STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING _____ B. WING _____	C 02/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/11/25 an on-site visit was conducted at Waterville Center for Health and Rehabilitation for the purpose of investigating a complaint #ME00050305. It was determined that Waterville Center for Health and Rehabilitation was not in substantial compliance with 42 CFR 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		

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

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F 842	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and	F 842		

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F 842	Continued From page 2	F 842		

interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed during an investigation of a facility-reported incident. (Resident #1)

Findings:

Resident #1 was admitted on 12/18/24 and had diagnoses to include venous stasis ulcers and deep vein thrombosis (DVT).

Review of Resident #1's Care plan, initiated on 12/19/24, states, " ...history of Deep Vein Thrombosis r/t [related to] Immobility ...at risk of developing another DVT ... Inspect legs and feet for Skin color/temperature (calf/thigh): pale, cool, edematous (DVT); pinkish red, warm along the course of the vein (superficial) ..."

Review of Resident #1's active physician orders, dated January 2025, lacked evidence that Resident #1 was being monitored for signs and symptoms related to a DVT.

Review of Resident #1's daily skilled assessments dated 1/12/25, 1/16/25, and 1/17/25 lacked evidence that a cardiovascular assessment was completed, and assessments dated 1/12/25 and 1/13/25 lacked evidence that a skin assessment was completed. There is no evidence that daily skilled assessments were completed on 1/7/25 and 1/14/25.

During an interview with 2 surveyors on 2/11/25 at 11:39 a.m., the Cove Harbor Unit Manager (UM) stated it was her expectation that monitoring for signs of a DVT would be documented on the Treatment Administration Record (TAR) or in the

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F 842	Continued From page 3 skin and cardiovascular sections in the daily skilled note and that all sections of the assessment should be complete. At this time, UM further reviewed Resident #1's clinical record and confirmed that the TAR lacked evidence of monitoring for signs of a DVT and that the skilled assessments were incomplete for the above dates.	F 842		