = E	Care Plan Timing and Revision	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0657 SS = E	Continued from page 4 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 5 of 7 residents reviewed for care planning (Residents #3, #6, #7, #9, and #24). Findings: 1. Review of Resident #3's clinical record revealed an MDS Quarterly Assessment was completed on 11/27/25. Further review of Resident #3's clinical record revealed that an IDT meeting was held 12/10/25 (13 days after assessment) and lacked evidence that an IDT	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0657 SS = E	Continued from page 5 meeting was held within 7 days following the assessment. Additional review of Resident #3's clinical record indicated that he/she sustained an unwitnessed fall at the facility on 12/17/25 and was subsequently admitted to an acute care hospital on 12/17/25, was diagnosed with a left hip fracture, and underwent left hip surgery on 12/18/25. Resident #3 returned to the facility on 1/3/26. The clinical record revealed an MDS Significant Change Assessment was completed on 1/13/26 but lacked evidence that an IDT meeting was held within 7 days following the assessment. A review of Resident #3's provider History & Physical dated 1/5/26 states, "...seen today for readmission following hospitalization for a mechanical fall resulting in left proximal femoral fracture... maintain post-op dressing precautions and monitor for bleeding, erythema, warmth, purulent drainage, wound dehiscence, or fever; reinforce to staff close supervision given attempts to remove Steri-Strips...." A review of Resident #3's physician orders revealed the following:An order with a start date of 1/27/26 for "Monitor L [left] hip incision, leave OTA [open to air] every day and evening shift for 7 Days..."An order with a start date of 1/20/26 for "Monitor dressing on L hip. Change dressing every 3 days and PRN [as needed] every day and evening shift for 7 days..."A review of Resident #3's care plan lacked evidence that goals and interventions were put into place for the left hip incision. On 2/5/26 at 8:30 a.m., the above finding was discussed during an interview with the Administrator and Regional Director of Clinical Operations. At this time, the Administrator reviewed Resident #3's care plan and stated that she would expect to see goals and interventions for the care of the left hip incision and confirmed the care plan was not revised to reflect Resident #3's current needs. 2. Review of Resident #6's clinical record revealed an MDS Annual Assessment was completed on 10/30/25 and an MDS Quarterly Assessment was completed on 1/22/26. Further review of Resident #6's clinical record lacked evidence that an IDT meeting was held within 7 days following the above assessments. 3. Review of Resident #7's clinical record revealed an MDS Quarterly Assessment was completed on 1/7/26. Further review of Resident #7's clinical record lacked evidence that an IDT meeting was held within 7 days	F0657		

Administrator 2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0657 SS = E	Continued from page 6 following the assessment. 4. Review of Resident #9's clinical record revealed an MDS Quarterly Assessment was completed on 11/18/25 and an MDS Significant Change Assessment was completed on 12/22/25 and that Resident #9 was admitted to hospice services. Further review of Resident #9's clinical record revealed that an IDT meeting was held 1/28/26 and lacked evidence that an IDT meeting was held within 7 days following the above assessments. 5. Review of Resident #24's clinical record revealed an MDS Annual Assessment was completed on 8/18/25 and that an IDT meeting was held on 9/10/25. Further review of Resident #24's clinical record revealed an MDS Quarterly Assessment was completed on 11/11/25 and that an IDT meeting was held on 12/11/25. Resident #24's clinical record lacked evidence that an IDT meeting was held within 7 days following the above assessments. On 2/5/26 at 8:05 a.m., during an interview, the MDS Coordinator stated that the facility does not schedule IDT meetings based off of MDS Assessment dates and that IDT meetings are scheduled based off of the date that the last IDT meeting was held. On 2/5/26 at 8:18 a.m. during an interview, the Licensed Social Worker (LSW) stated that she schedules IDT meetings based off of a report she receives, and that it is her understanding that IDT meetings for Long Term Care residents should be scheduled within 7 days of the review date indicated on the report and within 14 days of the review date for Skilled residents. On 2/5/26 at 8:30 a.m., the above findings were discussed with the Administrator and Regional Director of Clinical Operations.	F0657		
F0684 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:	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0684 SS = D	Continued from page 7 Based on observations, interviews, and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice in the area of nutrition and wound care for 2 of 20 sampled residents (Residents #6, #9). Findings: 1. Resident #6 was admitted in May 2023 with diagnoses to include Parkinson's Disease and dysphagia. On 2/5/26 at 8:05 a.m., a surveyor observed Resident #6 in bed with his/her over-the-bed table set up with his/her breakfast meal, including a spoon in the bowl of oatmeal and a fork by the entrée plate. No staff were in the room at the time of the observation. On 2/5/26 at 9:45 a.m. during an interview, the Director of Nursing (DON) stated that there have been concerns with aspiration and an overall functional decline and that staff have been assisting Resident #6 more with feeding recently. A review of Resident #6's clinical record revealed an active physician order with a start date of 5/14/25 for "Full supervision with all meals..." Further review of Resident #6's clinical record revealed a quarterly nutrition evaluation dated 1/21/26 that states, "...holding food in mouth/cheeks or having residual food in mouth after meals... needing supervision all meals..." and a physician progress note dated 1/27/26 that states, "...requires supervision with meals..." On 2/5/26 at 12:53 p.m., during an interview, CNA #1 stated that Resident #6 feeds himself/herself about 50% of the time, and that when he/she can eat on his/her own, the staff will set him/her up and then leave the room to get trays for the other residents. She then stated that the staff periodically check in on Resident #6. On 2/5/26 at 1:15 p.m., during a follow-up interview with 2 surveyors, the above finding was discussed with the DON. At this time, the DON stated that sometimes Resident #6 feeds himself/herself and sometimes he/she needs assistance and that she was unaware that an order for full supervision with meals has been in place since May. 2. Resident #9 was admitted in August 2025 with diagnoses to include chronic ulcer of the left leg.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0684 SS = D	Continued from page 8 A review of Resident #9's clinical record revealed an active physician order with a start date of 1/23/26 for "Wound care for LLE [left lower extremity] wound: cleanse LLE wound with sterile water (on days that we change collagen), apply a light dusting of collagen... to entire wound bed... apply oil emulsion over the collagen dusting, then apply barrier cream to wound edges (only outside wound edges) cover with large Abd pads [an absorbent, multi-layer dressing], and wrap with kerlix [a type of gauze bandage]..." On 2/1/26 from 12:14 p.m. to 12:43 p.m., a surveyor observed Registered Nurse (RN) #1 perform Resident #9's wound care. RN #1 removed the existing dressing and cleansed the wound with sterile water. RN #1 then applied the collagen to the wound bed, then applied oil emulsion, then covered the wound with the Abd pads, and wrapped Resident #9's lower leg with Kerlix. On 2/1/26 at 12:45 p.m., during an interview, the surveyor and RN #1 discussed Resident #9's wound care orders. At this time, RN #1 stated that Resident #9 often refuses barrier cream, but that she should have offered the treatment to him/her and missed that. Additional review of Resident #9's clinical record revealed a late-entry nursing progress note dated 2/1/26 that states, "This RN inadvertently did not apply barrier cream to wound edges during dressing change to left lower extremity. Reapproached resident and asked if [he/she] would like me to apply it. [He/She] states [he/she] did and I applied the barrier cream to wound edges..." On 2/1/26 at 1:10 p.m., the surveyor discussed the finding with the DON, the Administrator, and the Regional Director of Clinical Operations.	F0684		
F0761 SS = E	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	F0761		

Administrator 2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0761 SS = E	Continued from page 9 §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. §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 observations, interviews and record reviews, the facility failed to ensure medications, including treatments, were stored properly by failing to obtain physician orders for medications located at a resident's bedside for 2 of 20 sampled residents (Residents #64, #9). In addition, the facility lacked evidence of consistent monitoring of medication storage room refrigerator temperatures to ensure proper medication and vaccine storage temperatures for 5 of 7 months reviewed. Findings: 1. On 2/1/26 at 9:45 a.m., during an observation of Resident #64's room, a 43 g bottle of miconazole topical 2% powder with a pharmacy label for Resident #64 and a medicine cup containing an unknown white substance was located on the counter next to the shared sink. During an interview at this time, Resident #64 stated that he/she cannot apply the medications himself/herself because he/she is disabled and that staff apply his/her medications. 2. On 2/1/26 at 10:24 a.m., during an observation of Resident #9's room, a 6 fluid ounce bottle of Calamine lotion with a pharmacy label for Resident #9 was located on the counter next to the shared sink. A review of Resident #9's clinical record lacked evidence of a physician order for Resident #9 to self-administer medications. On 2/1/26 at 2:51 p.m., the above findings were discussed during an interview with the Director of Nursing (DON). At this time, the DON stated that	F0761		

Administrator 2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0761 SS = E	Continued from page 10 topical medications are stored in a separate bag for each resident in the treatment cart and should not be stored at the resident's bedside. 3. On 2/5/26 at 11:46 a.m., the surveyor observed the medication storage room refrigerator, which contained insulin, vaccinations and other medications requiring refrigeration. Review of the facility policy titled "Medication Storage - Storage of Medication" (Section 4.1, revised 01/25 directed that refrigerators storing vaccines be monitored. And recorded twice daily and maintained within 36 F – 46 F. The policy further indicates insulin products are to be stored in the refrigerator until opened and must not be frozen. Review of the "Refrigerator Temperature Log," which instructs staff to record temperatures twice daily, revealed missing documentation as follows: August 2025 4 of 31 days missing AM documentation 2 of 31 days missing documentation September 2025: 1 of 30 days missing AM documentation 1 of 30 days missing PM documentation October 2025: 4 of 31 days missing AM documentation November 2025: 1 of 30 days missing AM documentation December	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0761 SS = E	Continued from page 11 3 of 31 days missing AM documentation 3 of 31 days missing PM documentation On 2/5/26 at 1:30 p.m., the above findings were discussed with the Administrator and Regional Director of Clinical Operations.	F0761		
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to provide adaptive utensils for 1 of 3 residents reviewed for nutrition (Resident #6). Finding: Resident #6 was admitted in May 2023 with diagnoses to include Parkinson's Disease and dysphagia. On 2/5/26 at 8:05 a.m., a surveyor observed Resident #6's breakfast meal set up on his/her over-the-bed table. A standard spoon was resting in the bowl of oatmeal and a standard fork was set up next to Resident #6's entrée, served on a lip plate. There were no adaptive utensils or cups. Review of Resident #6's care plan revealed the following:"...ADL [Activities of Daily Living] self-care performance deficit...Lip plate with meals...L [left] and R [right] angled spoons..."" ...adaptive dining equipment: lip plate at meals. Blue insulated mug. Left and right angled spoon..."On 2/5/26 at 12:53 p.m., during a repeat observation, Resident #6 received his/her lunch tray in his/her room. The meal ticket indicated "...Blue insulated mug Left and right-angled spoon..." There were no adaptive utensils or specialized mug. During an interview at this time, Certified Nursing Assistant (CNA) #1 stated that the kitchen sends the specialized eating and drinking utensils on the resident's tray and confirmed that the specialized mug and spoon were not	F0810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0810 SS = D	Continued from page 12 on Resident #6's meal tray. CNA #1 then stated that Resident #6 feeds himself/herself about 50% of the time and when he/she can eat on his/her own, the staff will set him/her up and then leave the room to get trays for the other residents. On 2/5/26 at 1:10 p.m., during an interview, the Food Service Director stated that all resident specialized eating and drinking equipment is listed on the meal ticket and put on the resident's meal tray when it is sent to them. On 2/5/26 at 1:15 p.m. during an interview with 2 surveyors, the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated that sometimes Resident #6 feeds himself/herself and sometimes he/she needs assistance and that he/she does not require adaptive utensils if staff is feeding him/her. The surveyors discussed that the kitchen does not know whether Resident #6 is feeding himself/herself that meal or if he/she will need assistance, so the kitchen has no way of knowing which meals Resident #6 will require adaptive utensils or which meals he/she will have staff assistance.	F0810		
F0812 SS = D	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.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0812 SS = D	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall and the floor; failed to ensure foods were labeled and dated in a reach-in freezer; and failed to ensure kitchen staff with facial hair wore facial protection for 1 of 1 kitchen tour for 1 of 1 day of survey (2/1/26). Findings: On 2/1/26 from 9:05 a.m. to 9:35 a.m., a surveyor conducted an Initial Kitchen Tour in which the following findings were observed: - Two male kitchen workers with facial hair (beards and moustaches) were not wearing facial hair protection. - The wall behind the toaster had chipped/missing paint creating an uncleanable surface. - The kitchen floor had food debris and trash throughout the kitchen, under equipment and under shelving. - The Reach-in freezer, nearest the walk-in refrigerator, had a previously opened package of strips/tenders that was not labeled and dated. On 2/1/26 at 9:38 a.m., in an interview, a surveyor discussed the findings with the Dietary Aide. On 2/1/26 at 11:25 a.m., in an interview, a surveyor discussed the findings with the Acting Administrator.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0880 SS = D	Continued from page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0880 SS = D	Continued from page 15 actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and Centers for Disease Control and Prevention (CDC) guidance, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to transporting soiled linens and disinfecting a soiled surface during a wound dressing observation for 1 of 3 residents reviewed for wounds (Resident #9). Findings: On 2/1/26 from 12:14 to 12:43 PM, during an observation of Resident #9's left leg wound dressing change, Registered Nurse (RN) #1 sanitized her hands and donned (put on) Personal Protective Equipment (PPE) per the Contact precautions sign hanging outside Resident #9's door. RN #1 then placed Resident #9's left leg on a towel located on top of his/her bed and proceeded to remove Resident #9's existing dressing, provide wound care, and apply a new dressing. Resident #9's open wounds were in direct contact with the towel during the wound care and dressing change. After the dressing change, RN #1 discarded the soiled dressing and then removed the soiled towel from under Resident #9's leg. RN #1 then placed the unbagged, soiled towel on the counter of the sink that Resident #9 and Resident #61 share. RN #1 then placed her bandage scissors in the sink basin and proceeded to wash her hands, reposition Resident #9, and cover him/her with blankets. RN #1 then doffed (took off) her PPE and then picked up the unbagged, soiled towel with her ungloved hands and carried it out of the room and across the hall to the soiled utility room (Whirlpool room), where she discarded the towel. RN #1 then returned to Resident #9's room, sanitized her hands, donned new PPE, and cleaned the bandage scissors in the sink with disinfectant wipes. RN #1 then doffed her PPE,	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0880 SS = D	Continued from page 16 sanitized her hands, and without cleaning the sink counter, proceeded to leave the room. On 2/1/26 at 12:43 p.m. during an interview, Resident #61 stated that he/she and Resident #9 share the sink, and stated that he/she uses the sink to wash his/her face and bathe. On 2/1/26 at 12:45 p.m. during an interview, RN #1 stated that Resident #9 is on Contact precautions for Shingles. At this time, the surveyor discussed the above observation, and RN #1 stated that she does not like carrying soiled linens with her bare hands, but that she is not supposed to wear gloves in the hall. The surveyor also discussed the placement of the soiled towel on the shared sink counter, and that the counter was not cleaned after RN #1 removed the soiled towel. At this time, RN #1 stated she was going to go get disinfectant wipes to clean the sink and counter and proceeded to do so. On 2/1/26 at 1:10 p.m., the above finding was discussed during an interview with the Director of Nursing, the Administrator, and the Regional Director of Clinical Operations. At this time the Administrator stated that the facility's procedure is that staff do not wear gloves when transporting soiled linens in the hall. Centers for Disease Control and Prevention (CDC) Best Practices for Environmental Cleaning in Global Healthcare Settings, Appendix D- Linen and laundry management, dated 3/19/24 states, "Always wear reusable rubber gloves before handling soiled linen...	F0880		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;	F0887		

Administrator 2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0887 SS = D	Continued from page 17 (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure that the resident's medical record included documentation that indicated that the resident or resident representative accepted a COVID-19 vaccine	F0887		

Administrator 2/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA CENTER FOR HEALTH & REHABILITATION, LLC	188 EASTERN AVE , AUGUSTA, Maine, 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
F0887 SS = D	Continued from page 18 that the resident received for 1 of 5 residents reviewed for immunizations (Resident #24). Finding: Review of Resident #24's clinical record revealed a signed Immunization Consent Form dated 6/6/25, indicating Resident #24 declined the COVID-19 vaccine. Further review of the clinical record revealed that Resident #24 received the COVID-19 immunization on 11/5/25. On 2/5/26 at 1:08 p.m. during an interview, the Director of Nursing and the Administrator stated that they were looking for evidence that Resident #24 had consented to receive the COVID-19 vaccine administered on 11/5/25. At this time, the Regional Director of Clinical Operations stated that Resident #24 had refused the 2024-2025 COVID-19 vaccine but consented to receiving the 2025-2026 vaccine. The facility failed to provide evidence that Resident #24 consented to receiving the vaccine by the end of the survey.	F0887		

F0583 Privacy/ confidential

The facility acknowledges the importance of maintaining the confidentiality of protected health information (PHI) and recognizes its responsibility to ensure that all resident-identifiable information is properly safeguarded at all times.

On 2/1/26 the assignment and monthly weight sheets were immediately removed from the solarium upon notification. Other public areas of the facility were reviewed and no other resident-identifiable documents were noted to be left unattended.

Re-education will be provided to staff on maintaining confidentiality of protected health information to include not leaving documents unattended in public locations. Staff will provided clipboards/folders on the units to prevent documents from being left unattended in public locations.

The Administrator or designee will complete random weekly audits of resident/visitor/public locations to ensure confidentiality of protected health information is maintained until 100% compliance is met for 3 consecutive months. Patterns and trends will be reported to QAPI.

Compliance Date: 3/16/26

F0584 Environment

The facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 3 units.

Several Residents had potential to be affected by this practice with none directly affected.

Ceiling tile observed with brown stain on it by entrance door has been replaced.

Room 21 cup with liquid in room on floor was discarded. Bed pan was cleaned and properly stored, and the bathroom floor disinfected.

Room 22 powder was discarded in trash. Concentrator was cleaned and disinfected.

Room 25 tray table was cleaned and disinfected.

Room 6 and 29 window blinds were replaced. Purple top wipes were removed from bathroom and stored appropriately.

Room 1 and heating units were painted to have a cleanable surface.

An initial house wide audit will be conducted by maintenance director or designee to ensure all blinds are in proper working condition, heaters have no chipped paint and a cleanable surface, and no items stored inappropriately on floors, or in bathrooms, tray tables will be observed for cleanliness.

Maint director/Designee will conduct Random weekly audits will take place Monday-Friday for four weeks and 3 x a week for two months.

Audits will be submitted to qapi for 3 months by Maint director or Designee.

Compliance Date: 3/16/26

F0657 Care Plan/IDT

Residents # 6 and 7 were provided with a Care Plan Meeting by the IDT post survey to make up for their missed meeting following their latest MDS Assessments. Resident #3 was transferred to the hospital 2/16/26, therefore no care plan meeting was held. No residents had an adverse effect from this practice.

Resident #3 MDS quarterly assessment reference date (ARD) was 11/27/25. The assessment was completed on 12/3/25 (Z0500B). The care plan meeting was held timely on 12/10/26. Resident #3 Significant Change ARD was 1/13/26 and assessment was completed on 1/22/26 (Z0500B). The CAA Completion Date was 1/23/26 (V0200B2) and the Care Plan Completion Date was 1/23/26 (V0200C2).

Resident #6 MDS Annual ARD 10/30/25. The assessment was completed 11/6/25 (Z0500B). The CAA Completion Date was 11/6/25 (V0200B2) and the Care Plan Completion Date was 11/6/25 (V0200C2). Resident #6 Quarterly ARD 1/22/26. The assessment was completed on 1/29/26 (Z0500B). Upon notification, a Care Plan meeting was held 2/19/26.

Resident #7 MDS Quarterly ARD 1/7/26. The assessment was completed on 1/20/26 (Z0500B). The Care Plan meeting was held on 2/5/26.

Resident #9 MDS Quarterly ARD 11/18/25. The assessment was completed 11/20/25 (Z0500B). A Significant Change MDS for Resident #9 ARD 12/22/26. The assessment was completed on 1/5/26 (Z0500B). The CAA Completion Date was 1/5/26 (V0500B2) and the Care Plan Completion Date was 1/5/26 (V0200C2). A Care Plan meeting was held on 1/28/26.

Resident #24 MDS Annual ARD 8/18/25. The assessment was completed on 8/25/25(Z0500B). The CAA Completion Date was 8/25/25 (V0500B2) and the Care Plan

Completion Date was 8/25/25 (V0200C2). Resident #24 MDS Quarterly ARD 11/11/25. The assessment was completed on 11/14/25. The Care Plan meeting was held 12/11/25.

A house wide audit was completed to reconcile care plan meetings within the last 6 months. Residents identified as out of compliance were offered a care plan meeting with the IDT.

Education will be completed with the IDT on the Resident Assessment Process (RAI) including each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision must be completed within 7 days of completing the RAI (MDS (s)). On instances where an IDT member participates in care plan development, review or revision will be communicated in the medical record to reflect involvement of the resident and resident representative, if applicable, and other members of the IDT, as appropriate.

The IDT will review, at a minimum weekly, the Care Plan Due list to guide the team on which residents are scheduled in PCC; the IDT will review the Comprehensive Care Plan with the deadline of the Target Completion Date; the Social Worker/or designee will schedule the Care Plan Meeting thereafter, or as practicable with the resident/representative.

The Administrator or designee will complete random weekly audits to ensure the care plan is reviewed and revised by the IDT that includes, to the extent possible, participation of the resident and/or representative after each MDS assessment. Audits will be completed until 100% compliance is met for a period of 3 consecutive months. Patterns and trends will be reported to QAPI.

Resident #3 Left hip surgical wound was noted to be resolved on 2/5/26. Care plan was resolved at that time. Resident #3 had no adverse effects and surgical wound healed without any complications.

A house wide audit of wounds was conducted to ensure wounds have care plans to include goals and interventions. Any discrepancies noted were corrected.

Re-education will be completed with licensed nurses on initiating a care plan with goals and interventions when a wound is identified or a resident is admitted with a wound. Any wound identified as healed, care plan will resolved. PCC dashboard for incomplete wound care plans will be reviewed at Morning meeting and care plan will be updated. Wounds will be reviewed at the Standards of Care Meeting and will be reconciled to ensure wound care plans contain goals and interventions.

The DNS or designee will complete random weekly audits to ensure that wound care plans contain goals and interventions. Audits will be completed until 100% compliance is maintained for 3 consecutive months. Patterns and trends will be reported at QAPI.

Compliance Date: 3/16/26

F0684 Quality of Care

Resident #6's care plan/Kardex was updated for supervision with meals. Resident had no adverse effects from the occurrence. Resident #6 is encouraged to attend meals in the dining room if he/she does not, staff provides supervision in room.

A house-wide audit was completed on current resident diet orders and supervision requirements to ensure care plans accurately reflect physician orders. Any discrepancies noted were corrected.

A new workflow has been initiated to pull the Order listing report at morning meeting to identify new orders for supervision with meals. The care plan will then be updated by the ADNS. Therapy will complete the therapy to nursing evaluation with any changes requiring supervision with meals to ensure communication is completed from therapy to nursing.

Licensed nurses will be re-educated on verification of physician orders and transcription requirements to the Kardex/care plan. C.N.A. staff will be re-educated on following Kardex/care plans in regards to meal supervision.

The DON or designee will conduct random weekly meal observations until 100% compliance is met for a period of 3 consecutive months. Patterns and trends will be reported to QAPI.

Resident #9 received the treatment as ordered on 2/1/26. RN #1 went back to resident #9 and offered the barrier cream and the resident accepted the barrier cream.

RN#1 received re-education regarding adherence to physician orders and proper documentation of treatment refusals.

An audit of residents receiving wound care was conducted to ensure treatments were completed per physician orders. No discrepancies were identified.

Licensed nurses were re-educated on adhering to physician orders. Licensed nurses were advised that for more complicated wound treatments that the order can be printed to bring into the room to refer to, to ensure wound care is provided as ordered.

The DNS or designee will complete random weekly audits of wound care to verify physician order is followed. Audits will be completed until 100% compliance is met for a period of 3 consecutive months. Patterns and trends will be reported to QAPI.

Compliance Date: 3/16/26

F0761 Label Storage of drugs

Resident #64 had miconazole powder and medication cup removed from the shared sink area upon notification. Resident #9 had Calamine lotion removed from the shared sink area. Both residents receive treatments administered by licensed nurses. Treatments are now stored in the designated treatment cart.

A house-wide audit was conducted on residents to identify medications and treatments stored at bedside. Any medications or treatments identified were immediately removed and properly stored in the medication or treatment cart. Identified discrepancies were corrected.

The refrigerator temperature logs were reviewed. It was identified that documentation was incomplete for prior months. Current refrigerator temperatures were verified to be within the acceptable range per policy. The medication refrigerator was inspected to ensure no evidence of compromised medications.

Licensed nurses will receive re-education on:

- Bedside storage requirements and the need for a physician order
- Proper storage of medications and treatments
- Refrigerator temperature monitoring and required documentation twice daily

A revised workflow was implemented designating the Saco unit to record refrigerator temperatures twice daily. This will be completed as part of each nurse to nurse report. The Director of Nursing or designee will review refrigerator temperature logs weekly to ensure compliance.

The DON or designee will conduct random weekly audits of bedside medication/treatment storage and weekly refrigerator temperature logs until compliance is maintained for a period of 3 consecutive months. Audit results will be reviewed monthly at QAPI for patterns and trends. Any identified non-compliance will result in immediate corrective action and re-education.

Compliance Date: 3/16/26

F0810 Assistive Devices

Resident #6 was assisted with the lunch meal on 2/5/26 and consumed 26-50%, as resident was not feeling well. The resident was provided the correct adaptive dining equipment with the next scheduled meal. The resident's care plan and dietary meal ticket were immediately reviewed and revised to accurately reflect required adaptive dining equipment.

Nursing and dietary staff were re-educated on the process to ensure required adaptive dining equipment is identified on the meal ticket and placed on the meal tray for each meal service.

An audit was conducted, in collaboration with therapy, on residents with identified adaptive dining equipment needs to ensure care plans accurately reflect needs and that dietary meal tickets correspond with the required equipment. Any discrepancies noted were corrected.

The Director of Nursing or designee will conduct random weekly meal observations of residents requiring adaptive dining equipment until 100% compliance is met for 3 consecutive months. Patterns and trends will be reported to QAPI.

Compliance Date: 3/16/26

F0880 Infection Control

RN #1 disinfected the counter and sink on 2/1/26 immediately upon notification. Resident #9 and Resident #61 were assessed and confirmed not to have used the sink between the time of contamination and disinfection. No adverse outcomes were identified.

RN #1 received one-on-one education on 2/1/26 regarding maintaining a sanitary environment to prevent the development and transmission of infection, including proper transport of soiled linens, disinfecting contaminated surfaces, and appropriate hand hygiene during wound dressing changes.

An audit of current residents receiving wound care was conducted to evaluate infection control practices related to maintaining a sanitary environment. No additional deficient practices were identified.

Licensed nursing staff will receive re-education on infection control practices during wound dressing changes and handling of soiled linens. The Wound Management and

Soiled Linen policies will be reviewed with licensed staff. Competencies for clean dressing technique and hand hygiene will be completed.

The Infection Preventionist or designee will conduct weekly random wound care observation audits to ensure compliance with infection control practices, including disinfecting contaminated surfaces, hand hygiene, and proper transport of soiled linens. Audit results will be reviewed monthly at QAPI for patterns and trends. Any identified non-compliance will result in immediate corrective action and re-education.

Compliance Date: 3/16/26

F0812 Food Procurement

Facility failed to maintain kitchen in clean and sanitary manner.

All residents had potential to be affected with none directly affected.

Two male employees with facial hair, failed to wear facial hair protection- The two staff members were educated and utilized facial hair protection.

Wall behind the toaster had missing paint and no cleanable surface- Wall repaired, painted and is now cleanable.

Kitchen floor had debris and trash throughout the kitchen- Debris throughout the kitchen was swept and cleaned. Trash is thrown out in appropriate barrels.

Reach in freezer had an opened unlabeled and dated package of strips/tenders- Tenders were immediately discarded.

Staff were educated to wear appropriate facial coverings while in the kitchen if any facial hair present

Staff educated on daily assignments including sweeping under shelving and throwing trash out in appropriate barrels.

Staff were educated on dating and labeling all items in the freezer and refrigerator.

FSD or designee will conduct audits 3x a week x 4 weeks and 1x a week x 2 months to ensure staff are wearing appropriate facial covering when needed.

FSD or designee will conduct audits of refrigerated items to ensure they are labeled and dates appropriately 3x a week x 4 weeks and weekly x 2 months.

FSD or designee will conduct kitchen environmental audits to identify any potential area with needing paint or repair, these audits will be weekly x 4 weeks and monthly x 2 months

All results of audits will be submitted to the QAPI committee for review by FSD or designee

Compliance Date: 3/16/26

F0887 Covid 19 Immunization

Resident #24's EMR and paper chart were immediately reviewed.

The facility verified that consent was obtained prior to the Covid vaccine administration but was not properly filed in the medical record. Resident/resident representative was contacted to notify the documented consent omission and a new consent was obtained and filed in chart.

An audit was completed on residents who received the 2025-2026 Covid Vaccine to verify that the vaccine consent form was properly filed in the medical record. Any discrepancies noted were corrected.

Re-education provided to licensed nurses to ensure vaccine consent form is verified and properly filed prior to Covid vaccine administration. Licensed nurses will utilize PCC Immunization tab to document that consent was confirmed prior to Covid vaccine administration.

The Infection Preventionist or designee will complete random monthly audits to ensure Covid vaccine consents are properly filed until 100% compliance is obtained for a period of 3 consecutive months. Patterns and trends will be reported to QAPI.

Compliance Date: 3/16/26

2/27/26