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 _____	C 05/22/2024

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 On 5/21/24 and 5/22/24 unannounced on site visits were conducted at Maine General Rehab & Long Term Care-Gray Birch to investigate facility reported incidents #ME00045319 and #ME00045209 and complaints #ME00044977, #ME00046488, and #ME00047404. It was determined that Maine General Rehab & 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on facility policy, record review and interview, the facility failed to provide an environment free of abuse and neglect for 1 of 2 residents reviewed for facility reported investigations (Resident #1). Findings:	F 600		

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
	205054	A. BUILDING _____ B. WING _____	C 05/22/2024

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 600	Continued From page 1 Review of facility policy titled "Fall Risk Reduction and Fall Prevention" last revised "4/22" states "Upon incident of fall or found on floor: ... A registered nurse is required to assess residents after a fall. ... Appropriate incident reports will be filled out and required documentation completed in the patient/resident EMR." Review of Policy titled "Prevention and Reporting of Abuse, Neglect, Exploitation/Misappropriation" last revised "11/22" defines verbal abuse as "The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance regardless of their age, ability to comprehend, or disability," and defines neglect as "the deprivation of an individual of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being." On 10/26/23 the Division of Licensing and Certification received a "5 day Follow- Up Investigation" for facility reported incident dated 10/22/23 which states "[On 10/22/23 [Resident#1] had a fall from bed and states that the nurse made aware she came to the doorway and used profanity while speaking with him and did not come in the room at all to assess.]" Further review of 5 day follow- up revealed Registered Nurse (RN)#4 interview stating, "she did not reinsert the foley because she was busy doing the other tasks and she reported it off to the day nurse that it needed to be done." Resident #1 was admitted on 9/29/23 with diagnoses including paraplegia, neurogenic bladder, neuromuscular deficiency, and history of falls. Review of quarterly Minimum Data Set	F 600		

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 _____	C 05/22/2024

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 600	Continued From page 2	F 600		

(MDS) dated 10/7/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating he/she is cognitively intact.

Review of Resident#1's clinical record revealed "SBAR [Situation, Background, Assessment, Recommendation] ...Progress Note" dated 10/22/23 at 5:20 a.m., states "[Certified Nursing Assistant] CNA was doing rounds when resident called out to her. Upon entering the room resident was noted sitting on the floor, [When] asked resident stated that [he/she] fell out of bed. It was also noted that resident had pulled out [his/her] foley catheter again. Assessment Done. No injuries noted." Further review of "SBAR" states, "In LTC [Long Term Care] patients are required to be assessed by an RN after a fall ..." Resident#1's entire clinical record lacked evidence that RN#4 completed an assessment or notified provider after Resident #1's fall.

Review of Resident #'1s clinical record revealed order dated 9/29/23 to " ...reinsert .... suprapubic foley cath [catheter] or external foley cath if accidental d/c. SBAR provider if reinserted." Review of Resident #1's "2023 Treatment Administration Record" (TAR) revealed "progress note" dated 10/22/23 at 19:04 states: "Done @ 10am this morning. Late entry." By oncoming RN #5, (approximately 5 hours after it dislodged).

Review of CNA#5's written statement dated 10/23/23 revealed "She [RN#4] swore at and about [Resident#1] & the situation in front of all 3 of us CNAs" During an interview on 5/21/24 at 8:20 a.m., Resident#1 indicated that after he/she fell RN#4 stood in the doorway to his/her room and asked, "why the fuck would you do that?" Resident #1 further indicated that RN#4 refused

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 _____	C 05/22/2024

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 600	Continued From page 3 to come into his/her room or provide care. During an interview on 5/21/24 at 3:48 p.m., RN #2 indicated that she was present during shift report on 5/21/24 at 6:45 a.m. and confirmed RN #4 did not notify oncoming nurse of Resident #1's fall or that his/her catheter had dislodged. RN #2 further indicated that she was approached by CNA #5 who notified her of Resident #1's fall and RN #4's refusal to provide care. During the interview on 5/22/24 at 9:11 a.m., Director of Nursing (DON) confirmed RN#4 failed to complete an assessment, notify the provider, or provide care to Resident #1 after his/her fall.	F 600		
F 656 SS=D	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 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).	F 656		

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 _____	C 05/22/2024

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 656	Continued From page 4	F 656		

(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, interviews and facility policy's, the facility failed to update/implement goals and interventions for 2 of 5 care plans reviewed (Resident's #2 and #5).

Findings:

Review of facility policy "Care Plan Development, Evaluation, and Modification" dated 1/23 states: " ...Following initial assessment, licensed nursing will initiate an individualized, written plan of care specific to resident's strengths, needs, preferences, and goals ...Nursing will develop a

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 _____	C 05/22/2024

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 656	Continued From page 5	F 656		

comprehensive plan of care for a resident within 48 hours of admission ... Interventions will be modified, as necessary, to reflect resident/family's needs to enhance resident-focused care."

Review of facility policy "Psychopharmacological Medication Use and Monitoring: dated 7/24 states " ...Psychopharmacological Medication Use ... The care plan will be developed/updated as appropriate including goals of therapy and evaluation of progress towards goals..."

1. Resident # 2 was admitted on 8/17/21 with diagnoses to include schizophrenia, bipolar disorder, and anxiety.

Review of Resident #2's most recent signed provider orders dated 5/21/24 revealed [he/she] was receiving antipsychotic medications "thiothixene" and "lamotrigine" for schizophrenia, as well as antianxiety medication "lorazepam" for psychosis. Review of Resident #2's care plan initiated 8/17/21 lacked evidence that goals and interventions were put into place for psychotropic medication use.

Review of Resident #2's clinical record revealed "PASRRII" dated 6/11/2021 states " ... You meet the State of Maine's definition or serous mental illness due to your diagnoses of Bipolar disorder. ...As part of this Level II, your identified specialized and rehabilitative services should be incorporated into your plan of care ...." Review of Resident #2's care plan lacked evidence that goals and interventions were put into place for PASRRII.

Further review of Resident #2's care plan revealed "Goal: Impaired oral hygiene AEB has

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 _____	C 05/22/2024

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 656	Continued From page 6	F 656		

some broken teeth, inflamed gums. 5/10/24 Amoxicillin x 3 days for tooth pain .....-Foley Catheter-secondary to urinary retention 3/13/24 cefpodoxime times 7 days ..." Further review of Resident #2's care plan lacked evidence the care plan was updated after antibiotic use.

During an interview on 5/22/24 at approximately 12:21 p.m., Director of Nursing confirmed Resident #2's care plan was not updated after antibiotics were no longer in use, did not include goals and interventions for psychotropic medications, or PASRR II.

2. Resident #5 was admitted on 2/24/24 for a short term stay for skilled services with diagnoses to include anxiety, depression, and recent spinal fusion.

Review of admission Minimum Data Set (MDS) dated 3/7/24 revealed Resident # 5 had a Brief Interview for Mental Status (BIMS) of 12 of 15 indicating he/she is moderately impaired.

Review of Resident #5's provider orders dated April 2024 revealed he/she was taking antianxiety medication "lorazepam" and antidepressant "sertraline". Review of Resident #5's care plan initiated 2/24/24 lacked evidence that goals and interventions were put into place for these medications.

Review of Resident #5's clinical record revealed "progress note" dated 4/11/24 stating " ... self propels on the unit in [his/her] wheelchair ...has mild anxiety this evening because [he's/she's] unable to recall how to unlock and lock [redacted] wheelchair and [he/she] can't remember to use the call light for help so [he/she] yells or calls for

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 _____	C 05/22/2024

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 656	Continued From page 7	F 656		

help. [He/she] is frantic by the time someone gets to her ..."

Review of Resident #5's clinical record revealed the following provider notes:
-Note dated 4/02/24 stating " ...referral to psych may be reasonable as an outpt; [out patient] has made statements [thtat][he/she] feels that [he/she] would be better off dying but no plans and has not mentioned this today ..."
-Note dated 4/10/24 stating " ...concern for cognitive dysfunction-apparently even prior to this surgery but stm [symptom] has worsened which may be due to meds, hospitalization, et; outpt eval with geriatrics may be reasonable ...."
- note dated 4/11/24 states " ...depression/anxiety with emotional lability-poor safety awareness, concerns for possible cognitive issues, ...anxiety/depression-worsened after death of [husband/wife] in 2021; ...I do think referral to counseling would be helpful ...concern from dtr [daughter] who initially asked for palliative care consult but I think issues may be more psyche?? -states outburst with stff [staff], emotionally labile, will cry out c/o pain and then next thing will be getting out of bed on [his/her] own.

During an interview on 5/21/24 at 3:53 p.m., Certified Nursing Assistant (CNA)4 indicated that Resident #5 wandered in rooms a lot and seemed paranoid all the time. Review of Resident #5's care plan lacked evidence that goals and interventions were put into place for the above concerns.

During the interview on 5/21/24 at 1:17 p.m., Registered Nurse (RN)3 indicated that Resident#5 was paranoid from the time of his/her

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 _____	C 05/22/2024

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 656	Continued From page 8 admission, wandered in other resident rooms often and his/her original goal was to go home. At this time RN3 reviewed Resident #5's care plan with a surveyor and confirmed Resident #5's care plan did not include goals and interventions for wandering, psychotropic medication use, or discharge planning.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to adequately assess to ensure a residents safety, or provide appropriate psychiatric services in a timely fashion for 1 of 1 residents reviewed for accidents (Resident #5). Resident #5 was admitted to facility on 2/24/24 for skilled services with diagnoses to include anxiety, depression, and a recent spinal fusion. Review of admission Minimum Data Set (MDS) dated 3/7/24 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) of 12 of 15 indicating he/she is moderately impaired. Review of Resident #5's clinical record revealed the following provider notes: -Note dated 4/02/24 stating " ...referral to psych	F 689		

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 _____	C 05/22/2024

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 689	Continued From page 9	F 689		

may be reasonable as an outpt; [out patient] has made statements [thtat][he/she] feels that [he/she] would be better off dying but no plans and has not mentioned this today ..."
-Note dated 4/10/24 stating " ...concern for cognitive dysfunction-apparently even prior to this surgery but stm [symptom] has worsened which may be due to meds, hospitalization, et; outpt eval with geriatrics may be reasonable ...."
- note dated 4/11/24 states " ...depression/anxiety with emotional [lablity]-poor safety awareness, concerns for possible cognitive issues, ...anxiety/depression-worsened after death of [husband/wife] in 2021; ...I do think referral to counseling would be helpful ...concern from dtr [daughter] who initially asked for palliative care consult but I think issues may be more psyche??
-states outburst with stff [staff], emotionally labile, will cry out c/o pain and then next thing will be getting out of bed on [his/her] own. Review of Resident #5's entire clinical record lacked evidence that a psychiatric counseling appointment was made for Resident #5.

Review of Resident #5's clinical record revealed "progress note" dated 4/11/24 stating " ... self propels on the unit in [his/her] wheelchair ...has mild anxiety this evening because [he's/she's] unable to recall how to unlock and lock [redacted] wheelchair and [he/she] can't remember to use the call light for help so [he/she] yells or calls for help. [He/she] is frantic by the time someone gets to her ..."

Review of Resident #5's clinical record revealed "Nursing Note" dated 4/17/24 at 18:21 states "Res in room eating supper. Per CNA she was in there helping [him/her] eat and chatting. CNA left room for appox 2-3 minutes. When she returned

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 _____	C 05/22/2024

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 689	Continued From page 10	F 689		

she observed Res at wide open window push the screen out and do a "tuck and roll" out the window. CNA went out the window after Res. Another CNA sent out front door around building to intercept [him/her]. RN also went out the window to attempt to get Res up from ground where [he/she] was crawling toward the front of the building. Res highly agitated. Scratching at staff and picking up sticks, trying to hit staff with them. Other RN came out with wheelchair and instructed all other staff to go back into building and send out 2 male CNA's. She was able to get Res back into the building. On call notified of situation. Ok to send Res to ED for evaluation. 911 called for transport to [Acute Care Hospital]."

During an interview on 5/21/24 at 2:08 a.m., [family member] indicated that it was normal for [his/her] [mother/father] to wander into people's rooms and had ongoing stress, paranoia, and pain. Family member then indicated that [his/her] [mother/father] had tested positive for COVID [Coronavirus] and staff were trying to encourage [him/her] to stay in his/her room, but [mother/father] was so anxious [he/she] thought they were trying to keep [him/her] prisoner, so [he/she] jumped out the window requiring transport to an acute care hospital where [he/she] was subsequently admitted for severe delirium from being overmedicated.

During an interview on 5/21/24 at 3:53 p.m., Certified Nursing Assistant (CNA)4 indicated Resident #5 wandered in other resident rooms a lot and seemed paranoid all the time. Resident #5 was found in another resident's room ... going through their things and CNA4 redirected [him/her] to [his/her] room. Approximately 15 minutes later he went back to check on [him/her]

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 _____	C 05/22/2024

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 689	Continued From page 11	F 689		

and didn't see [him/her]. CNA4 then realized [Resident #5] was sitting on the window ledge and slid [him/herself] off the ledge and fell on [his/her] hands and knees into the mud outside of the window (approx. 3 foot drop). CNA4 further indicated he ran out of the room and down the hall looking for some help leaving Resident #5 outside and unsupervised for approximately 2 minutes. CNA4 further stated the nurse, and a nursing student ran down the hall out Resident #5's window and he went out the front door, around the building to help. CNA4 indicated that Resident #5 was very agitated and was trying to hit staff with sticks, refused any help and got [him/herself] back into the wheelchair.

During an interview on 5/21/24 at 1:17 p.m., Registered Nurse (RN)3 indicated Resident #5 was paranoid from the time of his/her admission and wandered into residents' rooms, had tested negative for urinary tract infection, but had tested positive for COVID before this incident. At this time RN3 reviewed Resident #5's clinical record and confirmed an elopement evaluation was not completed for Resident #5, but it probably should have been.

During an interview on 5/22/24 at 12:43 p.m., Nurse Practitioner (NP) indicated that Resident #5. Had a lot of anxiety, and they tried multiple things to help her. At this time NP confirmed the facility did not make the psychiatric referral and feels it's because [he/she] was a short stay resident and the hospital takes the long term residents first.

During an interview on 5/22/24 at approximately 12:50 p.m., the above concerns were discussed with Director of Nursing.

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 _____	C 05/22/2024

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 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy, the facility failed to ensure residents were free from unnecessary medication use for 2 of 2 residents reviewed for psychotropic medication use (Resident's #2 and #5). Findings: Review of facility policy "Psychopharmacological Medication Use and Monitoring: dated 7/24 states " ...Psychopharmacological Medication Use:"	F 757		

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 _____	C 05/22/2024

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 757	Continued From page 13	F 757		

Psychoactive drugs may not be used on an as needed basis exceeding five times in a 7 day period unless clinically indicated. A PRN will not be administered for more than 7 days without a scheduled dose unless otherwise ordered by the provider. Resident and family member(s), if appropriate, will be provided with verbal and/or written materials regarding the ordered medication and potential risks and benefits. The Consent for Long Term Psychoactive Medication Use form will be completed if an antipsychotic will be used for a period greater than 7 days."

1. Resident # 2 was admitted to facility on 8/17/21 with diagnoses to include schizophrenia, bipolar disorder, and anxiety.

Review of Resident #2's most recent signed provider orders dated 5/21/24 revealed the following:
-Order with start date of 2/6/24 for antipsychotic "thiothixene 10 mg capsule (50 mg) oral for schizophrenia."
-Order with start date of 2/22/24 for anticonvulsant "lamotrigine 200 mg tablet (1) tablet oral for schizophrenia"
-Order with start date of 5/15/24 for antianxiety "lorazepam 0.5 mg tablet (0.5 mg) tablet for psychosis"
Review of Resident #2's entire clinical record lacked evidence that a consent was obtained from resident and/or resident representative for these medications.

2. Resident #5 was admitted to facility on 2/24/24 for skilled services with diagnoses to include anxiety, depression, and recent spinal fusion.

Review of Resident #5's Medication

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 _____	C 05/22/2024

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 757	Continued From page 14 Administration Record (MAR) dated April 2024 revealed: -Order with start date of 3/5/24 for "sertraline 50 mg tablet (2) tablet oral one time daily for depression and anxiety increase." -Order with start date of 3/8/24 for "lorazepam 0.5 mg tablet oral as needed two times for generalized anxiety." Review of Resident #5's MAR revealed Resident #5 received 20 doses of this medication over 14 days. Review of Resident #5's clinical record lacked evidence that a consent was obtained for the above psychotropic medications. Further review Resident #5's clinical record lacked evidence that and failed to obtain a scheduled dose for lorazepam after 7 days of use. During an interview on 5/22/24 at 12:20 p.m., Director of Nursing confirmed above findings.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		

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 _____	C 05/22/2024

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 842	Continued From page 15	F 842		

(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;

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 _____	C 05/22/2024

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 842	Continued From page 16 (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, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 5 residents, and failed to obtain a providers order for 1 of 1 residents reviewed for documentation (Resident's #1 and #5). Findings: Review of facility policy titled "Fall Risk Reduction and Fall Prevention" last revised "4/22" states "Upon incident of fall or found on floor: ... A registered nurse is required to assess residents after a fall. ... Appropriate incident reports will be filled out and required documentation completed in the patient/resident EMR [Electronic Medical Record]." On 10/22/23 the Division of Licensing and Certification received a facility reported incident indicating Resident#1 fell in his/her room and Registered Nurse (RN)#4 was made aware. It further revealed that RN#4 was overheard swearing at Resident #1 and refused to do a post fall assessment.	F 842		

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 _____	C 05/22/2024

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 842	Continued From page 17	F 842		

1.Resident #1 was admitted on 9/29/23 with diagnoses including paraplegia, neurogenic bladder, neuromuscular deficiency, and history of falls. Review of quarterly Minimum Data Set (MDS) dated 10/7/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating he/she is cognitively intact.

Review of Resident#1's clinical record revealed incident report dated 10/22/23 at 5:20 a.m,. stating "CNA was doing rounds when resident called out to her. Upon entering the room resident was noted sitting on the floor, When asked resident stated that [he/she] fell out of bed. It was also noted that resident had pulled out [his/her] foley catheter again. Assessment Done. No injuries noted." Further review of incident report states, "In LTC patients are required to be assessed by an RN after a fall ..." Review of Resident#1's entire clinical record lacked evidence that a complete assessment was done after this incident.

During the interview on 5/22/24 at 9:11 a.m., Director of Nursing (DON) confirmed RN#4 failed to complete an assessment on Resident #1 after his/her fall.

2. Resident #5 was admitted to facility on 2/24/24 for skilled services with diagnoses to include anxiety and depression.

Review of Resident #5's active orders dated April 2024 revealed order with start date of 2/29/24 for "Behavior Monitoring Two times daily...for increased agitation, refusal of care, physically abusive behavior, crying..."

Review of Resident #5's clinical record revealed

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 _____	C 05/22/2024

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 842	Continued From page 18	F 842		

provider note dated 4/10/24 states " ... Concern for cognitive dysfunction-apparently even prior to this surgery but has worsened which may be due to meds, hospitalization, etc; outpt [outpatient] eval with geriatrics may be reasonable." Further review of Resident #5's clinical record lacked evidence that a referral for with geriatrics was obtained for this resident.

During an interview on 5/22/24 at 12:43 p.m., Nurse Practitioner confirmed Resident #5 was not referred to geriatrics for evaluation, and an order was not given for Resident #5's respiratory panel on 4/11/24.

Review of "provider note" dated 4/11/24 states " ...depression/anxiety with emotional lability-poor safety awareness, concern for possible cognitive issues, ... outbursts with staff..."

Review of Resident #5's clinical record revealed "progress note" dated 4/11/24 stating " ... self propels on the unit in [his/her] wheelchair ...has mild anxiety this evening because [he's/she's] unable to recall how to unlock and lock her wheelchair and [he/she] can't remember to use the call light for help so [he/she] yells or calls for help. [He/she] is frantic by the time someone gets to her ..." Review of Residents Treatment Administration Record (TAR) dated April 2024 revealed Resident had "no behaviors" on 4/11/24 through 4/13/24 or 4/15/24 through 4/17/24.

Review of Resident #5's clinical record revealed provider note dated 4/11/24 stating "[...this afternoon found a lab result on my desk that was a resp [respiratory] panel from Friday April 6th that was positive for covid; there was no lab order for a resp panel and not of the providers had

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 _____	C 05/22/2024

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 842	Continued From page 19 ordered this; there is a nursing note that indicates a resp panel was sent to due to gi sx, for throat and malaise; we were never notified of the pos result and it is unclear who put the lab on my desk ...]" Further review of Resident #5's clinical record lacked evidence that an order was obtained for above. During interview on 5/21/24 at 1:17 p.m. Registered Nurse (RN)#3 confirmed Resident #5 clinical record lacked documentation reguarding the above behaviors.	F 842		