Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1170	A. BUILDING: _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REH	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) COMPLETE DATE
P 000	Initial Comments On 6/10/25, an unannounced, on-site visit was conducted at Waterville Center for Health and Rehab-Fontbonne for the purpose of investigating facility-reported incident #ME00051752. It was determined that Waterville Center for Health and Rehab-Fontbonne is not in substantial compliance with 10/144, Chapter 113-Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000	Waterville Center for Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations.	7/18/25
P 203 SS=D	5.10 Resident Rights Right to freedom from abuse, neglect or exploitation. Residents shall be free from mental, verbal, physical and/or sexual abuse, neglect and exploitation. [Class I, II, III, IV] This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to notify the physician of an injury following a resident fall to ensure that the resident received the necessary treatment in a timely manner for 1 of 1 resident reviewed for falls (Resident #1). Finding: On 5/23/25 at 10:16 p.m., the Division of Licensing and Certification received the following facility-reported incident "Fall occurred on 5/19/25 at 2020 [8:00 p.m.]. Fall was unwitnessed. Resident found in middle of bedroom floor face down. No apparent injuries at time of fall. .. Today [5/23/25] resident presented with altered mental status, unable to follow directions, refusing food, liquids, increased fatigue, increased tremors. Sent to ...Emergency room at 1755 [5:55 p.m.].	P 203	Resident #1 is no longer a resident of this facility. Resident Care Coordinator or designee will re-educate all CRMA staff to the post fall policy and to notification of providers about change in conditions. Policy regarding "when to notify providers" will be reviewed and updated, as needed. Clarification to the policy to include that staff must have verbal acknowledgement that they have spoken with a provider and if there are any new orders. The policy will also include all falls that are unwitnessed or known to have a head strike will be transferred to the ED. Facility will conduct weekly random audits of resident incidents including falls, all provider notifications s/p fall, and immediate interventions s/p fall times 5 days a week x (1) month and then random, monthly audits for two (2) months to ensure compliance.	

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P 203	Continued From page 1 Notified at 2055 [8:55 p.m.] of dx [diagnosis] of intracranial hemorrage [hemorrhage]. POA [Power of Attorney] notified at 2115 [9:15 p.m.] ... NP [nurse practitioner] for ...PCP [primary care physician] notified at 2130 [9:30 p.m.]. Previous fall with (L) [left] shoulder fracture on 5/7/2025. At time of fall on 5/19/25-No bruising seen but following bruising noted around Right Eye and Right side of face." Review of Resident #1's physician orders revealed an order for "Aspirin Tablet Delayed Release 81 MG Give 81 mg by mouth one time a day ..." and an order for "Eliquis Tablet 5 MG (Apixaban) Give 5 mg by mouth two times a day ..." Review of Resident #1's Service Plan, most recently revised on 2/8/25, revealed, " ... Receiving anticoagulant [blood thinner] therapy ... report any abnormalities to the nurse, i.e. bruising, bleeding ...Observe for and report to the nurse any of the following adverse reactions of anticoagulant therapy ...nose bleeds (epistaxis) ...sudden change in mental status ..." A progress note dated 5/19/25 by the Certified Residential Medication Aide (CRMA) states, " ...unwitnessed fall. staff was at med cart and heard a loud bang come from this resident's room ... resident was found in middle of bedroom floor lying face down ...residents nose bled small amount and stopped. Staff called nurse [Registered Nurse #1] on memory unit who came to unit to assess resident... POA ... and On call/after hours for PCP ...office notified ...staff continues to monitor closely." Further review of the clinical record lacked evidence that the CRMA spoke to a provider or that the provider was aware that Resident #1 was on an anticoagulant	P 203	A report of the findings will be submitted monthly x3 to the facility Quality Assurance Performance Improvement Committee for further review and recommendations.	

Kimberly Connelly RN-DON 7-10-25

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P 203	Continued From page 2 and had a nosebleed following the fall. Review of Resident #1's May 2025 Medication Administration Record indicates Resident #1 continued to receive his/her anticoagulant medications from 5/20/25 through 5/23/25, when he/she was sent to the emergency room. On 6/10/25 at 11:20 a.m., during an interview, the Residential Care Manager stated if a resident falls and hits his/her head and is on an anticoagulant, he/she should be sent out to the hospital for evaluation. On 6/10/25 at 1:22 p.m., during an interview, Registered Nurse (RN) #1 stated Resident #1 had no visible injuries when she assessed him/her following the fall and that she doesn't remember being told about a nose bleed. RN #1 stated when she is asked to assess a resident after a fall, she checks vital signs, checks the resident's skin, and checks the lower extremities to make sure the resident has not broken a hip, but she does not usually document her assessment. RN #1 stated she does not know any medical history or medication history for the Residential Care residents she assesses. On 6/10/25 at approximately 2:00 p.m., the above concerns were discussed with the Director of Nursing.	P 203		

Kimberly Connelly RN, DON 7-10-25