STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clover Health Care	440 Minot Ave Auburn, ME 04210

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observation, it was determined the Facility has violated a Residents right to be free from discrimination, coercion, and interference as evidenced by the facility's refusal to readmit him/her when ready for discharge because of the resident's known behavior issues for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Findings:A review of the Facility Assessment, dated 2/8/25, indicated the Facility cared for individuals with a diagnosis of Psychosis (Hallucinations, Delusions, etc.) Impaired Cognition, Mental Disorders. Behavior that requires Interventions. Alzheimer's Disease, Non-Alzheimer's Dementia. Further review states [NAME] is reserved specifically for resident with dementing illness that require the safety of a secured neighborhood. Resident #1 was transferred to the Long Term Care facility from the Assisted Living Facility (ALF), (where [he/she] had known behaviors) in November of 2025 with a diagnosis of Alzheimer's dementia with behaviors, chronic obstructive pulmonary disease (COPD), and major depression.Review of Minimum Data Sets (MDS)assessment, dated 5/25/25 revealed Resident #1 had a Brief Interview for Mental Status score of 0 of 15 indicating he/she is not cognitively intact Review of Resident #1's Progress Notes revealed: -On 11/7/25 at 6:00 a.m., Resident was wandering the unit and was restless. Medication Technician (Med Tech) attempted to administer medication, but he/she threw them at her. Resident attempted to go after 2 CNA's and picked up an iPad in attempt to hit a staff member while trying to elope. Resident was not redirectable and 911 was called. At 7:06 a.m. Resident attempted to pull another resident out of a shower chair and started throwing furniture (chairs) across the room. Emergency medical and police arrived and attempted redirection, but resident attempted to strike out at them as well. They were able to get Resident in the stretcher and transported to [acute care hospital] for further evaluation.-11/7/25 at 11:11 a.m., states Spoken to [acute care hospital #1] ER nurse concerning patients' behavior.Informed [case manager] that we would not be accepting this patient back until we have a safety plan in place and a medicine regimen change.-11/12/25 14:22 Return from Hospital (acute care hospital #1): resident returned to facility at 1345 via stretcher (5 days later) .-On11/14/25 at 7:48 a.m., Resident punched CNA with left fist to her left cheek. Residents aggressively swing, kicking, and stomping staff and attempting to go after residents in common areas. Unable to redirect or provide incontinent care. 911 called due to safety [forothers]. Two staff members ambulated with resident to direct [him/her] away from other residents. Resident continued to stomp on staff feet when not ambulating or turning around. Police present and observing until EMS arrived. Patient transported to acute care hospital via ambulance. Resident returned from acute care hospital #1 at 10:58 a.m.,On 11/14/25 at 11:54 Resident was brought back by EMS [from acute care hospital #1]. After a few brief minutes resident walked out of his bedroom and tried walking into other residents' rooms. Doors were promptly closed, and residents were allowed to walk freely through the halls. Resident saw one female activities worker with a female resident and threatened to get (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them, he then changed his direction towards them. [a staff member stayed close by to redirect, but far enough to give space] At one point the resident was able to grab this writers hand and squeeze hard enough for a pop to be heard. Resident stated, I should hit you, but I won't.11/14/25 11:30 a.m., Resident sent to [acute care hospital #2] via ambulance for aggressive behavior towards staff.11/23/25 09:46 am Health Status Note called [acute care hospital #2) to see status of patient. RN told me .that he has a very flat affect that he is very somnolent. There have been no aggressive behavior or IM meds in 5 days, IV fluids for hydration Medications continue with no changes. [He/she] is taking medications whole with ice cream or pudding. Review of ED Physician Note dated 11/14/25 at 11:34 a.m., states BIBA (brought in by ambulance) for agitation, violent behavior, dementia hx, assaulted CNA coming from clover seen at [acute care hospital #1 this am for same x2, behavior health screen, Clover states cannot return.Review of ED Physician Note dated 11/14/25 at 14:49 p.m. states: .The patient does not appear to suffer from any acute comorbidities and has already had multiple evaluations in the past 24 hours, and it appears that [his/her] nursing home facility is seeking placement at a different facility that is more equipped for geriatric psychiatric patients. While I feel this would be beneficial for the patient, there is no acute indication for admission to the hospital to seek admission to such facility. And the nursing home that [he/she] is currently residing in is an appropriate place for him to await transfer to a geriatric psychiatric facility.Review of ED Physician Note dated 11/15/25 at 3:47 a.m., Apparently after case management was consulted earlier today to arrange for discharge, [his/her] current living facility was not comfortable or confident in managing his condition and was requesting the patient be placed in another facility that could better manage h[his/her] outburst of aggression.there is no medical indication for inpatient admission to the hospital.Review of ED Physician Note dated 11/17/25 at 9:57 a.m., states . no inpatient hospitalization at this time is indicated.Review of ED Physician Note-Addendum. dated 11/18/25 at 15:41: leadership would like to hold [him/her] in the ED for another 24 hour period. Still trying to get a plan in place with [facility] as they are not willing to create a safe d/c [discharge] plan at this time.Resident #1 was admitted to [acute care hospital #2] on 11/18/25 at 15:54.During an interview on 11/24/25 at 10:45 a.m., with acute care hospital staff, Senior [NAME] President of Operations (SVPO) stated that Resident #1 did not meet the requirements for hospital level of care, and the facility has been refusing to taking [him/her] back. SVPO states that the facility has the same resources for psychiatric evaluations as the hospital does and there is no medical reason for Resident #1 to not return to the facility.Review of Transfer and Discharge Policy dated 10/18/25 states In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding the reason for the transfer or discharge will be provided by a physician.During an interview on 12/24/25 at 3:10 p.m., facility Administrator stated that the facility has not refused to take Resident #1 back, but they wanted to ensure an appropriate safety plan was in place for staff and residents for [his/her] return. The Administrator was unable to provide this writer with written physician documentation indicating resident's clinical or behavioral status endangers the safety or health of individuals in the facility.Resident #1 was transferred back to the facility on [DATE] after an 11 day hospital stay.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews, interviews, and facility policy, the facility failed to ensure physician orders for an as needed (PRN) anti-psychotic contained a duration/stop date and failed to ensure the physician evaluated a resident and wrote a new physician order to renew the PRN anti-psychotic medication every 14 days, for 1 of 3 residents reviewed during a complaint investigation (Resident #1).Findings:Review of policy Psychotropic Medication Usage. dated 8/19/24 states .PRN orders for psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication and documents the findings. When entering a PRN order for a psychotropic medication, the licensed nurse should indicate in the 'Scheduling section for the order a completion date of 14 days and check the box that a re-assessment is due. Review of Resident #1's active order dated 10/31/25 for antipsychotic Risperidone Oral Tablet 0.5 mg by mouth PRN (as needed) every 4 hours for dementia with behavioral disturbance: agitation. At least 4 hours apart and a max of 2 a day. End date: indefinite.During an interview with Administrator and DON on 11/24/25 at 2:39 p.m. the DON confirmed this finding.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review, interviews, and policy review, the facility failed to obtain written informed consent for use of psychotropic medications for 2 of 3 residents reviewed (Residents #1 and #2), and failed to obtain written informed consent for the use of opioid medication for 1 of 3 residents reviewed (Resident #2). In addition, the facility failed to monitor and document targeted behaviors to support the use of psychotropic medications for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Findings:Review of Psychotropic Medication Policy dated8/19/24 states: It is the policy of this Community. That residents will not receive unnecessary psychotropic medications., and that the resident/Responsible party will consent to the use of any psychotropic medications ordered by a physician. Psychotropic drugs are defined as Any drug that affects brain activities associated with mental processes and behaviors . Psychotropic drugs include, but are not limited to the following categories: anti-psychotics, anti-depressants, anti-anxiety, hypnotics/sedatives, anti-convulsant.All psychotropic medications must have a consent form signed by the resident/authorized representative prior to the first administration, even if the resident has received the medication in the past. The consent will indicate the name of the medication, the drug glass and indication of use. Review of Resident #1's active Medication Administration Record (MAR) revealed the following:-Order with state date of 11/6/25 for antidepressant Mirtazapine Tablet 30 mg give 1 tablet by mouth at bedtime for Dementia with behaviors.-Order with start date 11/7/25 for antidepressant Sertraline HCT tablet 50 MG. Give 1 tablet by mouth one time a day for Dementia with behaviors.-Order with start date of 11/6/25 for antidepressant Trazodone HCL Tablet 100 mg Give 1 tablet by mouth one time a day for insomnia.-Order with start date of 11/7/25 for Risperidone Tablet 1 MG Give 1 tablet by mouth two times a day for agitation.-Order with start date of 11/12/25 for anticonvulsant Depakote Oral Table Delayed Release 5000 mg (Divalproex Sodium) give 1 tablet by mouth two times a day for dementia, danger to self/others.Review of Resident #1 clinical record revealed Anti-Anxiety Informed consent for medication [a] dated 11/6/25 states .Medication Category: Anti-anxiety; Medication: Ativan Diagnoses: dementia with behaviors. further review of this document lacks evidence that Resident #1's Power of Attorney (POA) gave written consent for this medication.Review of Resident #1's clinical record revealed Psychotropic/Antipsychotic medication Informed consent for medication [b] dated 11/6/25 states Medication Category: Psychotropic/Antipsychotic; Medication: Clover; diagnoses Dementia with behaviors further review of this document lacks evidence that Resident #1's Power of Attorney (POA) gave written consent for this medication.Review of Anti-Depressant Informed Consent for Medication dated 11/6/25 states .Medication Category: Antidepressant; Medication: [blank] Diagnosis: Dementia with behaviors. further review of this document lacks evidence that Resident #1's Power of Attorney (POA) gave written consent for this medication.Review of Medication Informed Disclosure dated 11/13/25 states .Antipsychotic Medication: Mirtazapine/Aricept/Naproxen/Depakote/Risperdal. Signature of Resident/Responsible Party: Verbal consent given from [POA] date: 11/13/25. Further review of this document lacks evidence that Resident #1's Power of Attorney (POA) gave written consent for this medication.During a telephone interview on 11/24/25 at 3:28 p.m., Resident #1's Power of Attorney (POA) stated that she was aware Resident #1 was going to receive Seroquel but was never asked to sign consent forms for any psychotropic medications.2.Review of facility policy Psychotropic Medication Usage . dated 8/19/24 states Anti-psychotic medication.The licensed nurse shall also enter and order on the MAR/TAR for Behavior Monitoring. Review of Resident #1's active MAR/TAR dated November 20205 lacked evidence he/she was being monitored for behaviors. During an interview on 11/24/25 at 3:40 p.m., the Director of nursing stated that residents on psychotropic medications should be monitored for behaviors. At this time (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed Resident #1 showed no evidence on MAR/TAR the he/she was being monitored for behaviors.3 Review of Resident #2's clinical record revealed the following:-Order with start date 2/21/24 for antidepressant Mirtazapine Oral Tablet 7.5 MG (Mirtazapine) Give 1 tablet by mouth one time a day for insomnia.-Order with start date 10/17/25 for anti-depressant Trazodone HCL Tablet 50 MG. Give 0.5 tablet by mouth in the morning for agitation. Give one hour before care.-Order with start date 11/15/25 for opioid Tramadol HCL Oral Tablet 25 MG (Tramadol HCL). Give 25 MG by mouth one time a day for pain. Review of Resident #2's clinical record lacked evidence that written consent was obtained for the use of the above medications. During an interview on 11/24/25 at 3:40 p.m., the Director of Nursing (DON) stated that she normally contacts the resident representative over the phone to get consent for psychotropic/pain medications and at some point, in time if/when they come in, they sign them. At this time DON confirmed the consents were not done in writing.