STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 000	INITIAL COMMENTS (Census 91 Capacity 111 beds) On 9/9/24 through 9/13/24, and on 9/17/24 on-site visits were conducted at Waterville Center for Health and Rehab for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification, facility reported incident #ME00048842, and complaints #ME00046903, #ME00047476, #ME00047498, #ME00047617, #ME00047975, #ME00048363, and #ME00048683. It was determined that Waterville Center for Health and Rehab was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities. F604 - Right to be Free from Physical Restraints. Noncompliance with this requirement constitutes a determination of immediate jeopardy (IJ), beginning on 7/26/24. IJ 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 §483.10(e) also known as F604 for details. F609 - Reporting of Alleged Violations. Noncompliance with this requirement constituted a determination of immediate jeopardy (IJ), beginning on 7/26/24. IJ 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 §483.12(b) also known as F609 for details.	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 000	Continued From page 1	F 000		

F610 - Investigate/Prevent/Correct Alleged Violation. Noncompliance with this requirement constituted a determination of immediate jeopardy (IJ), beginning on 7/26/24. IJ 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 §483.12(c) also known as F610 for details.

On 9/13/24 at 2:25 p.m., the Administrator, Director of Nursing, and Regional Director of Clinical and Quality Assurance was provided written notification (IJ templates for F604, F609, and F610) related to the IJ situation and a removal plan was requested.

On 9/16/24 at 9:12 a.m., the facility submitted an acceptable removal plan. The removal plan was reviewed and approved by the State Agency on 9/16/24 at 9:37 a.m. This removal plan indicated the following:

F604 - Right to be Free from Physical Restraints:
-Resident number 99 is no longer a resident at the facility as of July 26, 2024.

-The Social Service department will interview all residents regarding resident rights and physical restraint use. Residents that are not able to be interviewed will be observed to ensure no restraints are in use. Any resident identified with restraint use will be evaluated to ensure restraint use policy has been followed, if not in compliance the resident will be evaluated for physical or psychological harm, the facility will complete a reportable incident report, and a full investigation

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 000	Continued From page 2	F 000		

will be completed by September 17, 2024.

-The resident interviews and observations of residents was completed on September 13, 2024, resident reported understanding of their resident rights, and none reported being restrained, residents who were not able to be interviewed were observed to be restraint free.

-The Director of Clinical Services and/or designee will conduct two interviews and two observations of residents, including new admissions, that are not able to be interviewed weekly alternating 6a-2p, 2p-10p and 10p-6a times four weeks, then monthly times eight weeks. A report of findings will be submitted to the Quality Assurance Performance Improvement [QAPI] Committee for further review and recommendations.

-The Director of Clinical Services and/or designee will provide re-education to staff regarding resident rights, abuse, restraint use and incident reporting. Initiated on September 13, 2024, to be completed by September 17, 2024. It is facility policy that all staff receive education regarding resident rights, abuse, restraint use, and incident reporting on hire and annually. Administrator and/or designee will conduct weekly audits times four weeks, monthly times eight weeks and ensure compliance. Results will be reviewed by QAPI committee for further recommendations.

F 609 Reporting of alleged violations:

Removal plan:
-Resident number 99 is no longer a resident at the facility as of July 26, 2024.

-The Social Service department will interview all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 000	Continued From page 3	F 000		

the residents regarding resident rights and physical restraint use. Residents that are not able to be interviewed will be observed to ensure no restraints are in use. Any resident identified with restraint use will be evaluated to ensure restraint use policy has been followed, if not in compliance the facility will complete a reportable incident report and initiate a full investigation by September 17, 2024.

-The resident interviews and observations of residents was completed on September 13, 2024, resident reported understanding of their resident rights, and none reported being restrained, resident who were not able to be interviewed were observed to be restraint free.

-The Administrator and/or designee will review the last three months of facility incident reports to ensure reportable incidents indicating use of restraints have been reported, fully investigated and corrective actions taken. Any identified to not be in compliance will be reported and a full investigation will be completed by September 17, 2024.

-The Director of Clinical Services and/or designee will provide re-education to all staff regarding resident rights, abuse, restraint use, incident reporting. Initiated on September 13, 2024, to be completed by September 17, 2024.

-The Regional Director of Clinical Servies will provide education to the current administrative team regarding reporting and investigation of reportable incidents. (The Interim Director of Clinical Servies and Interim Administrator who had not fully investigated and reported the incident are no longer at the facility) Initiated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 000	Continued From page 4	F 000		

September 13, 2024, to be completed by September 17, 2024.

-The Administrator and Director of Clinical Servies completed the reportable incident report, sent to DHHS-Licensing and Regulatory Services and Adult Protective Services and notified resident's responsible party on September 13, 2024.

-Upon the investigation's completion, the facility was able to verify that the resident's [family], per [family] report, placed the sheet around the resident and tied it to the back of her wheelchair. A follow up report, as required, was faxed to DHHS-Licensing and Regulatory Services on September 15, 2024.

-The Director of Clinical Services and/or Administrator will review staff and resident concerns/reports and incident reports of alleged reportable violations to ensure it has been reported timely and fully investigated. A report of the findings will be submitted monthly, for two quarters, to the facility Quality Assurance Performance Improvement Committee for further review and recommendations.

F 610 Investigate/Prevent/Correct Alleged Violations
-Resident number 99 is no longer a resident at the facility as of July 26, 2024.

-The Social Service department will interview all the residents regarding resident rights and physical restraint use. Residents unable to be interviewed will be observed to ensure no restraints are in use. Any resident identified with restraint use will be evaluated to ensure restraint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 000	Continued From page 5	F 000		

use policy has been followed, if not in compliance the resident will be evaluated for physical or psychological harm and the facility will complete a reportable incident report and initiate a full investigation by September 17, 2024.

-The interviews and observations of residents was completed on September 13, 2024, resident reported understanding of their resident rights, and none reported being restrained, residents who were not able to be interviewed were observed to be restraint free.

-The Director of Clinical Services and/or designee will provide re-education to all staff regarding resident rights, abuse, restraint use, incident reporting. Initiated September 13, 2024, and will be completed by September 17, 2024.

-The Regional Director of Clinical Servies will provide education to the current administrative team regarding reporting and investigation of reportable incidents. (The interim Director of Clinical Services and interim Administrator who had not fully investigated and reported the incident are no longer at the facility) Initiated on September 13, 2024, to be completed by September 17, 2024.

-The Administrator and Director of Clinical Servies completed reportable incident report, which was sent to DHHS-Licensing and Regulatory Services and Adult Protective Services and notified resident's responsible party on September 13, 2024.

Upon the investigation's completion, the facility was able to verify that the resident's [family], per [his/her] report, placed the sheet around the

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 000	Continued From page 6 resident and tied it to the back of her wheelchair. A follow up report, as required, was faxed to DHHS-Licensing and Regulatory Services on September 15, 2024. -A Root Cause Analysis (RCA) which was initiated on 9/13/24, will be developed to identify potential contributing/causal factors and implement measures to prevent further incidents and will be completed by 9/16/2024 at which time the findings will be reviewed by an Ad Hoc Quality Assurance and Performance Improvement Committee. -The Director of Clinical Services and/or designee will review staff and resident reports and/or grievances of alleged reportable violations to ensure it has been reported timely, fully investigated and a root cause analysis has been completed to identify potential contributing/causal factors and implement measures to prevent incident from reoccurring. A report of the findings will be submitted monthly, for two quarters, to the facility Quality Assurance Performance Improvement Committee for further review and recommendations. On 9/17/24, surveyors verified that the facility's plan to remove the IJ(s) was implemented and was effective by observations of residents; interviews with staff; and document review of policies and education content and sign in sheets. The surveyors determined the removal of the IJ(s) on 9/17/24.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii)	F 567		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 567	Continued From page 7 §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.	F 567		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 567	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide a resident access to personal funds (Resident #47 [R47]). Finding: On 9/9/24 at 11:41 a.m., in an interview with a surveyor, R47 stated, "I didn't get the $40.00 for the last 2 months. I was fighting about that this morning. Corporate took it all instead of giving it to me. They said they need to find out why." Review of R47's financial statements indicated the facility's cost of care deduction for R47 was $1,251.00 per month, which left $40.00 dollars in an account for personal use. The facility deducted $1,291.00 for cost of care on 8/2/24 and 9/3/24 with out explanation for the increased charge. On 9/12/24 at 7:50 a.m., in an interview with a surveyor, the Nursing and Operations Assistant stated she became aware of this when R47's guardian came to do some shopping for R47 but there was not enough money in the account; an email was sent on 9/9/24 regarding this error, and compensation had to wait until a reply was received from the Corporate office. At this time a surveyor confirmed that a resident did not have access to the $80.00 of personal funds that was deducted without explanation.	F 567		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 578	Continued From page 9	F 578		

formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 578	Continued From page 10	F 578		

facility failed to provide/obtain Resident and/or Resident's Representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive for 8 of 8 Resident's reviewed for Advance Directives (Resident #26 [R26], R46, R251, R252, R43, R4, R64, and R34).

Findings:

Review of facility policy "Advance Directive" undated states, " ...As part of the admission process, [Facility] Social Service Department shall ask and document in the resident's medical record whether the resident has executed an Advance Directive (i.e., Living Will or Durable Healthcare Power of Attorney), if so, the social worker shall obtain a copy and place it in the resident's current medical record. ... In the absence of an Advance Directive, the social worker shall provide to the Resident and/or the admitting party written information about Maine's Advance Directive laws, the right to refuse or accept medical care, sample forms, and this policy. ..."

1. R26 was admitted on 7/11/24 and has diagnoses to include recent liver transplant, chronic kidney disease, and presence of heart valve on admission.

Review of R26's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

2. R46 was admitted on 11/27/23 and has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 11	F 578		

diagnoses to include diabetes mellitus II, chronic obstructive pulmonary disease (COPD), hypertension, and end stage renal failure and is dialysis dependent.

Review of R46's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

3. R251 was originally admitted on 8/28/24 and has diagnoses to include heart failure, diabetes mellitus and chronic kidney disease.

Review of R251's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

4. R252 was admitted on 8/27/24 and has diagnoses to include recent history of heart attack, left bundle branch block and first degree atrioventricular block with recent pacemaker placement.

Review of R252's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

5. R43 was admitted on 5/6/21 and had diagnoses to include multiple sclerosis, convulsions and multiple pressure ulcers.

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F 578	Continued From page 12	F 578		

Review of R43's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

6. R4 was admitted on 11/2/23 and had diagnoses to include hypoxic ischemic encephalopathy, heart failure, acute respiratory failure, chronic obstructive pulmonary disease and acute kidney failure.

Review of R4's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

7. R64 was admitted on 5/15/23 and had diagnoses to include chronic kidney disease, type 2 diabetes mellitus and heart failure.

Review of R64's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive.

8. R34 was admitted on 1/5/18 and had diagnoses to include acute and chronic respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease,

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 578	Continued From page 13 obstructive sleep apnea, a traumatic brain injury and bipolar disorder. Review of R34's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. During an interview with four surveyors on 9/11/24 at 11:03 a.m., the Administrator and Social Worker confirmed above findings.	F 578		
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. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 584	Continued From page 14 §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 environment on 2 of 4 units (Mountain Top Unit and Harbor Unit) for 3 of 3 facility tours (9/9/24, 9/10/24 and 9/12/24). Findings: 1. On 9/9/24, the following observations were made and confirmations received at time of observation: > On 9/9/24 at 12:52 p.m., in the Cranberry dining room on the Mountain Top Unit, a surveyor observed a pile of wet towels under the ice machine, the flooring had stripped away and the cabinet laminate had peeled back. Mildew was visible on the wall and the floor. At this time, in	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 584	Continued From page 15	F 584		

an interview, Certified Nursing Assistant #2 (CNA2) observed and confirmed the findings.

> On 9/9/24 at 12:12 p.m., in the Blueberry dining room on the Mountain Top Unit, a surveyor observed fruit flies over the stove and around the sink. At this time, in an interview, Registered Nurse #2 (RN2) observed and confirmed the findings.

> On 9/9/24 at 12:36 p.m., a surveyor observed fruit flies in Resident room 436 during an interview with Resident #3 (R3).

2. On 9/10/24 the following observations were made and confirmations received at time of observation:

> On 9/10/24 at 8:15 a.m., a surveyor observed in Resident Room 436, R3 sitting in his/her wheelchair by his/her bed. A fruit fly was observed flying in the room over a blue tote. R3 was observed waving the fly away.

> On 9/10/24 at 8:16 a.m., in R5's room, a surveyor observed a fruit fly flying around during an interview. The resident was observed waving the fly away.

> On 9/10/24 at 8:25 a.m., in the Cranberry dining room on the Mountain Top Unit, a surveyor observed fruit flies over the counter space.

> On 9/10/24 at 11:53 a.m., in the Harbor Unit dining area, two surveys observed a fly buzzing around in the metal container containing a trifle cake partially covered with plastic wrap. Half of the trifle cake was gone and CNA1 confirmed the finding and remove the cake from the lunch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 584	Continued From page 16 service. 3. On 9/12/24 from 9:30 a.m. to 9:40 a.m., an Environmental Tour was conducted with the Administrator and the Director of Facilities Operations in which the following findings were observed: > The shower room across from Resident Room 205 had sections of non-skid tape peeling up in the shower. > Resident Room 208 had a bathroom wall that had chipped/gouged paint creating an uncleanable surface. R4's wheelchair had a right armrest that was ripped and torn. > Resident Room 215 had a ceiling vent that was dusty/dirty. On 9/12/24 at 9:40 a.m. in an interview, a surveyor discussed and confirmed all the above findings with the Administrator and the Director of Facilities Operations.	F 584		
F 604 SS=L	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12	F 604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 604	Continued From page 17	F 604		

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on interviews, policy review and record review, the facility failed to ensure a resident's right to remain free from a physical restraint in accordance with §483.12, resulting in an immediate jeopardy situation with psychosocial harm and the risk of physical harm including the potential to cause death [Resident #99 (R99)]. All residents remained at risk as the facility failed to develop and/or implement measures, to protect the residents from further use of unnecessary restraints.

Findings:

On 7/31/24 at 12:35 p.m., the State of Maine's Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 604	Continued From page 18	F 604		

Assistants) were tying residents to chairs.

On 9/10/24 at 10:45 a.m., in an interview with a surveyor, the Life Enrichment and Pastoral Care staff member stated, "I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident were involved but they were on Cove [Unit]." The surveyor was directed to ask Registered Nurse #1 (RN1).

On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident.

On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident.

On 9/12/24 at 8:52 a.m., in an interview the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder containing partial notes that appeared as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 604	Continued From page 19	F 604		

timeline . The notes did not indicate who wrote them or when, but did include a copy of the visitor log on the day of the incident, and 2 witness statements from facility employees CNA6 and CNA7 both dated 7/25/24.

According to CNA6's witness statement dated "July 25th, 2024", at approximately 6:30 p.m., CNA6 and CNA7 found R99 "sitting in [his/her] wheelchair attempting to get out of it. This was due to a sheet wrapped around [his/her] waist, we witnessed that it was double knotted in the back of [his/her] wheelchair ... The sheet seemed to act as a restraint due to the fact [he/she] couldn't get out of [his/her] wheelchair."

According to CNA7's witness statement dated "7-25-24", at approximately 6:30 p.m., CNA7 and CNA6 "found [R99] in [his/her] wheelchair trying to stand up but couldn't because there was a sheet tied around her waist then double knotted to the back of [his/her] wheelchair ... the sheet seemed to act as a restraint."

On 9/12/24 at 9:40 a.m., a surveyor confirmed with the DON that a physical restraint was used to confine R99 to a wheelchair without a physician's order, evaluation/assessment, monitoring or informed consent, and the clinical record lacked documentation regarding the medical need for a physical restraint.

On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated R99 was known for getting out of his/her wheelchair and walking from his/her room to the nurse station. CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time. CNA3 stated she was investigated for a day or two but was told it wasn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 604	Continued From page 20	F 604		

her fault.

The facility's "Restraint Use" policy, dated 6/24/2014, states "the resident has the right to be kept from any chemical/physical restraint imposed for discipline or convenience and not requested to treat his/her medical condition."
For residents requiring some level of physical restraint use the following documentation must be in place:
-Medical reason or use and type of device with a signed physician order. PRN (as needed) orders are not acceptable.
-Documentation indicating the assessment of risk, the interdisciplinary process that determined the least restrictive device, and plan of care for the restrictive device.
-Documentation must reflect either the MDS (Minimum Data Set)/Triggers CAA's (Care Area Assessments), continued assessment of the need for, or the medical improvement of the resident that may support a reduction in the means of restraint.
-A daily documentation tool indicating the release of the restraint every 2 hours for a minimum of 15 minutes and the type of activity in which the resident participates to enhance mobility.
-The resident and/or representative will be informed of risk and benefits and possible negative outcomes and a written consent for use will be obtained.
-The consent must be signed by a competent resident, responsible party, or legal representative. -The resident / responsible party has the right to refuse a restraint.

The medical record had no such documentation.

The immediate jeopardy began on 7/25/24 when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	7 HIGHWOOD ST WATERVILLE, ME 04901

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F 604	Continued From page 21 the facility failed to ensure R99's right to freedom from physical restraint, and all residents remained at risk of not being free from the use of unnecessary restraints. The immediate jeopardy was identified on 9/13/24. The Administrator, Director of Nursing, and Director of Clinical and Quality Assurance were notified of the immediate jeopardy at 2:25 p.m. on 9/13/24. Please See F-000 Initial Comments related to the IJ removal plan.	F 604		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 607	Continued From page 22 (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on employee record review, facility policy review, and interview, the facility failed to implement its own Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition policy to ensure Maine background checks were completed for new employees before they were permitted to work for 2 of 12 sampled employees (Certified Nursing Assistant #5 [CNA5] and Registered Nurse #1 [RN1]). Findings: The facility's "Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition" Policy "Date: 7/1/2021" and "Revised: April 21, 2023", indicates under "A. Screening ... 1. At a minimum this Community will do the following prior to hiring a new colleague: a. Criminal background checks are conducted per state/federal law/regulation and per [Facility] guidelines." 1. On 9/13/24, a review of CNA5's employee file indicated the date of hire as 6/12/23. CNA5's Maine background check was completed on 7/30/23 (48 days after date of hire and working). 2. On 9/13/24, a review of RN1's employee file indicated the date of hire as 11/6/23. RN1's Maine background check was completed on 9/13/24 (295 days later after date of hire and working).	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 607	Continued From page 23 On 9/13/24 at 5:11 p.m., in an interview with a surveyor, the Human Resource Director stated the date of hire is the day an employee starts working in the facility. At this time a surveyor confirmed CNA5 and RN1 were hired and working with Resident's prior to the completion of a Maine background check.	F 607		
F 609 SS=L	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 609	Continued From page 24	F 609		

appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
Based on interviews, facility policy review, and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Social Security Act, resulting in failure to protect the resident from further potential harm from the perpetrator. In addition, the facility failed to report to law enforcement or the State Survey Agency (SA) an incident of possible abuse including the violation of a resident's right to be free from a physical restraint in accordance with §483.12, which kept the resident from ambulating from a wheelchair [Resident #99 (R99)]. This had the potential to affect all residents in the facility.

Findings:

The facility's "Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy" last revised on April 21, 2023 indicated under the Definitions heading:
"Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." It also states
"Timing: incidents and/or allegations of abuse ... should be reported to the Administrator and/or his/her designee immediately. The Administrator or his/her designee will notify the State Agency of alleged violations involving abuse, neglect ... and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to them."

The "Restraint Use" Policy dated 6/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 609	Continued From page 25	F 609		

states "The resident has the right to be kept from any chemical/physical restraint imposed for discipline or convenience and not requested to treat his/her medical condition."

On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs.

On 9/10/24 at 10:45 a.m. in an interview with a surveyor the Life Enrichment and Pastoral Care staff member stated, "I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident were involved but they were on Cove [Unit]." The surveyor was directed to ask Registered Nurse #1 (RN1).

On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident.

On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 609	Continued From page 26	F 609		

been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident.

On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time. CNA3 stated she was investigated for 1 to 2 days but was told it wasn't her fault.

On 9/12/24 at 8:52 a.m., in an interview with a surveyor the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with the name of the resident and a folder containing the facility's handwritten notes regarding the incident. The folder lacked evidence that the facility reported the incident to law enforcement agencies or to the SA .

On 9/12/24 from 8:58 a.m.- 9:40 a.m., interviews were completed with a surveyor and the DON. During the interview:
The Director of Clinical and Quality Assurance confirmed she did not report this incident to law enforcement or the SA.
The IDON at the time of the incident joined the interview by phone, and confirmed she did not report this incident to law enforcement or the SA.
The Interim Administrator at the time of the incident joined the interview by phone and confirmed she did not report this incident to law enforcement or the SA.

On 9/12/24 at 9:40 a.m., in an interview with the DON a surveyor confirmed that the facility failed to report the incident to law enforcement or the SA within 24 hours and failed to report a Follow-Up Investigation within 5 working days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 609	Continued From page 27 The immediate jeopardy began on 7/25/24 when the facility failed to report the violation of R99's right to be free from a physical restraint. All residents remained at risk of such reports not being made as the facility failed to implement policy and procedures to ensure reasonable suspicion of a crime against a resident is reported. Immediate Jeopardy was identified on 9/13/24. The Administrator, Director of Nursing, and Director of Clinical and Quality Assurance were notified of the immediate jeopardy at 2:25 p.m. on 9/13/24. Please See F-000 Initial Comments related to the IJ removal plan.	F 609		
F 610 SS=L	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 610	Continued From page 28	F 610		

by:
Based on interviews, record review, and policy review, the facility failed to fully investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident, which kept the resident from ambulating from a wheelchair (Resident #99 (R99). This had the potential to effect all residents in the facility.

Findings:

On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs.

On 9/10/24 at 10:45 a.m., in an interview with a surveyor, the Life Enrichment and Pastoral Care staff member stated, "I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident was involved but they were on Cove." The surveyor was directed to ask Registered Nurse #1 (RN1).

On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 610	Continued From page 29	F 610		

On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident.

On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time, she believed the visitors had gone home. CNA3 stated she was investigated for 1 to 2 days but was told it wasn't her fault.

The facility's "Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy" last revised on April 21, 2023 indicates under the Investigation heading it states:
"As part of the investigation, the Administrator or his/her designee, shall coordinate the investigative process ...and take the following action(s): Interview the resident, the accused, and potential witnesses. Witnesses may include anyone who: Witnessed or heard the incident; Came in close contact with either the resident the day of the incident (including other residents, family members, etc.); and Colleagues who worked closely with the accused colleague(s) and/or alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated."

On 9/12/24 at 8:52 a.m., in an interview the Director of Nursing (DON) stated she knows of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 610	Continued From page 30	F 610		

the incident but was not here at the time. The DON provided the surveyor with a folder containing partial notes that appeared as a timeline . The notes did not indicate who wrote them or when. The folder also contained a copy of the visitor log on the day of the incident, and 2 witness statements from facility employees CNA6 and CNA7 both dated 7/25/24. Review of the documents indicated:
- the resident was able to independently transfer from her bed to her chair .
-The visitor log showed only one person had signed in to visit R99 on 7/25/24. The visitor returned the visitor's badge at 2:02 p.m.
- CNA3 last saw the resident in a wheelchair between 4:30-5:30 p.m. when CNA3 went into R99's room to pick up a meal tray . There is no mention in the documents of R99 being restrained at this time.
- RN1 last saw R99 in bed between 5-5:30 p.m., when R99 received their evening meal tray. There is no mention in the documents of R99 being restrained at this time.
-RN3 was notified at approximately 6:30 p.m. that R99 was trying to stand up while restrained to a wheelchair. The evening meal tray was observed on the floor.
-There was a change for the worse in the resident's condition at 6:30 p.m., for which hospice was notified.
- The resident was resisting the restraint but unable to get out of it.
- The facility notes have no information about any visitors other than the one who returned the visitor's badge at 2:02p.m., when R99 transferred from the bed to the wheelchair, or who restrained R99 to the wheelchair.

On 9/12/24 from 8:58 a.m.- 9:40 a.m., interviews

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 610	Continued From page 31	F 610		

were completed with a surveyor and the DON. During the interview:
-The Unit Manager denied investigating the incident. She stated RN3 had texted her at 6:41 p.m. to inform her that R99 was found "in the chair tied with the sheet behind it and like a double knot, that they had let [him/her] out". The UM notified the prior IDON and from there the Director of Clinical and Quality Assurance and the prior IDON took control of the incident.
-The Director of Clinical and Quality Assurance denied investigating this incident.
-The IDON at the time of the incident joined the interview by phone and confirmed that she had not spoken with the family or fully investigated this incident.
-The Interim Administrator at the time of the incident joined the interview by phone and confirmed she had not spoken with the family or full investigated this incident.
- The resident had a Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment; and was thus unable to be interviewed at the time of the incident. The resident died on 7/26/24 and was not available to be interviewed by surveyors.

On 9/12/24 at 9:40 a.m., in an interview with the DON, a surveyor confirmed that the facility failed to fully investigate this incident, and at the time it was still unknown who had restrained R99 to the wheelchair.

A surveyor requested the Incident Policy, and the DON provided the "Accidents/Incidents Involving Residents" policy dated 7/1/2021 which requires "each incident or accident must be detailed in the medical record of the resident," and "each incident, accident, or medication error must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 610	Continued From page 32 investigated immediately for determination of root cause." Review of the facility Incident Report #1944 dated 7/25/24 and timed as having been written at 8:38 p.m., states " [6:30 p.m.]- [Certified Nursing Assistants] called nurse into [patient's] room where [he/she] was found restrained to [his/her] wheelchair by wrapping a bedsheet around [his/her] waist and the wheelchair ending with a double knot. Resident unable to give Description ." There was no documentation in the medical record to indicated this incident occurred or was fully investigated. The immediate jeopardy began on 7/25/24 when the facility failed to fully investigate the violation of R99's right to be free from a physical restraint in accordance with §483.12. All residents remained at risk as the facility failed to implement its policy and procedures to report and thoroughly investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident . Immediate Jeopardy was identified on 9/13/24. The Administrator, Director of Nursing, and Director of Clinical and Quality Assurance were notified of the immediate jeopardy at 2:25 p.m. on 9/13/24. Please See F-000 Initial Comments related to the IJ removal plan.	F 610		
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	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 33	F 623		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 623	Continued From page 34	F 623		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 623	Continued From page 35 §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(k). This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews, the facility failed to issue a written transfer/discharge notice to a Resident or their legal representative for a facility-initiated transfer/discharge for 2 of 3 Resident's reviewed for hospitalization (Resident #68 [R68], and R48). Findings: 1. R68 was admitted on 5/25/23 and has diagnoses to include dementia, dysphagia and atrial fibrillation. Review of R68's clinical record revealed on 9/5/24 he/she was transferred to an acute care hospital and subsequently admitted to the hospital. Further review of R68's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written transfer/discharge notice. During a review of R68's clinical record on 9/11/24 at 1:40 p.m. with a surveyor, the Administrator confirmed the clinical record lacked	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 623	Continued From page 36 evidence that a transfer notice was provided in writing to the Resident and/or Resident Representative. 2. R48 was admitted on 11/11/20 and has diagnoses to include Escherichia coli, dysphagia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and chronic respiratory failure. Review of R48's clinical record revealed on 7/22/24 he/she was transferred to an acute care hospital and subsequently admitted. Further review of R48's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written transfer/discharge notice. During a review of R48's clinical record on 9/12/24 at 1:20 p.m. with a surveyor, the Administrator confirmed the clinical record lacked evidence that a transfer notice was provided in writing to the Resident and/or Resident Representative.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 625	Continued From page 37	F 625		

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 issue written bed hold notices to include cost of care to the Resident and/or legal representative for 2 of 3 sampled Resident's reviewed for transfer to an acute care hospital (Residents #68 [R68], and R48).

Findings:

1. R68 was admitted on 5/25/23 and has diagnoses to include dementia, dysphagia and atrial fibrillation.

Review of R68's clinical record revealed on 9/5/24 he/she was transferred to an acute care hospital and subsequently admitted to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 625	Continued From page 38 Review of R68's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written bed hold notice upon this transfer. During a review of R68's clinical record on 9/11/24 at 1:40 p.m. in an interview with a surveyor, the Administrator confirmed the clinical record lacked evidence that a written bed hold notice was provided in writing to Resident and/or Resident Representative. 2. R48 was admitted on 11/11/20 and has diagnoses to include Escherichia coli, dysphagia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and chronic respiratory failure. Review of R48's clinical record revealed on 7/22/24 he/she was transferred to an acute care hospital and subsequently admitted to the hospital. Further review of R48's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written bed hold notice upon this transfer. During a review of R48's clinical record on 9/12/24 at 1:20 p.m. in an interview with a surveyor, the Administrator confirmed the clinical record lacked evidence that a written bed hold notice was provided in writing to Resident and/or Resident Representative.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 645	Continued From page 39 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 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.	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 645	Continued From page 40	F 645		

(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 residents with a specialized mental health diagnosis had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review (PASRR) evaluation and determination for 3 of 3 residents reviewed for PASRR evaluation (Resident #90 [R90], R25, and R11).

Findings:

1. Clinical record review indicates R90 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 645	Continued From page 41 re-admitted to the facility on 8/1/24, diagnoses to include bipolar disorder, anxiety disorder, and depression. Review of R90's PASRR Level I dated 5/31/24 indicates R90 had a Convalescence Categorical exemption (a time-limited 30-day exemption). R90's clinical record lacks evidence that the resident had been re-evaluated for a PASRR Level II determination after the Convalescent period ended. On 9/12/24 at 4:40 p.m., in an interview with the Administrator, a surveyor confirmed R90 had not been re-evaluated for a PASRR Level II determination after the Convalescent period ended.	F 645		
F 675 SS=G	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews , the facility failed to protect and promote a resident's right be free from a physical restraint in accordance with §483.12 [Resident #99 (R99)]. A reasonable and prudent person would suffer anxiety, distress, and fear from the involuntary loss of independent movement.	F 675		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 675	Continued From page 42	F 675		

Findings:

On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. The following is a result of the investigation:

R99 was admitted on 7/19/24 to the facility on hospice. The resident had a Brief Interview for Mental Status (BIMS)which indicated severe cognitive impairment and was unable to make his/her needs known. Diagnoses included dementia, lung cancer, acute respiratory failure with hypoxia, and anxiety disorder with a history of panic attacks. The Care Plan initiated on 7/19/24 indicated the resident has "difficulty breathing (dyspnea) on exertion. Remind me not to push beyond endurance."

Review of the facility-provided Incident Report "#1944" dated 7/25/24 and timed as having been written at 8:38 p.m ., states "[6:30pm.] -[Certified Nursing Assistants] called nurse into Pt's (patient's) room where [he/she] was found restrained to [his/her] wheelchair by wrapping a bedsheet around [his/her] waist and the wheelchair ending with a double knot. Resident Unable to give Description ."

On 9/12/24 at 8:52 a.m., in an interview with a surveyor the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder which contained handwritten notes, 2 witness statements, and a copy of the visitor log for 7/25/24. Review of folder contents indicated:
- the resident was able to independently transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	7 HIGHWOOD ST WATERVILLE, ME 04901

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F 675	Continued From page 43 from her bed to her chair. -The resident had a change in condition at 6:30 p.m. on 7/25/24 for which hospice was notified. -Witness statements indicate the resident was found restrained at approximately 6:30 p.m. and was observed resisting the restraint by attempting to stand and get out of it. On 7/26/24 at 12:07 a.m., RN3's nurse note indicated he contacted hospice because R99 "had changed from [his/her] baseline to severe anxiety and agitation, constantly shouting", and the Doctor had called back with new orders for Effexor [used to treat anxiety] and Clonidine [treats high blood pressure, withdrawal symptoms, anxiety, and post-traumatic stress disorder]. This behavior had started at 6:30 p.m., per the facility's hand written notes, when R99 was found by staff attempting to stand while restrained. On 9/13/24 at 2:25 p.m., during an interview with the DON, the Administrator, and the Director of Clinical and Quality Assurance 2 surveyors reviewed and confirmed R99 had increased anxiety and distress after the use of a physical restraint.	F 675		
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	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 684	Continued From page 44	F 684		

care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, and interview the facility failed to ensure that physician orders were updated and/or followed for 1 of 5 Resident's reviewed for unnecessary medications. (Resident #29 [R29]).

Findings:

On 9/12/24 during R29's clinical record review, R29 had a new physician order filed in the paper record and scanned into the electronic record dated 9/4/24 to, "1) discontinue acetaminophen 650 mg (milligram [m.g.]) 3 times daily, 2) Begin acetaminophen 1 g (gram) (1000 m.g. equals 1 g) 3 times daily for chronic pain, 3) physical therapy evaluation and treatment for decreased mobility with the patient goal of regaining independence in bed mobility, and 4) occupational therapy evaluation and treatment for decreased mobility with the patient goal of regaining independence in bed mobility."

Review of R29's clinical record lacked evidence that R29's acetaminophen order, physical therapy order, and occupational therapy order dated 9/4/24 was reviewed and/or updated by a provider.

On 9/12/24 at 9:28 a.m. in an interview with a surveyor, Registered Nurse #4 (RN4), Charge Nurse on Memory Care Unit, states that R29 gets acetaminophen 325 m. g. two tabs by mouth three times per day according to his/her physician order. RN5 is unaware of the physician orders dated 9/4/24 pertaining to acetaminophen, physical therapy, and occupational therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 684	Continued From page 45 orders. On 9/12/24 at 9:34 a.m. in an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) Unit Manager Memory Care Unit, states regarding the orders dated 9/4/24 for R29, that somebody filed this without addressing it. On 9/13/24 at 4:29 p.m. in an interview with LPN1, a surveyor confirmed that the facility failed to follow physician orders for the change in dose of acetaminophen, order for physical therapy evaluation and treatment, and order for occupational therapy evaluation and treatment. LPN1 states that this should have been addressed.	F 684		
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 and interviews, the facility failed to provide a sanitary environment to ensure that respiratory equipment was clean to help prevent the development and transmission of disease and infection related to nebulizer and oxygen tubing for 3 of 3 residents reviewed for respiratory care (Resident #251 [R251], R3, and R47).	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 46 Findings: Review of facility policy "Nebulizer Cleaning" dated 7/1/21 states " ..., store the nebulizer in a zip lock plastic bag ..." 1. Observations of R251 on 9/9/24 at 11:45 a.m., and 9/10/24 at 8:08 a.m., a nebulizer was observed on bedside table with tubing connected to mask lying on top of table not labeled or bagged. Observation of oxygen concentrator on opposite side of room with nasal cannula/tubing connected and observed lying on floor, undated and unbagged. Review of R251's active orders dated September 2024 lacked evidence of an order for oxygen or nebulizer use. During an interview on 9/09/24 at 11:49 a.m. with a surveyor, Registered Nurse (RN) #1 indicated R251 does not use a nebulizer or oxygen. During an observation of R251 on 9/10/24 at 9:50 a.m. with a surveyor, the Unit Manager (UM) indicated it was her expectation that nebulizer and oxygen tubing would be labeled and in bag when not in use. At this time the UM confirmed a nebulizer and oxygen tubing was not dated or bagged. 2. On 9/9/24 at 11:04 a.m., a surveyor observed the filter to R3's oxygen concentrator to be heavily soiled, the oxygen tubing was dated 8/21/24, and the nebulizer mask and tubing were not stored in a sanitary manner.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 695	Continued From page 47 On 9/10/24 at 3:31 p.m., during an interview, the surveyor observed and confirmed the above findings with RN2. 3. On 9/09/24 at 12:04 p.m., a surveyor observed R47's concentrator was missing its filter. The label on R47's oxygen tubing was dated 7/21/24. On 9/10/24 at 3:29 p.m., during an interview with a surveyor, RN2 stated, the night nurse usually changes the oxygen tubing. The tubing is labelled with the date it was changed and should be changed weekly. At this time a surveyor observed and confirmed with RN2 that R47's oxygen tubing was labelled 7/21/24 and the filter was missing from the oxygen concentrator.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 725	Continued From page 48	F 725		

this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record review, and staffing schedule review, the facility failed to ensure sufficient staff were scheduled and on duty to meet the needs of resident's (Resident #25 [R25], R64, and R18) with the potential to affect all resident's.

Findings:

On 9/09/24 at 12:52 p.m., in an interview with a surveyor, Certified Nursing Assistant #2 (CNA2) stated, it's hard to provide care timely, "lately it's me; a nurse will have 2 floors, and a med tech (Certified Medication Assistant - Medications [CNA-M])."

On 9/10/24 at 7:30 a.m., in an interview with a surveyor, R25 states they had not received a bath 3 times in a row in the past month because staff wouldn't provide it.
Record review of R25's Care Plan indicates, "[R25] requires extensive assist for toileting and personal hygiene, and physical assist with bathing" and "patient to have a shower twice a week and prn [as needed]."

On 9/10/24 at 10:45 a.m., in an interview with a surveyor, RN1 states there is a delay in care due to staffing. Resident's still get what they need but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 725	Continued From page 49	F 725		

they may be sitting in incontinence for too long before staff can respond. On Cove Unit, a lot of resident's require 2-assist, and a resident that needs the Hoyer lift can be very time consuming. I only have two people on the floor, I don't have anyone on the floor for that amount of time (spent with a 2-assist Resident for Activities of Daily Living Living).

On 9/10/24 at 3:13 p.m., in an interview with a surveyor, CNA-M3 states, resident's on Mountain Top Unit get everything they need as long as they are full staffed. Showers are the hardest to provide as a lot of resident's are 2-assist for showers. CNA-M3 clarified, 2-assist are not just resident's that require the Hoyer lift, but resident's who use psychiatric medications also need 2-assist for staff safety. CNA-M3 stated Memory Lane and Harbor are the units that will skip bathing care for resident's related to staffing.

On 9/11/24 at 7:50 a.m., in an interview with a surveyor, R64 states, "the other day staff were rushed around because everything wasn't done before they came in for the day shift. Some days we have 2-3 (staff), some days there is only 1 person. They are trying to answer call bells and help people get ready for the day. Today, those that (staff) didn't get up in time for breakfast, (staff) make sure are up by lunch. There are resident's that do complain about the call bells, but staff answer the call bells in the order they come in. They can only do what they can do."

On 9/11/24 at 8:26 a.m., in an interview with a surveyor, R18 states, "there have been a few days where I missed my shower days. It only happens when there are only 2 aides (CNA's) on the floor for 28 residents with 28 meals to pass

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 725	Continued From page 50 out." Shower time is usually during breakfast time. On 9/12/24 at 8:51 a.m., during an interview with the Scheduler, and the Director of Nursing (DON), staffing schedules were reviewed with a surveyor. The facility did not meet minimum staffing ratios on day shifts for 9/4/24, 8/31/24, 8/29/24, 7/26/24, and 7/22/24. The DON states they are working on staffing to meet the minimum ratio then will work up to staffing for acuity. At this time a surveyor confirmed the facility is not staffing based on the resident's needs.	F 725		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 1 of 5 sampled employees (Certified Nursing Assistant #2 [CNA2]). Findings: 1. CNA2 was hired on 7/1/21. The facility was unable to provide evidence of completed annual performance evaluations for 2023 and 2024. On 9/13/24 at 1:00 p.m., in an interview with a	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 730	Continued From page 51 surveyor, the Administrator confirmed that CNA2 had not received annual performance evaluations in 2023 and 2024.	F 730		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 755	Continued From page 52	F 755		

by:
Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book [a logbook used to record medication] Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts on 2 of 3 units observed for medication storage (Cove and Harbor).

Findings:

1. Review of bound controlled medication book labeled Harbor Log #119 lacked evidence that controlled medication counts were conducted by the oncoming nurse on 8/17/24 at 18:20 (6:20 p.m.). Further review of controlled medication book lacked evidence that controlled medication counts were conducted by the outgoing nurse on 8/17/24 at 5:40 a.m., 8/18/24 at 6:00 a.m., and on 8/28/24 at 6:00 a.m.

During an interview on 9/10/24 at 6:30 a.m. with a surveyor, Certified Nursing Assistant- Medications #1 (CNA-M1) confirmed above findings.

2. Review of bound controlled medication book labeled Cove #21 lacked evidence that controlled medication counts were conducted by the oncoming nurse on 7/26/24 at 18:00 (6:00 p.m.), on 7/27/24 at 5:30 a.m., on 8/7/24 (no time noted), and on 9/3/24 at 21:00 (9:00 p.m.). Further review of controlled medication book lacked evidence that controlled medication counts were conducted by the outgoing nurse on 7/5/24 on 5:30 a.m., on 7/11/24 at 18:00 (6:00 p.m.), on 7/25/24 at 6:00 a.m., on 8/8/24 at 6:00 a.m., on 8/10/24 at 18:00 (6:00 p.m.), on 8/11/24 at 6:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 755	Continued From page 53 a.m., and on 9/4/24 5:30 a.m. During an interview on 9/10/24 at 7:59 a.m. with a surveyor, CNA-M2 confirmed above findings. During review of controlled medication books #119 and #21 with a surveyor on 9/10/24 at 8:45 a.m., the Administrator confirmed the above findings. During a follow up interview on 9/10/24 at approximately 11:20 a.m. with a surveyor, the Director of Nursing confirmed that controlled medication should be counted during each shift change and was aware of the above concerns because the facility has a previous performance improvement plan in this area, but no one followed through with it.	F 755		
F 761 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 §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	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 761	Continued From page 54	F 761		

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, record reviews, and policy review, the facility failed to adequately date and properly dispose of biological's according to manufacturer specifications and expired medications on 1 of 1 unit (Cove). In addition, the facility failed to adequately store controlled substances in a permanently affixed compartment and double locked in 2 of 2 medication rooms observed (Cove and Harbor). Furthermore, the facility failed to ensure proper vaccine storage temperatures for 1 of 1 unit (Cove) and failed to monitor and record medication refrigerator temperatures for 3 of 4 medication refrigerators observed (Cove and Harbor).

Findings:

1. Review of facility policy "Storage and Expiration Dating of Medications and Biological's" dated 12/1/07 states " ...Facility should ensure that medications and biological's that (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines ... Medications with a manufactured expiration date expressed with month and year will expire on the last day of the month...Facility personnel should inspect nursing station storage areas for proper storage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 761	Continued From page 55 compliance on a regularly scheduled basis ..." Observation of vaccination refrigerator located on the Cove Unit on 9/10/24 at 8:17 a.m., with Registered Nurse #1 (RN1) revealed the following vaccinations stored with unexpired vaccinations and available for use: -1 Flu Vaccine (Flu Zone Quad 2022-2 60Mcg (micrograms)/0.5ml (milliliter) syringe expiration date June 30, 2023. -10 boxes containing 10 individual dose syringes of influenza vaccine Afluria with expiration date May 31, 2024 (total of 100 doses) -5 individual doses of Prevnar 20 0.5ml syringe with expiration date July 2024. -1 Prevnar 20 0.5ml syringe with expiration date 12/28/23 -1 multi dose vial of Moderna COVID-19 vaccine 100 mcg/0.5ml vial use by day 6/9/23 -1 multidose vial of Moderna Covid Bival (18 50 mcg/0.5ml) with use by date 6/13/23. -2 multidose vial of Pfizer COVID-19 30mcg/0.3ml vial use by date 1/6/23 -1 multidose vial of Pfizer COVID-19 30mcg/0.3ml vial use by date 12/2/22. 2. Review of facility policy "Storage and Expiration Dating of Medications and Biologicals" dated 12/1/07 states "Store all drugs and biological's in locked compartments, including the storage of Schedule II-V medications in separately locked, permanently affixed compartments. ..." During an observation of Cove Medication Room on 9/10/24 at 8:15 a.m. with a surveyor and RN1, the following was observed:	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 761	Continued From page 56	F 761		

-Mini Controlled medication refrigerator located on top of counter containing an unlocked, unaffixed small index card sized metal box containing 1 box of Lorazepam 2mg (milligram)/ml concentrate, and one box of Lorazepam 2mg/ml concentrate lying on the shelf. At this time RN1 confirmed above findings. On 9/10/24 at 8:22 a.m., observation of the Harbor Medication room with Licensed Practical Nurse #3 (LPN3), the surveyor noted mini refrigerator containing 1 box of Lorazepam 2mg/ml concentrate located in refrigerator door. During an observation with surveyor on 9/10/24 at 8:45 a.m., the Administrator confirmed above findings

3. Review of facility policy "Storage and Expiration Dating of Medications and Biologicals" dated 12/1/07 states "Facility should ensure that medications and biological's are stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance. Facility staff should monitor the temperature of vaccines twice a day. Refrigeration: 36*-46* F (Fahrenheit) or 2*-8* C (Celsius). Facility should monitor the temperature of medication storage areas at least once a day. Facility should monitor cold storage containing vaccines two time a day per CDC (Centers for Disease Control) guidelines ..."

Review of provided "Cove Refrigerator temperature logs" revealed the following:
--Review of "Cove Tall Refrigerator Temperatures" dated "August 2024" revealed temperatures were taken 7 of 31 days.
-Review of "Cove Vaccine Refrigerator Temperatures "dated September 2024" revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 761	Continued From page 57 temperatures were taken 1 of 10 days -Review of "Cove Controlled Refrigerator Temperatures " dated "September 2024" revealed temperatures were taken 4 of 10 days. -Review of "Unlabeled Cove Refrigerator Temperatures" dated August 2024 revealed temperatures were taken 12 of 31 days. Review of facility provided "Harbor Medication Refrigerator Log" revealed the following: -Review of "Harbor Medication Refrigerator Log" dated "July 2024" revealed temperatures were taken 7 of 31 days. -Review of "Harbor Medication Refrigerator Log" dated "August 2024" revealed temperatures were taken 11 of 31 days. -Review of "Harbor Medication Refrigerator Log" dated" September 2024" revealed temperatures were taken 10 of 30 days. During observations of Cove and Harbor Units with surveyor on 9/10/24 at 8:45 a.m., the Administrator confirmed above findings.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, Resident	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 804	Continued From page 58	F 804		

Council Meeting Minutes and lunch meal test trays, the facility failed to serve hot foods hot, and cold foods cold for 2 of 4 lunch meals (lunch 9/9/24, and lunch 9/10/24) tested for appetizing temperatures (Resident #4 [R4], R5, R16, R34, R47, and R59).

Findings:

1. On 9/09/24 at 11:13 a.m., in an interview with a surveyor, R59 states, "The food is lukewarm most of the time."

2. On 9/09/24 at 11:50 a.m., in an interview with a surveyor, R47 states, "The vegetables are soft and squishy."

3. On 9/9/24 at 11:55 a.m., a surveyor received a test tray from the Harbor Unit with Hot Potato salad, Green Beans and a Hamburger. The temperature of the Hot Potato salad was 95.3 degrees Fahrenheit (F). The temperature of the Green Beans was 95 degrees F. The temperature of the Hamburger was 99.6 degrees F. The hot foods on the test tray were found not to be palatable at those temperatures by the surveyor.

4. On 9/09/24 at 1:59 p.m., in an interview with a surveyor, R4 states, "The food that comes is always cold and has to be reheated. It is never hot and is not good to eat and tastes terrible when it's not hot and cold foods not cold."

5. On 9/09/24 at 2:05 p.m., in an interview with a surveyor, R34 states, "I like my food hot, and it always comes cold. The staff has to heat it for me."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 804	Continued From page 59	F 804		

6. On 9/10/24 at 8:20 a.m., a surveyor discussed the lunch meal and food temperatures from the Harbor unit the surveyor received on 9/9/24 with the Interim Food Service Director. The surveyor discussed with him that the meal was not hot and not palatable. At this time, the Interim Food Service Director confirmed that those temperatures were not appropriate, the food was not hot and that it would not be palatable at that temperature.

7. On 9/10/24 at 11:15 a.m., in an interview with a surveyor, Registered Nurse #1 (RN1) states, "On days like today, I have someone that has to go to dialysis, and [he/she] is very particular about [he/she] doesn't want to be up early and doesn't want to sit in [his/her] chair long before [he/she] is taken. We try to accommodate that the best that we can but then it becomes an issue of well now I have only two Certified Nursing Assistant's (CNA's) and they're tied up in this room for a solid half hour and its right smack dab during breakfast. So lately I go and help the CNA, and I have one CNA go and do breakfast but then then you have all these Resident's that are complaining their foods cold. By the time we get the trays all passed, sometimes some are really cold and then we're running back and forth trying to heat it up."

8. On 9/10/24 at 11:40 a.m., in an interview with a surveyor, a family member of R16 states, "The food comes up to the second-floor dining room cold. It comes up and just sits there in the cart. Sometimes the carts are even delivered before the Residents are out to the table so the cart will sit there for half hour before the trays are delivered. The CNA's have to heat up many of the meals because they are cold, and the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 804	Continued From page 60	F 804		

don't like it cold. I have complained to the nursing staff many times and it doesn't seem to make a difference."

9. On 9/10/24 at 8:16 a.m., in an interview with a surveyor, R5 states, "The food is disgusting. There is a lack of seasoning, and the food is warm but not hot. Flavor and texture of meat has been so bad that I have become a bit of a vegetarian but recently told them to stop sending salad because the lettuce has been "rusty". I do not enjoy meals anymore."

10. On 9/10/24 at 11:55 a.m., a large, enclosed food cart came up from the kitchen to the Harbor Unit. A small, enclosed food cart came up at 12:03 p.m. from the kitchen. Both carts were in the Harbor dining room at 12:05 p.m. in the unit. Three CNA's started serving the Residents. It was not until 12:25 p.m. that the large cart was emptied, and 13 residents were served at the table. The surveyors observed a CNA heating up a resident's meal.

11. On 9/10/24 at 12:40 p.m., two surveyors received a test tray from the Harbor Unit with Breaded Italian Style Chicken, Rice Pilaf and California Mixed Blend Vegetables. The temperature of the Breaded Italian Style Chicken was 116 degrees Fahrenheit (F). The temperature of the Rice Pilaf was 116.7 degrees F. The temperature of the California Mixed Blend Vegetables was 117 degrees F. The hot foods on the test tray were found not to be palatable at those temperatures by the surveyors.

On 9/10/24 at 2:20 p.m., in an interview with a surveyor, the Interim Food Service Director confirmed that the food temperatures for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 804	Continued From page 61 lunch tray were not hot like they were supposed to be. He stated that the company policy is food heated appropriately and held at least 140 degrees F. 12. Review of the Facility's Resident Council minute meetings reveals the following: 8/6/24 at 2:00 p.m. - The majority states: 1. They are still not getting menus choose alternate dishes. Would like to see a variety of meals and not just sandwiches. 2. Meals are still being served cold. 7/9/24 - [Resident] had mentioned, [he/she] has not been receiving menus to fill out and receiving cold meals daily. Majority states not given menus weekly, not offered, no menus to fill out. Majority states portions are too small a lot of the time. On 9/11/24 at 8:30 a.m., in an interview, the surveyor discussed the findings with the Administrator.	F 804		
F 810 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 record review, observations, and interview, the facility failed to provide adaptive built-up utensils and Kennedy cups for 1 of 5 residents reviewed for nutrition (Resident #11	F 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 810	Continued From page 62 [R11]).	F 810		

Findings:

Clinical record review indicates R11 was admitted on 11/13/19, diagnoses to include generalized muscle weakness, dysphagia (difficulty swallowing), and protein-calorie malnutrition. R11's Care Plan initiated on 7/9/24 states, "[R11] has or may have a nutritional problem", the interventions for this include "Adaptive equipment at meals: Kennedy cup, rimmed plate, built-up utensils". The Dietary Communication Slip dated "11/26" states "Please issue weighted utensil."

On 9/09/24 at 12:58 p.m., a surveyor observed R11 eating lunch in bed. The meal ticket on the tray indicates use of a Kennedy cup, and built-up utensils. R11's meal tray did not include a Kennedy cup or built-up utensils.

On 9/10/24 at 8:30 a.m., a surveyor observed R11's breakfast tray did not include a Kennedy cup or built-up utensils.

On 9/11/24 at 12:09 p.m., a surveyor observed R11 lying in bed, 2 open face cups with a straw and a standard spoon observed on the bedside table. At 12:29 p.m., a surveyor observed Licensed Practical Nurse #2 (LPN2) deliver R11's lunch tray. The lunch tray did not include a Kennedy cup or built-up utensils.

On 9/11/24 at 12:29 p.m., in an interview with a surveyor, the LPN2 states, she has seen R11 use adaptive dishes before but not in "a while". At this time the surveyor confirmed adaptive equipment was not provided to R11 as directed by the Dietary Communication, R11's meal ticket, or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 810	Continued From page 63 Care Plan.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility logs and the facility's Dish Machine Temperatures policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall mounted fan, food disposals, the dishwasher, the standing floor mixer, ceiling air vents, ceiling tiles, and the walk-in freezer; failed to ensure hair protection was worn by staff; failed to ensure foods were dated/labeled appropriately; failed to ensure kitchen sanitizer was monitored and failed to ensure that kitchen and unit refrigerator/freezer and dishwasher temperatures were monitored appropriately for 1 of 1 kitchen tours (9/9/24) and	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 64 2 of 2 kitchen observations (9/9/24 and 9/10/24). This has the potential to affect all residents that eat food prepared by kitchen staff. Findings: Review of the facility's "Dish Machine Temperatures" policy revised 1/24 noted: Dish machine wash and rinse water should be maintained at temperatures that meet guidelines established by the Food and Drug administration. State or local regulations will apply if stricter. Note: The range for optimal cleaning performance of the Diversey dish detergent is 150° Fahrenheit (F) to 165°F. Supervisor: If documentation of temperatures and test strips/max temperatures results has been assigned to a food and nutrition associate, confirm that it is completed at each meal period. Director: In the event of inappropriate temperature, make management decision concerning adequacy of sanitation of service ware. If due to inappropriate water temperature, high temperature machine, implements disposable service ware or use three compartment sink for sanitation. Notifies nursing units of use of disposal service ware. Contact sources of repairs. Documents action taken on the back of form. Director/designee: Verifies completion of logs, initials weekly. Initial Kitchen Tour on 9/9/24 from 10:45 a.m. to 11:30 a.m. with a surveyor and Kitchen Supervisor in which the following findings were observed: -The wall mounted fan in the dietary office was heavily soiled with dust/dirt. -A male kitchen worker with facial hair was not	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 812	Continued From page 65	F 812		

wearing facial hair protection.
-2 food disposal units had dried food and dried liquid residue on the outside of them.
-The high temperature dishwasher was only washing at 110° F and would not reach 150 F after 5 tries.
- There were 4 ceiling air vents and 6 ceiling tiles that were dusty/dirty.
-The standing floor mixer had chipped/missing paint on the mix arm and the base.
-The walk-in freezer had ice build-up on 2 boxes of sheet cakes and on 1 blueberry pie. Additionally, there were 2 bags of waffles, 2 bags of tater tots, 4 bags of hot dog buns, 2 bags of sliced potatoes and 1 bag of French fries that were unlabeled and undated.

On 9/9/24 at 11:30 a.m., in an interview a surveyor, the Kitchen Supervisor confirmed the findings.

-On 9/10/24 at 8:00 a.m., a surveyor observed a male kitchen worker with facial hair who was not wearing facial hair protection. At this time, the Interim Food Service Director confirmed the finding.

The surveyor had requested the Dish machine Temperature Logs, the kitchen/unit refrigerators/freezers daily temperatures and Sanitizing Testing Logs for June, July, August and September 2024 on 9/9/24, 9/10/24, 9/11/24, and finally received them on 9/12/24 from the Administrator at 8:20 a.m. The surveyor reviewed them with the Administrator and found many missing days of monitoring and documenting temperatures.

Monitoring and Documentation of Dish Machine

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 812	Continued From page 66	F 812		

Temperature Logs: 2024
June - missing 14th - 30th
July - missing 1st - 31st
August - missing 18th - 31st
September - missing 1st - 13th

Monitoring and Documentation of Sanitizing Testing Logs: 2024
June - missing 14th, 15th, 25th -30th

Monitoring and Documentation of Refrigerator/Freezer Temperatures: 2024
Kitchen:
June - Refrigerator and Freezer - missing 26th -30th
Harbor Unit(2nd floor)(1 Refrigerator/Freezer):
June - missing 3rd-30th
July - missing 20th-31st
August - missing 1st-31st
September - missing 1st-5th and 10th-30th

Cove Unit(2nd floor)(2 Refrigerators/Freezers):
#1 June - missing 28th-30th
#1 July - missing 1st-31th
#1 August - missing 2nd-9th, 11th, 13th and 15th-31st
#1 September - missing 11th-21st and 10th-30th
#2 June - missing 1st-30th
#2 July - missing 1st-31st
#2 August - missing 1st-31st
#2 September - missing 7th, 8th and 12th-30th

Memory Unit(3rd floor)(3 Refrigerators/Freezers):
#1 June 2024- missing 26th-30th
#1 July 2024 - missing 20th-31st
#1 August - missing 1st-31st
#1 September 2024- missing 1st-30th
#2 June 2024- missing 1st-30th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 67 #2 July 2024 - missing 1st-31st #2 August - missing 1st-31st #2 September 2024- missing 1st-30th #3 June 2024- missing 1st-30th #3 July 2024 - missing 1st-31st #3 August 2024- missing 1st-31st #3 September 2024- missing 1st-30th Mountaintop Unit(4h floor)(2 Refrigerators/Freezers):2024 #1 June 2024 - missing 28th-30th #1 July 2024 - missing 28th-31st #1 August - missing 1st-31st #1 September 2024- missing 1st-30th #2 June 2024- missing 1st-30th #2 July 2024 - missing 1st-31st #2 August - missing 1st-31st #2 September 2024- missing 1st-30th On 9/12/24 at 8:24 a.m., in an interview with a surveyor, the Administrator confirmed that temperatures were not monitored and documented daily for the Dish machine Temperature Logs, the kitchen/unit refrigerators/freezers daily temperatures, and Sanitizing Testing Logs for June, July, August and September 2024.	F 812		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 835		

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 68 Based on the cumulative effect of deficiencies cited during the recertification survey from 9/9/24 through 9/17/24, the facility failed to ensure the facility was Administered in a manner that enabled residents to attain or maintain their highest practicable well-being as evidenced by Federal findings listed under §483.10 - Resident Rights (F567, F578, F584); § 483.12 - Freedom from Abuse, Neglect, and Exploitation (F604, F607, F609, and F610); §483.15 - Admission, Transfer, and Discharge (F623, and F625); §483.20 - Resident Assessments (F645); §483.24 - Quality of Life (F675); §483.25 - Quality of Care (F684, F695); §483.35 - Nursing Services (F725, and F730); §483.45 - Pharmacy Services (F755, and F761); §483.60 - Food and Nutrition Services (F804, F810, and F812); §483.70 - Administration (F842); §483.80 - Infection Control (F880, and F883); §483.90 - Physical Environment (F908); and §483.95 - Training Requirements (F940, F942, F943, F944, F946, F947, and F949). These failures to ensure a process was in place to monitor staff development and resident care resulted in the facility failing to assist Resident's to maintain their highest functional and practicable well-being and has the potential to affect all 91 Resident's. In addition, the Administration failed to follow the Facility Assessment ensuring staff education/training and competencies were completed. Findings: 1. Based on interviews and record review, the facility failed to provide a Resident access to personal funds (Resident #47 [R47]). (F567) 2. Based on record review and interviews the	F 835		

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 835	Continued From page 69	F 835		

facility failed to provide/obtain Resident and or Resident Representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive for 8 of 8 Resident's reviewed for Advance Directives (Resident #26 {R26], R46, R251, R252, R43, R4, R64, and R34). (F578)

3. 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 environment on 2 of 4 units (Mountain Top Unit and Harbor Unit) for 3 of 3 facility tours (9/9/24, 9/10/24 and 9/12/24). (F584)

4. Based on interview, internal facility notes, policy review and record review, the facility failed to ensure a Resident's right to remain free from a physical restraint which kept the Resident from ambulating from his/her wheelchair resulting in an immediate jeopardy situation with psychosocial harm and the risk of physical harm including the potential to cause death [Resident #99 (R99)]. All Residents (91 of 91 Residents) remained at risk as the facility failed to develop and/or implement measures to report, fully investigate, and protect the Resident's from further use of unnecessary restraints. (F604)

5. Based on employee record review, facility policy review, and interview, the facility failed to implement its own Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition policy to ensure Maine background checks were completed for new employees before they were permitted to work for 2 of 12 sampled employees (Certified Nursing Assistant #5 [CNA5] and Registered Nurse #1 [RN1]).

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 835	Continued From page 70 (F607)	F 835		

6. Based on interviews, facility policy review, record review and facility notes, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Social Security Act, resulting in failure to protect the resident from further potential harm from the perpetrator. In addition, the facility failed to report to the State Survey Agency (SA) an incident of possible abuse including the violation of a resident's right to be free from a physical restraint, which kept the resident from ambulating from a wheelchair [Resident #99 (R99)]. This had the potential to affect all residents in the facility (91 of 91 Resident's). (F609)

7. Based on interviews, record review, policy review, and review of the facility's handwritten notes, the facility failed to fully investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident, which kept the resident from ambulating from a wheelchair (Resident #99 (R99). This had the potential to affect all residents in the facility (91 of 91 Resident's). (F610)

8. Based on record reviews, and interviews, the facility failed to issue a written transfer/discharge notice to a Resident or their legal representative for a facility-initiated transfer/discharge for 2 of 3 Resident's reviewed for hospitalization (Resident #48 [R48], and R68). (F623)

9. Based on record review and interview, the facility failed to issue written bed hold notices to

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 835	Continued From page 71	F 835		

include cost of care to the Resident and/or legal representative for 2 of 3 sampled Resident's reviewed for transfer to an acute care hospital (Resident #68 [R68], and R48). (F625)

10. Based on record reviews and interviews, the facility failed to ensure Residents with a specialized mental health diagnosis had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review (PASRR) evaluation and determination for 3 of 3 Residents reviewed for PASRR evaluation (Resident #90 [R90], R25, and R11). (F645)

11. Based on observations, record reviews, and interview, the facility failed to ensure a Resident was free from psychosocial harm when a Resident was restrained to a wheelchair, preventing them from ambulating, which resulted in increased anxiety, distress, and increased perception of pain [Resident #99 (R99)]. (F675)

12. Based on record reviews, and interview the facility failed to ensure that physician orders were updated and/or followed for 1 of 5 Resident's reviewed for unnecessary medications. (Resident #29 [R29]). (F684)

13. Based on observations and interviews, the facility failed to provide a sanitary environment to ensure that respiratory equipment was clean to help prevent the development and transmission of disease and infection related to nebulizer and oxygen tubing for 3 of 3 residents reviewed for respiratory care (Resident #251 [R251], R3, and R47). (F695)

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 835	Continued From page 72 14. Based on interviews, record review, and staffing schedule review, the facility failed to ensure sufficient staff were scheduled and on duty to meet the needs of Resident's (Resident #25 [R25], R64, and R18) with the potential to affect all Resident's (91 of 91 Resident's). (F725) 15. Based on performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 1 of 5 sampled employees (Certified Nursing Assistant #2 [CNA2]). (F730) 16. Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts on 2 of 3 units observed for medication storage (Cove and Harbor). (F755) 17. Based on observations, interviews, record reviews, and policy review, the facility failed to adequately date and properly dispose of biological's according to manufacturer specifications and expired medications on 1 of 1 unit (Cove). In addition, the facility failed to adequately store controlled substances in a permanently affixed compartment and double locked in 2 of 2 medication rooms observed (Cove and Harbor). Furthermore, the facility failed to ensure proper vaccine storage temperatures for 1 of 1 unit (Cove) and failed to monitor and record medication refrigerator temperatures for 3 of 4 medication refrigerators observed (Cove and Harbor). (F761)	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 73	F 835		

18. Based on observations, interviews, Resident Council Meeting Minutes and lunch meal test trays, the facility failed to serve hot foods hot, and cold foods cold for 2 of 4 lunch meals (lunch 9/9/24, and lunch 9/10/24) tested for appetizing temperatures (Resident #4 [R4], R5, R16, R34, R47, and R59). (F804)

19. Based on record review, observations, and interview, the facility failed to provide adaptive built-up utensils and Kennedy cups for 1 of 5 residents reviewed for nutrition (Resident #11 [R11]). (F810)

20. Based on observations, interviews, facility logs and the facility's Dish Machine Temperatures policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall mounted fan, food disposals, the dishwasher, the standing floor mixer, ceiling air vents, ceiling tiles, and the walk-in freezer; failed to ensure hair protection was worn by staff; failed to ensure foods were dated/labeled appropriately; failed to ensure kitchen sanitizer was monitored and failed to ensure that kitchen and unit refrigerator/freezer and dishwasher temperatures were monitored appropriately for 1 of 1 kitchen tours (9/9/24) and 2 of 2 kitchen observations (9/9/24 and 9/10/24). This has the potential to affect all residents that eat food prepared by kitchen staff. (F812)

21. Based on record reviews, and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 3 of 20 residents reviewed for documentation (Resident #46 [R46], R3, and R47). (F842)

22. Based on observations, and interviews the facility failed to maintain an Infection Control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 835	Continued From page 74 Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to enhanced barrier precautions (EBP's) pertaining to Residents (Resident #70 [R70], R87, and R84) with a wound(s) for 2 of 5 days of survey (9/9/24, and 9/10/24). (F880) 23. Based on record review, and interview, the facility failed to ensure Residents were offered pneumococcal vaccinations in accordance with their policy and the Centers for Disease Control and Prevention (CDC) recommendations for 5 of 5 residents reviewed for immunizations (Resident [R] 87, R90, R29, R1, and R70). (F883) 24. Based on observations, interviews, the facility's "Dish Machine Temperatures", and a food equipment service company work log, the facility failed to ensure that the kitchen high temperature dish machine was maintained in good repair and in safe operating condition for 1 of 1 dish machine observations (9/9/24) and failed to ensure proper cleaning and sanitizing of dishes for 1 of 1 kitchen tours (9/9/24). (F908) 25. Based on interview and employee personnel record reviews, the facility failed to implement and maintain an effective training program by failing to ensure that 1 of 1 Certified Nursing Assistant's (CNA) employed for less than 1 year, completed training prior to independently providing services to Residents (CNA4). (F940) 26. Based on employee files review and interview, the facility failed to develop and implement an education program that included training on Resident Rights for 1 of 5 Certified Nursing Assistant's (CNA) reviewed (CNA4).	F 835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 835	Continued From page 75 (F942)	F 835		

27. Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed yearly training for Abuse, Neglect, Exploitation and Misappropriation of Property (CNA1). (F943)

28. Based on record review and interview, the facility failed to ensure staff received mandatory training on its Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 1 of 5 employee files reviewed (Certified Nursing Assistant #4 [CNA4]). (F944)

29. Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed Compliance and Ethics Training on hire (CNA4). (F946)

30. Based on Certified Nursing Assistant's (CNA) employee education records review and interviews, the facility failed to monitor and ensure that CNA's attended the required 12 hours of annual in-service education, for 1 of 5 randomly selected CNA's employed greater than 1 year (CNA3). (F947)

31. Based on review of Certified Nursing Assistant's (CNA) in-service training and interview the facility failed to maintain an effective training program for staff when 2 of 10 sampled Certified Nursing Assistant's did not receive annual training for Behavioral Health (Certified Nursing Assistant #4 [CNA4], and CNA5). (F949)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 835	Continued From page 76 32. Based on review of the staffing schedules, daily resident census, and interview, the facility failed to ensure staffing minimums were met in accordance with the "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., 5 days out of 35 days reviewed for minimum staffing (7/22/24, 7/26/24, 8/29/24, 8/31/24, and 9/4/24). (State of Maine's T0222) 33. Based on observations and interviews, the facility failed to have the current menu plan posted and readable for personnel, Resident's and dietetic services staff on 5 of 5 Units (Harbor, Cove, Memory Care, Blueberry Hill, and Cranberry Island) for 3 of 5 days of survey (9/9/24, 9/10/24, and 9/11/24). (State of Maine's T0480) On 9/13/24 at 6:50 p.m., during an interview, the Administrator confirmed the facility failed to ensure the facility was Administered in a manner that enabled residents to attain or maintain their highest practicable well-being.	F 835		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 842	Continued From page 77 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842		

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F 842	Continued From page 78	F 842		

(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 3 of 20 residents reviewed for documentation (Resident #46 [R46], R3, and R47).

Findings:

R46 was admitted on 11/27/23 and has diagnoses to include diabetes mellitus II, chronic obstructive pulmonary disease (COPD), hypertension, vision loss, depression, chronic pain, and end stage renal failure - dialysis dependent.

Review of R46's clinical record revealed active orders dated "September 2024" and revealed the following:

-Order with start date of 12/6/23 for "Bupropion HCl ER (XL) Oral Tablet Extended Release 24 Hour (Bupropion HCl). Give 150 mg (milligram)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 842	Continued From page 79	F 842		

by mouth one time a day for depression 150 mg."
-Order with start date of 7/12/24 for "Famotidine Oral Tablet 10 mg. Give 1 tablet by mouth one time a day every [Mon, Wed, Fri, Sun] for GERD (gastroesophageal reflux disease)."
-Order with start date of 2/15/24 for "Apixaban Oral Tablet 5 MG (Apixaban). Give 1 tablet by mouth two times a day for anticoagulation. Review of clinical record lacked evidence it was given on 9/8/24 at 7:00 a.m."
-Order with start date of 2/15/24 for "Carvedilol Oral Tablet 12.5 MG (Carvedilol). Give 1 tablet by mouth two times a day related to essential (Primary) hypertension. Hold for Systolic BP <110 or HR <60."
-Order with start date of 2/15/24 for "Timolol Maleate Ophthalmic Solution 0.5 % (Timolol Maleate (Ophth). Instill 1 drop in right eye two times a day related to unspecified vision loss."
-Order with start date of 11/28/24 for "Sevelamer carbonate 800mg tablet. Give 2 tablet by mouth three times a day for Monitoring related to end stage renal disease. Administer with meals."
-Order with start date of 7/3/24 for "Tramadol HCl Oral Tablet 50 mg. Give 1 tablet by mouth three times a day for pain related to chronic pain syndrome."

Review of R46's clinical record lacked evidence the above medications were given or refused on 9/8/24.

-Order with start date of 2/15/24 for "Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro.) Inject 8 unit subcutaneously before meals for diabetes. Review of R46's clinical record lacked evidence it was given or refused on 9/7/24 at 1600 (4:00 p.m.).

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 80	F 842		

-Order with start date of 2/15/24 Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 100 - 199 = 4 units; 200 - 299 = 6 units; 300 - 399 = 8 units; 400 - 499 = 10 units; 500 - 599 = 14 units, subcutaneously before meals for diabetes. Review of R46's clinical record lacked evidence it was given or refused on 9/7/24 at 1600 (4:00 p.m.).

During a record review on 9/11/24 at 7:20 a.m. with a surveyor, the Director of Nursing confirmed the above findings.

2. On 9/10/24 at 3:31 p.m., during an interview, the surveyor observed and confirmed R3's oxygen concentrator to be heavily soiled and the oxygen tubing was dated 8/21/24 with the Registered Nurse #2 (RN2).

On 9/10/24 at 3:51 p.m., during an interview with a surveyor, RN2 reviewed R3's clinical record and states, "It looks like the tubing was changed on 8/28/24, and 9/4/24." At this time a surveyor confirmed the documentation for R3's oxygen tubing was not accurate as the tubing had not been changed.

3. On 9/10/24 at 3:29 p.m., during an interview, a surveyor and RN2 observed and confirmed R47's oxygen tubing was labelled 7/21/24 and the filter was missing from the oxygen concentrator.

On 9/10/24 at 3:51 p.m., during an interview with a surveyor, RN2 reviewed R47's clinical record and states, it looks like the oxygen tubing was changed 7/28/24, 8/4/24, 8/11/24, 8/18/24, 9/1/24,

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 842	Continued From page 81 and 9/8/24. The surveyor confirmed at this time that documentation was not accurate as the tubing had not been changed.	F 842		
F 880 SS=E	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. §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	F 880		

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

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F 880	Continued From page 82 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 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 observations, and interviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to enhanced barrier precautions (EBP's) pertaining	F 880		

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 880	Continued From page 83	F 880		

to Residents (Resident #70 [R70], R87, and R84) with a wound(s) for 2 of 5 days of survey (9/9/24, and 9/10/24).

Findings:

On 9/9/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or personal protective equipment (PPE) other than gloves for R70's room who has a wound and is on EBP's.

On 9/10/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R70's room who has a wound and is on EBP's.

On 9/9/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R87's room, who has a wound and is on EBP's.

On 9/10/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R87's room who has a wound and is on EBP's.

On 9/9/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R84's room, who has a wound and is on EBP's.

On 9/10/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R84's room who has a wound and is on EBP's.

On 9/10/24 at 11:15 a.m. during a tour of the Memory Care Unit, LPN1 Unit Manager of Memory Care Unit and a surveyor observed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 880	Continued From page 84 signage or PPE for EBP's for R70, R87, and R84's rooms. In an interview with LPN1 Unit Manager of Memory Care Unit, a surveyor confirmed no signage or PPE for R70, R87, and R84's rooms. The LPN1 Unit Manager of Memory Care Unit state there should have been signage and PPE because R70, R87, and R84 are on EBP's.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 85 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure Residents were offered pneumococcal vaccinations in accordance with their policy and the Centers for Disease Control and Prevention (CDC) recommendations for 5 of 5 residents reviewed for immunizations (Resident [R] 87, R90, R29, R1, and R70). Findings: Review of the facility "Pneumococcal Vaccine Policy Statement, 1. Prior to or upon admission,	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 86	F 883		

residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.", and "7. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination."

1. R87's admission date to the facility was on 1219/23. During review of immunization records, a surveyor could not locate evidence that R87 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over 65 years of age.

2. R90's admission date to the facility was on 8/1/24. During review of immunization records R90 received a PPSV23 immunization on 2/29/11. A surveyor could not locate evidence that R90 received a pneumococcal vaccine according to CDC recommendations. The Resident is over 65 years of age. On 8/1/24, R90's representative signed a consent for R90 to receive a PPSV23 and as of 9/12/24 R90 has not received a PPSV23.

3. R29's admission date to the facility was on 12/8/23. During review of immunization records, a surveyor could not locate evidence that R29 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over 65 years of age.

4. R1's admission date to the facility was on 1/24/24. During review of immunization records,

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 883	Continued From page 87 R1 received a PPSV23 on 8/7/23. A surveyor could not locate evidence that R29 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over 65 years of age. 5. R70's admission date to the facility was on 3/11/22. During review of immunization records, R1 received a PCV13 on 1/20/23. A surveyor could not locate evidence that R70 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over 65 years of age. On 9/12/24 at 4:40 p.m., during an interview with the LPN1 Memory Care Unit Manager, a surveyor confirmed that R87, R90, R29, R1, and R70 were not reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations, and should have been.	F 883		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, the facility's "Dish Machine Temperatures", and a food equipment service company work log, the facility failed to ensure that the kitchen high temperature dish machine was maintained in good repair and in safe operating condition for 1 of 1 dish machine observations (9/9/24) and failed to ensure proper cleaning and sanitizing of dishes for 1 of 1 kitchen tours (9/9/24).	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	**7 HIGHWOOD ST WATERVILLE, ME 04901**

(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 908	Continued From page 88 Findings: Review of the facility's "Dish Machine Temperatures" policy revised 1/24 noted: Dish machine wash and rinse water should be maintained at temperatures that meet guidelines established by the Food and Drug administration. State or local regulations will apply if stricter. Note: The range for optimal cleaning performance of the Diversey dish detergent is 150° Fahrenheit (F) to 165°F. Supervisor: If documentation of temperatures and test strips/max temperatures results has been assigned to a food and nutrition associate, confirm that it is completed at each meal period. Director: In the event of inappropriate temperature, make management decision concerning adequacy of sanitation of service ware. If due to inappropriate water temperature, high temperature machine, implements disposable service ware or use three compartment sink for sanitation. Notifies nursing units of use of disposal service ware. Contact sources of repairs. Documents action taken on the back of form. Director/designee: Verifies completion of logs, initials weekly. Review of a food equipment service company work log, dated 8/29/24 noted: Hobart dishwasher -"Came in and replaced upper float switch, wash and rinse thermometers, rinse pressure gauge, and toggle switch. Noticed that there was another water level float that is broken as well. Ran machine and watched for any leaks. Operated unit and watched gauge. Unit not heating at all. Found low flow probe getting continuity when closed but not sending contact to border element. Need float switches. Need low water probe, float assembly, one tech 2 hours. Please quote."	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 908	Continued From page 89 On 9/9/24 from 10:45 a.m. to 11:30 a.m., a surveyor completed an initial kitchen tour with the Kitchen Supervisor. During this time, the kitchen staff operated the high temperature dishwasher 5 times for surveyor observation and the dishwasher was only washing at 110 degrees (°) Fahrenheit (F) and would not reach 150°F according wash temperature gauge. The surveyor also noted a sign on the dishwasher that said "Remember to turn water off or it could flood the kitchen! T. Y." At this time, the Kitchen Supervisor stated that the dish machine wash temperature gauge was not working accurately, and the machine has been having a lot of problems and that the water has to be shut off every time they're not using it or it will flood the kitchen. The Kitchen Supervisor confirmed that the dish machine wash temperature was 110°F and not up to 150°F and that the dish machine leaked water and was not operating safely and properly. On 9/9/24 at 11:45 a.m., in an observation and interview in the kitchen with a surveyor, the Director of Facilities Operations stated that the dish machine had been worked on 2 weeks ago and they found it needed more parts. He stated that the kitchen was not to be using the dish machine. He confirmed at this time that the dish machine was not maintained in a safe operating condition, was not washing at the proper wash temperature and the water was running all the time when used and it should not be used until fixed. On 9/10/24 from 8:00 a.m. to 8:20 a.m., in an observation and interview in the kitchen with a surveyor, the Interim Food Service Director stated that when the dish machine broke down about 2	F 908		

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	205120	A. BUILDING _____ B. WING _____	C 09/17/2024

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F 908	Continued From page 90 weeks ago, the facility had it worked on, and it was found out it needed more parts. He stated that he instructed the kitchen staff to wash dishes by hand in the 3 bay pot sink until further notice. He stated that he was unaware that the kitchen staff was using the dish machine. He was going to lock it out but forgot, he said. At this time, the Interim Food Service Director confirmed that the dish machine was not washing dishes at the proper temperature, was not in a safe operating condition and the water was running all the time when used and it should not be used until fixed. On 9/10/24 at 9:35 a.m., in an interview, a surveyor discussed with the Administrator the kitchen dish washer issues and that the equipment was not being maintained in proper working condition but was still being used by the staff. She confirmed the staff was still using the dishwasher and it was not functioning properly and not maintained in a safe operating condition. She stated that it would not be used from this time forward until fixed. Review of a food equipment service company work log, dated 9/11/24 noted: "Installed new float switch and filled unit. Found wash heater high limit tripped. Reset OK, brought unit up to temp on wash. Found booster not working period addressed this on separate call. Pics in file room period found machine time are not working. Unrelated issue opening new call."	F 908		
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and	F 940		

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F 940	Continued From page 91 existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview and employee personnel record reviews, the facility failed to implement and maintain an effective training program by failing to ensure that 1 of 1 Certified Nursing Assistant's (CNA) employed for less than 1 year, completed training prior to independently providing services to Residents (CNA4). Findings: CNA4 was hired on 6/27/22. A review of CNA4's education record lacked evidence that she received the required in-service training for new hires upon hire. On 9/13/24 at 2:10 p.m., in an interview with the Human Resource Director, a surveyor confirmed that there is no evidence that CNA4 received training upon hire on 6/27/22.	F 940		
F 942 SS=D	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced	F 942		

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F 942	Continued From page 92 by: Based on employee files review and interview, the facility failed to develop and implement an education program that included training on Resident Rights for 1 of 5 Certified Nursing Assistant's (CNA) reviewed (CNA4). Findings: CNA4 was hired on 6/27/22. A review of CNA4's education records revealed she has not received yearly education for Resident Rights since 6/27/22. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed that CNA4 had not received the above In-service training in 2023 and 2024.	F 942		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced	F 943		

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F 943	Continued From page 93 by: Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed yearly training for Abuse, Neglect, Exploitation and Misappropriation of Property (CNA1). Finding: A review of the Facility Assessment for 2024-2025 revealed "Required in-service training for new aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired." CNA4 was hired on 6/27/22. A review of CNA4's education records revealed she has not received yearly education for Abuse, Neglect, Exploitation and Misappropriation of Property since hired. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed that CNA4 had not received the above in-service training in 2023 and 2024.	F 943		
F 944 SS=D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.	F 944		

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F 944	Continued From page 94 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff received mandatory training on its Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 1 of 5 employee files reviewed (Certified Nursing Assistant #4 [CNA4]). Finding: CNA4 was hired on 6/27/22. A review of CNA4's education records lacked evidence she received annual mandatory training regarding the facilities QAPI program. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed the CNA4 had not received the above in-service training in 2023 and 2024.	F 944		
F 946 SS=D	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced	F 946		

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F 946	Continued From page 95 by: Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed Compliance and Ethics Training on hire (CNA4). Finding: CNA4 was hired on 6/27/22. A review of CNA4's education records revealed she did not receive education in Compliance and Ethics on hire. On 9/13/24 at 2:10 p.m., in an interview with a surveyor, the Human Resource Director confirmed the CNA4 had not received the above In-service training.	F 946		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also	F 947		

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F 947	Continued From page 96 address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant's (CNA) employee education records reviews and interviews, the facility failed to monitor and ensure that CNA's attended the required 12 hours of annual in-service education, for 1 of 5 randomly selected CNA's employed greater than 1 year. (CNA3). Findings: A review of the Facility Assessment for 2024-2025 revealed "Required in-service training for new aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired." CNA3 was hired on 6/27/22. A review of CNA3's education records revealed she has not received the required 12 hours of in-service training in 2023 or 2024. On 9/13/24 at 2:10 p.m., the Human Resources Director confirmed the CNA3 had not received the above in-service training in 2023 and 2024.	F 947		
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and	F 949		

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F 949	Continued From page 97 as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on review of Certified Nursing Assistant's (CNA) in-service training and interview the facility failed to maintain an effective training program for staff when 2 of 10 sampled Certified Nursing Assistant's did not receive annual training for Behavioral Health (Certified Nursing Assistant #4 [CNA4], and CNA5). Findings: 1. CNA4 was hired on 6/27/22. A review of CNA4's education records revealed she did not receive Behavioral Health training on hire. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed that CNA4 had not received the above in-service training for Behavioral Health. 2. CNA5 was hired on 6/12/23 and last completed Behavioral Health Training on 6/23/23. On 9/13/24 at 5:18 p.m., in an interview with a surveyor, the Human Resource Director confirmed that CNA5 had not completed the annual training for Behavioral Health Training.	F 949		