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

PRINTED: 08/19/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205054	A. BUILDING ______ B. WING ______	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAINEGENERAL REHAB & LONG TERM CARE - GRAY BIRCH	37 GRAY BIRCH DRIVE AUGUSTA, ME 04330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 8/5/24 through 8/7/24, unannounced on-site visits were conducted at Mainegeneral Rehab and Long Term Care - Gray Birch for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate facility reported incidents #ME00047958, #ME00047999 and #ME00048064. It is determined that Mainegeneral Rehab and Long Term Care - Gray Birch was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Martin, MLA
TITLE: Administrator
(X6) DATE: 8/28/24

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to promote care to residents in a manner that maintains each resident's dignity for 2 of 3 meals observed. (Resident #21 [R21], R11, and R7). Findings: 1. On 8/05/24 from 12:00 through 12:45 p.m., during observation of lunch meal pass, a surveyor observed R21, R11 and R7 sitting at the same table. At 12:10 p.m., Staff served R21 and R7. R11 was observed watching R21 and R7 eat, while staff served other tables. At 12:24 p.m., R11 was served lunch. 2. On 8/6/24 from 8:20 a.m. through 8:30 a.m. during observation of breakfast meal pass, R21, R11, and R7 were observed sitting at the same table. At 8:20 a.m. staff served breakfast to R21	F 550		

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F 550	Continued From page 2 and R7. R11 was observed watching R21 and R7 eat, while staff served other tables. At 8:30 a.m., R11 was served breakfast. On 8/06/24 at 2:13 p.m., in an interview with the Administrator, a surveyor confirmed residents were not served with dignity when meals were not served to all residents at a table at the same time.	F 550		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583		

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F 583	Continued From page 3 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the confidentiality of protected resident health information by displaying on monitors next to a resident's name and room number identification, what therapeutic needs they required, time of a meal corresponding with a group activity, what device was required to obtain the resident's weight, walking program, and shower day for 2 of 3 days of survey. In addition, the facility failed to protect and promote a resident's privacy and confidentiality for 1 of 1 residents reviewed for privacy (Resident #54 [R54]). Findings: 1. On 8/5/24 at noon, during an initial tour, it was observed that on the corridor walls, outside the resident's room, on the Birch Unit and the Pine Unit, the resident's full name, room number and bed location ('A' means bed by door of room/'B' means bed by window of room) is posted. On 8/5/24 between noon and 1:00 p.m., the surveyors observed a large monitor on the wall across from the Birch Unit nurse's station and a large monitor on the wall near the Pine Unit nurse's station that could be seen by other residents, and visitors. In bright colors, the monitors displayed the residents first name, first initial of last name,	F 583		

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F 583	Continued From page 4 room number and bed location. Next to the resident's name indicated the time the resident was going to receive Occupational Therapy, Physical Therapy, or Speech Therapy. Also displayed is the type of device the resident would be weighed on (floor scale or chair scale) and what day they received a shower. Also displayed is who is on a walking program and what time a resident will be eating-corresponding with a group. On the bottom left hand side of the monitor is a key indicating information in a color code. On 8/6/24 at approximately 10:00 a.m., in an interview with the Director of Nursing, she confirmed that this information was on monitors in the corridors and at 2:15 p.m., this finding was discussed with the Administrator. 2. On 4/30/24, R54 was admitted with "Developmental disorder of scholastic skills" and "severe intellectual disabilities". On 8/05/24 at 1:00 p.m., a surveyor observed the MDS Coordinator (MDS2) conduct an interview for depression with R54 in the hallway. On 8/05/24 at 1:03 p.m., in an interview MDS2, a surveyor confirmed that the depression interview was held in a public space and did not protect the resident's privacy.	F 583		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		

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F 641	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately for 1 of 1 resident reviewed for discharged to the community (Resident #68 [R68]) and 1 of 3 residents reviewed for Pre Admission Screening And Resident Review (PASARR) (Resident #47 [R47]). Findings: 1. On 8/7/24, R68's clinical record was reviewed for discharge. Medical record indicated R68 was discharged to the community on 5/8/24. Review of the discharge MDS dated 5/8/24, section 2A105 states R68 was discharged to short term general hospital. On 8/7/24 at 10:35 a.m. during an interview, the MDS coordinator confirmed the MDS was coded inaccurately for discharge. 2. On 8/5/24, R47's clinical record was reviewed. On 4/8/24, R47's PASSAR was completed and indicated that R47 qualified for Level II services. Review of R47's Annual MDS, dated 4/16/24, Section: A1500 was coded to indicate that R47 did not have a Level II PASSAR. On 8/7/24 at 9:27 a.m., during an interview with a surveyor, the MDS coordinator stated the MDS was coded inaccurately. The surveyor confirmed this finding during this interview.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		

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F 644	Continued From page 6 A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 3 sampled residents reviewed for PASRR (Resident #56 [R56]). Finding: On 8/6/24, a surveyor reviewed R56's clinical record which included a PASRR evaluation completed by the hospital, dated 11/5/21, that indicated no PASRR level II was required and there was no mental health diagnosis. A review of R56's diagnosis list included in the clinical	F 644		

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F 644	Continued From page 7 record: Post-traumatic stress disorder (PTSD) , Major depressive disorder, and Generalized anxiety disorder, all added to the clinical record on 11/5/21, the date of admission. A physician progress note with the topic of PTSD, dated 12/14/21, talked about trauma, abuse, and that R56 was having nightmares. On 1/24/22, R56 started medication for anxiety and on 3/17/22, R56 started medication for depression. On 8/07/24 at 2:12 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed that information for R56 was not sent to the State mental health authority for re-evaluation since the original PASRR did not include the mental health diagnosis on the original submission and R56 had started to have symptoms related to the diagnosis of PTSD. The DON stated that the facility had just done an audit of residents with PTSD and R56 must have been missed.	F 644		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		

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F 656	Continued From page 8 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to develop a Comprehensive Care Plan that addressed the physical needs of 1 of 5 residents reviewed for Respiratory (Resident #15 [R15]) and failed to ensure that a care plan was developed in the area of Post Traumatic Stress	F 656		

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F 656	Continued From page 9 Disorder (PTSD) for 1 of 1 residents reviewed for PTSD (R56). Findings: 1. On 8/7/24, clinical record review indicated R15 was admitted on 9/29/23. Admitting diagnoses included Obstructive Sleep Apnea (OSA) and Congestive Heart Failure (CHF). Orders for these diagnoses include the use of 2 liters of oxygen at night and daily weight monitoring. On 8/7/24 at 11:02 a.m., the surveyor confirmed with the Director of Nursing that the Care Plan does not address R15's use of oxygen, or the diagnoses of OSA or CHF. 2. On 8/6/24, a surveyor reviewed R56's clinical record which included a diagnosis of Post-traumatic stress disorder (PTSD) with a start date of 11/5/21, which was the admission date for R56. A physician progress note with the topic of PTSD, dated 12/14/21, talked about trauma, abuse, and that R56 was having nightmares. There was no evidence of a problem area of PTSD or triggers and interventions that addressed R56's PTSD in the current care plan. On 8/07/24 at 2:12 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed this finding. The DON stated that the facility had just done an audit of residents with PTSD and R56 must have been missed.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 10 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview the facility failed to update a care plan in the area of Diabetes for 1 of 1 sampled resident who utilizes a continuous glucose monitoring device. (Resident #20 [R#20]) Finding: On 8/5/24 at 3:28 p.m., observation of R20 with a continuous glucose monitoring device attached to	F 657		

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F 657	Continued From page 11 back of his/her right arm. Review of physician orders dated 1/22/24, states, FreeStyle Libre 2 Sensor kit (1) KIT Subcutaneous Every Fourteen Days Starting 1/26/24 ...Notes: Change per package instructions. Check finger stick if reading is <70 or >350 or if pt is having symptoms of hypoglycemia Dx type 2 dm on insulin. R20's care plan for Diabetes Management, last revised on 4/19/23 lacks evidence of a glucose monitoring device and/or safety instructions/interventions. On 8/7/24 at 11:20 a.m., during an interview, the Director of Nursing confirmed the care plan did not contain the continued glucose monitoring device and/or safety interventions.	F 657		
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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure that physician's orders were followed for 1 of 2 sampled residents for wound management (Resident #12 [R12]) and 1 of 5 residents reviewed for unnecessary medications. (Resident #47 [R47])	F 684		

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F 684	Continued From page 12 Findings: 1. On 8/5/24, R12's clinical record was reviewed and included a physician order for wound care instructing nursing to "Cleanse legs with Vashe - apply clobetasol to legs- cover open areas with xeroform, then Abd pads and the hold in place with netting. DX: venous insufficiency (chronic) (peripheral)". On 8/5/24 from 12:49 p.m. through 1:36 p.m., 2 surveyors observed the Licensed Practical Nurse (LPN #1) perform R12's bilateral leg dressing changes. The LPN #1 wet a facecloth with faucet water and cleansed R12's legs and then applied clobetasol to the open wounds. On 8/5/24 at 1:36 p.m., the LPN #1 confirmed she did not follow the physician orders by using water to clean R12's legs and should have applied clobetasol to the legs not the open wounds. 2. On 8/7/24, R47's clinical record was review and included a physician order, dated 6/4/24, to administer Novolog Insulin based on blood sugar results as follows: Instructions: 0-150: 0 units 151-200: 2 units, 201-250: 4 units, 251-300: 6 units, 301-350: 8 units, 351-400: 10 units, equal to or greater than 401: 12, units Alert provider if BG is less than 70 or greater than 400. On 8/2/24, R47's blood sugar results was 330. Documentation indicated that R47 received 10 units and should have received 8 units. R47's clinical record was further reviewed for physician notification for high blood sugars for July 2024, for the 7:30 a.m. blood sugar results with the following documented but lacked	F 684		

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	205054	A. BUILDING ______ B. WING ______	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAINEGENERAL REHAB & LONG TERM CARE - GRAY BIRCH	37 GRAY BIRCH DRIVE AUGUSTA, ME 04330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 evidence that the Medical Provider was notified: On 7/18/24, the blood sugar was not documented but R47 received 12 units which indicated that the blood sugar was grater than 401; On 7/20/24, the blood sugar was 531; On 7/23/24, the blood sugar was 531; On 7/24/24, the blood sugar was 411; On 7/25/24, the blood sugar was 421; and On 7/30/24, the blood sugar was 418. On 8/7/24 at 11:38 a.m., during an interview with the Pines Nurse Manager, a surveyor confirmed these findings.	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, record reviews, facility policy, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 5 of 6 residents reviewed for respiratory care (Resident #9 [R9]), Resident #60 [R60], Resident #221 [R221]), Resident #15 [R15], Resident #49 [R49]).	F 695		

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F 695	Continued From page 14 Findings: The facilities policy on "Obtaining and Use of Oxygen Devises", last revised on 7/23/24. Under section 4 procedures, subsection C "Cleaning/changing of oxygen equipment" states the particle filter on the concentrators should be removed and cleaned weekly. 1. On 8/5/24 at 3:56 p.m., observation of R9's oxygen (O2) nasal cannula tubing stored over the O2 concentrator handle. On 8/6/24 at 8:00 a.m., and on 8/7/24 at 7:12 a.m., additional observation of R9's O2 nasal cannula tubing wrapped up and hanging over the cylinder on the back of his/her wheelchair. 2. On 8/5/24 at 12:41 p.m., observation of R221's O2 nasal cannula tubing wrapped up and stored under the handle of the oxygen concentrator. On 8/6/24 at 7:43 a.m., and 8/7/24 at 7:11 a.m., additional observations of his/her O2 nasal cannula tubing wrapped and hanging over oxygen concentrator. On 8/7/24 at 7:20 a.m., both the surveyor and Director of Nursing observed the above finding. 3. On 8/5/24 at 12:32 p.m., observation of R60's O2 tubing wrapped up and stored under the handle of the concentrator and on 8/6/24 at 7:35 a.m., additional observation of the oxygen nasal cannula being stored by lying across his/her bed. On 8/7/24 at 10:35 a.m., during an interview, the	F 695		

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	205054	A. BUILDING ____ B. WING ____	08/07/2024

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MAINEGENERAL REHAB & LONG TERM CARE - GRAY BIRCH	37 GRAY BIRCH DRIVE AUGUSTA, ME 04330

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F 695	Continued From page 15 DON stated the O2 tubings are expected to be stored in the provided bags for when the tubing is not in use. 4. On 8/5/24 at 1:31 p.m., a surveyor observed R15's oxygen concentrator filter to be heavily soiled. On 8/7/24 at 11:13 a.m., a surveyor and the Director of Nursing (DON) observed R15's concentrator to be set to 3 liters of oxygen flow and the filter was heavily soiled. Review of the clinical record indicated the oxygen is to be used during hours of sleep at 2 liters per minute. The surveyor confirmed these findings at the time of the observations with the DON. 5. On 8/6/24 at 12:19 p.m., a surveyor observed R49 connected to a portable oxygen tank set to 3 liters of oxygen flow; the tank was observed to be empty. R49's oxygen saturation was observed to be 88% on room air. At 2:36 p.m., review of the care plan indicated, "To ease breathing, oxygen is used at 2 liters via nasal cannula, to maintain an oxygen saturation of 92% or greater." On 8/7/24 at 1:27 p.m., in an interview with the DON, a surveyor confirmed respiratory care was not implemented as directed.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the	F 698		

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MAINEGENERAL REHAB & LONG TERM CARE - GRAY BIRCH	37 GRAY BIRCH DRIVE AUGUSTA, ME 04330

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F 698	Continued From page 16 facility failed to ensure that the clinical record contained information necessary to meet the professional standards of practice for monitoring a dialysis catheter site for 1 of 1 residents reviewed for dialysis (Resident #56 [R56]). Finding: On 8/6/24, R56's clinical record was reviewed it stated R56 was admitted to the facility on 11/5/21. The clinical record indicated that R56 had received dialysis prior to admission and currently was using a right chest dialysis catheter for treatments. The surveyor was unable to find in the physician orders, an order to monitor the dressing that covered the right chest dialysis catheter or daily documentation that it was being monitored. On 8/06/24 at 02:35 p.m., during an interview with a surveyor, the Pines Unit Manager stated that they monitor the clear dressing that covers the catheter site, but not sure if there was an order to do so. The surveyor also asked about instructions on what to do in case of an emergency related to R56's dialysis catheter site as the surveyor could not find instructions in the physician orders or the care plan. The Pines Unit Manager stated she would check on it. On 8/7/24 at 8:09 a.m., during an interview with a surveyor, the Pines Unit Manager stated she was unable to find an order for the monitoring of the catheter dressing or what to do in case of an emergency related to R56's dialysis catheter site at the time of yesterday's interview with the surveyor.	F 698		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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MAINEGENERAL REHAB & LONG TERM CARE - GRAY BIRCH	**37 GRAY BIRCH DRIVE** **AUGUSTA, ME 04330**

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F 812	Continued From page 17 §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 and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing dishes and food in a sanitary manner, not maintaining a clean kitchen floor, and not ensuring that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 days of survey (8/5/24 and 8/6/24). This has the potential to effect all residents. Findings: On 8/05/24 at 11:10 a.m., during the initial kitchen tour, a surveyor observed with the Food Service Director (FSD), the floors to be heavily soiled with crumbs, grease, fruit, and unidentifiable debris. A container full of measuring cups used for food preparation was observed with the lid ajar and covered in crumbs.	F 812		

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F 812	Continued From page 18 The measuring cups within the container had visible food debris inside them. A large bin containing oats was observed with the lid partially open to the environment. The air gap for the left kitchen sink was less than 1 inch, in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). Observation of the walk-in refrigerator revealed the floor was heavily soiled with food debris including shredded pieces of chicken. Observation of dry food storage revealed on the shelf and available for use: 3 cans - 6 pounds (lbs) 10 ounces (oz) West Creek Diced Beets, 1 had a dented in side, 2 had dented bottom seals. 1 can - 6lbs 12 0z Magellan Pineapple Slices with a dented top seal. 2 cans - 7lbs West Creek Banana Pudding both dented on the top seal. Observation of the walk-in freezer revealed on the shelf and available for use: 1 box - 10.25lbs Perdue Breaded chicken breasts open and undated, open to the environment. 1 box - 10lbs Pork Sausage 2oz patties (fully cooked heat & serve), open to the environment. These findings were observed and confirmed with the FSD at the time of the observation.	F 812		

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F 812	Continued From page 19 On 8/6/24 at 9:57a.m., observation of the dry food storage revealed on the shelf and available for use, 2 cans of 6lbs 10oz West Creek Diced Beets, both dented on the bottom seal. Observation of the walk-in refrigerator revealed soiled flooring including plastic tape, food debris and a potato on the floor. Observation of the kitchen revealed the air gap for the left kitchen sink and the air gap for the steamer were less than 1". These findings were observed and confirmed with the FSD at the time of the observation.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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 §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 20 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective 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.	F 880		

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F 880	Continued From page 21 §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, interviews, and record reviews the facility failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection related to wound management for 1 of 2 residents sampled for wound care. (Resident #12 [R12]). Finding: On 8/5/24 from 12:49 p.m. through 1:36 p.m. 2 surveyors observed the Licensed Practical Nurse (LPN 1) perform R12's bilateral leg dressing change. During the observation the following was observed: LPN1 gowned and gloved, entered the room and closed curtain with her gloved hand. With the same gloved hands, she began removing the xeroform from the wound bed, removed her gloves then exited the room and returned with a handful of facecloths. Next, she donned a new gown and gloves and cleansed both legs using the face cloths with faucet water. With the same gloved hands, she applied clobetasol ointment to several wounds using her gloved fingers. She then stopped, removed gown and gloves, performed hand hygiene and exited the room returning with Q-tips. She washed her hands and applied new gown and gloves. The following care was all completed with the same gloved hands and without performing hand hygiene. With her gloved hand she tucked her hair behind her ear, lifted up her gown and removed the packages of Q-tips from her scrub pocket. She opened the Q-tips and continued to	F 880		

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F 880	Continued From page 22 apply the ointment to the wound beds. Then she again lifted her gown and removed more Q-tips from her scrub pocket and continued to apply the ointment. She then took a package of xeroform off the windowsill, reached under her gown again to her name badge which had an attached black marker and dated the package of xeroform. She then obtained scissors off the windowsill and cut a piece of the xeroform off, placing each piece of xeroform on an open wound beds, during this process she placed the scissors into the basin filled with the residents personal belongings 6 times. Next, she obtained the abdominal pads off the windowsill, opened and placed them on the legs, again reached under her gown to obtain the marker and dated the ABD pads. Finally, she applied the netting to bilateral legs, all with the same gloved hands and without performing hand hygiene. On 8/5/24 at 1:36 p.m., during an interview, LPN1 confirmed she failed to provide an environment to prevent development and transmission of disease and infection during the dressing change. On 8/6/24 at 9:38 a.m., the above concerns were discussed with the Director of Nursing.	F 880		
F 883 SS=D	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;	F 883		

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F 883	Continued From page 23 (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. §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	F 883		

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F 883	Continued From page 24 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 reviews and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Resident #54 [R54] and R66). Findings: 1. R54 was admitted to the facility on 6/7/24. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. 2. R66 was admitted to the facility on 6/7/24. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done. On 8/7/24 1:22 p.m., during an interview with a surveyor, the Infection Preventionist stated that the Medical Provider follows the CDC recommendations for vaccinations. The surveyor confirmed these findings.	F 883		

08/28/2024

Mainegeneral Rehab and Long Term Care – Gray Birch

PLAN OF CORRECTION

F 550: Resident Rights/Exercise of Rights

The Nursing Facility failed to promote care to residents in a manner that maintains each resident's dignity for 2 of 3 meals observed.

- Education will be provided to nursing and dietary staff regarding serving residents at the same table at the same time.
- Dietary manager, Director of Nursing or designee will complete random meal observations.
- The results of the observations will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 583: Personal Privacy/Confidentiality of Records

The Nursing Facility failed to ensure the confidentiality of protected resident information, and failed to protect and promote a resident's privacy and confidentiality for 1 of 1 residents reviewed for privacy.

- The monitors displaying resident information were turned off and have remained off at this time.
- Education will be provided to staff regarding confidentiality of resident information.
- Director of Nursing, or designee, will complete random observations to ensure resident information is confidential.
- The results of the observations will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 641: Accuracy of Assessments

The Nursing Facility failed to ensure that the Minimum Data Set (MDS) was coded accurately for 1 of 1 resident reviewed for discharge to the community and 1 of 3 residents reviewed for PASRR.

- The MDS's were resubmitted.
- DNS or Designee will randomly audit MDS's to ensure accuracy.
- The results of the reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 644: PASRR

The Nursing Facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of services was required for 1 of 3 residents reviewed for PASRR (Resident #56)

- A new PASRR was sent to the mental health authority for resident #56.
- A PASRR audit was completed.
- PASRR Education to be provided to care management regarding accuracy of PASRR.
- At each resident's CPS meeting, Social Services will review PASRR's and send an update if needed, for residents remaining in the facility after 30 days.
- The Administrator, or designee, will complete random record reviews.
- The results of the reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 656: Develop/Implement Comprehensive Care Plan

The Nursing Facility failed to develop a Comprehensive Care Plan that addressed the physical needs of 1 of 5 residents reviewed for Respiratory (Resident #15) and failed to ensure that a care plan was developed in the area of Post-Traumatic Stress Disorder (Resident #15) for 1 of 1 resident reviewed.

- The care plans for Resident #15 and #56 were updated.
- An audit of care plans was completed for residents with respiratory and PTSD.
- Education provided to nursing and social services on Respiratory care plans and PTSD care plans, respectively.
- DNS or Designee will randomly audit care plans for Respiratory and PTSD.
- The results of the reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 657: Care Plan Timing and Revision

The Nursing Facility failed to update a care plan in the area of Diabetes for 1 of 1 sampled resident who utilizes a continuous glucose monitoring device (Resident #20).

- Resident #20's care plan has been updated.
- Care plans for residents utilizing Continuous Glucose Monitors were reviewed.
- Education to be provided to nursing staff.
- DNS or Designee will randomly review admission orders to ensure appropriate follow up.
- The results of the reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 684: Quality of Care

The Nursing Facility failed to ensure that physician's orders were followed for 1 of 2 sampled residents for wound management (Resident #12) and 1 of 5 residents for unnecessary medications (Resident #47).

- Education to be provided to nursing staff on following orders for wound changes, insulin administration and physician notification of blood sugars.
- DNS or Designee will randomly review orders for physician notification related to blood sugars, and insulin administration and randomly observe wound changes for accuracy of following orders.
- The results of the reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 695: Respiratory/Tracheostomy Care and Suctioning

The Nursing Facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 5 of 6 residents reviewed for respiratory care.

- Nursing staff immediately provided new tubing and bags to cover tubing to recipients of oxygen.
- Education to be provided to nursing staff on the procedure for oxygen care and management.
- Director of Nurses or designee will complete random observations to ensure oxygen care is per protocol.
- The results of audits and reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 698: Dialysis

The Nursing Facility failed to ensure that the clinical record contained information necessary to meet the professional standards of practice for monitor a dialysis catheter site for 1 of 1 residents reviewed for dialysis.

- Resident 56's orders were updated to include monitoring of dialysis catheter site and emergency protocol.
- An audit was completed on all residents receiving dialysis services to ensure monitoring and emergency protocol were in place.
- Education to be provided to nursing staff regarding monitory of dialysis catheter site and emergency protocol.
- DNS or Designee will compete random audits to ensure monitoring orders and emergency protocol are in place.
- The results of audits and reviews will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 812: Food Procurement, Store/Prepare/Serve-Sanitary

The Nursing Facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing dishes and food in a sanitary manner, not maintaining a clean kitchen floor and not ensuring that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 days of survey (8/5/24 and 8/6/24).

- The air gap was fixed and a surveyor acknowledged air gap in compliance.
- Education to be provided to Food and Nutrition staff on labeling of products and cleanliness of the kitchen.
- Food and Nutrition staff will document the following on a daily inspection log; clean floors, clean equipment, covers on products, dates on open packages, food not exposed to environment, no dented cans on shelves for use.
- Results of daily inspections will be provided to the documented Food and Nutrition Supervisor.
- Results of daily inspections and any corrective actions taken will be reviewed at QAPI for a period of three months. After three months the QAPI committee will determine if auditing should continue and at what frequency/duration.

Completion Date: 09/13/2024

F 880: Infection Prevention & Control

The nursing facility failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection related to would management for 1 of 2 residents sampled for wound care.

- Education to nursing staff on infection control practices during wound dressing changes to be completed.
- DNS or Designee will randomly observe wound dressing changes to monitor infection control practices.
- The results of observations will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

F 883: Influenza and pneumococcal immunizations

The Nursing Facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Residents #54 and #66).

- Residents #54 and #66 were offered pneumococcal vaccination.
- An audit of all vaccination records was completed.
- Newly admitted resident vaccination records will be reviewed and pneumococcal vaccination will be offered.
- DNS or Designee will randomly audit resident records to ensure vaccination was offered.
- The results of observations will be shared with the QAPI Committee for 3 months (October, November, December). After 3 months, the QAPI Committee will determine the continuation and frequency of audits.

Completion Date: 09/13/2024

Melissa Martin, MLA
8/28/24