STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205077	A. Building B. Wing	09/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Center for Health & Rehabilitation, LLC	188 Eastern Ave Augusta, ME 04330

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review and interview, the facility failed to notify the physician of significant change in condition when a resident expressed signs of suicidal ideation. In addition, the facility failed to notify the physician after same resident was found in the street by a passerby during an attempt for self-harm for 1 of 3 residents reviewed for elopement (Resident #1). Findings: Resident #1 was admitted to facility on 9/13/21 with diagnoses to include, seizure disorder, hemiplegia, right leg below the knee amputation, major depressive disorder, malignant bladder cancer and a cognitive communication deficit. Resident has a wander guard placed on his/her left ankle for safety and is received Hospice services for end-of-life care. Review of quarterly Minimum Data Set (MDS) dated [DATE] indicates Resident #1 had a Brief Interview for Mental Status (BIMS) of 11 of 15 indicating moderate impairment. Resident #1 self ambulates in wheelchair. Review of Resident #1's clinical record revealed nursing note dated 7/4/2022 stating .[pt] was [over hear] by another [res] that [he/she] was going to get out and get a gun to kill [himself/herself], brought to nurse attention, nurse asked [pt he/she] said yes [he/she] said it when asked why no response , will do 15 min check. Review of Resident #1's clinical record lacked evidence the provider was notified of his/her desire to self-harm. Review of Resident # 1's clinical record revealed nurses note dated 9/11/22 . resident was observed out by the road in the front of the building. [He/she] stated I want to be left alone. and refused to voluntarily return on [his/her] own. At this point, this reporter, had to propel [his/her] wheelchair backwards to successfully return [him/her] safely to the building. Note left for provider . Review of Resident #1's clinical record laced evidence that the provider was notified of this incident. During an interview on 9/21/22 at 250 p.m., Social Services (SW) indicated that she did not notify the provider that Resident #1 had statements of suicidal ideation on 7/4/22 because when she spoke to him/her on 7/5/22 he/she had no plan in place and he/she felt safe. SW indicated that she did not call the medical provider because Resident #1 already had Hospice services in place and did not feel the need to go that route because the Hospice Social Worker comes on a regular basis. (continued on next page)

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.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 9/21/22 at 3:07 p.m., Licensed Practical Nurse (LPN) indicated that on 9/11/22 he let Resident #1 outside with the understanding that he/she would stay under the awning. his way out a bystander was coming in to get help with Resident #1 who was physically in the road and would not leave the road. LPN and passerby had to physically picked up resident in wheelchair to bring him/her inside for safety. LPN indicated he did not contact the medical provider regarding this incident, but he did write it in the communication book. During an interview on 9/22/22 at 9:07 a.m., Nurse Practitioner (NP) indicated that he was not made aware of Resident #1's statement of self-harm made on 7/4/22. NP further indicated that he was not made aware that Resident #1 was found in the road by a passerby during an attempt to self -harm until he read it in the provider log the next morning. NP indicated had he known at the time he would have given an order for immediate hospitalization for an evaluation. During an interview on 9/22/22 at 3:30 p.m., the Administrator confirmed the provider was not notified of Resident #1's desire to self-harm on 7/4/22 and that provider was not aware Resident #1 was found in the road by a passerby during an attempt to self-harm. Review of facility policy Accident/Incident Policy and Procedure dated 12/18 states, It is the responsibility of all staff to report all incidents and accidents that occur at the facility. To ensure that residents. Involved received immediate assessment and treatment, as appropriate. the attending physician will be notified with the date and time of notification documented on the Accident/incident form and in nurses' notes. Document any new orders made by the physician. If unable to reach physician in a timely manner, call the Medical Director.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, observations and interview, the facility failed to implement a care plan in the area of psychosocial needs for 1 of 3 care plans reviewed. (#1). Findings: Review of facility policy titled Comprehensive Care Planning dated 11/01 states .The CCP [Comprehensive Care Plan] will be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the care plan when there is a new problem that requires that discipline to intervene .All clinical department heads are responsible to ensure that there is a system for monitoring implementation of the resident care plans. This is accomplished via quality assurance auditing, observation on rounds, and interview with staff residents and families. Corrective action will be carried out when problems with implementation of care plans have been identified. Resident #1 was admitted to facility on 9/13/21 with diagnoses to include, seizure disorder, hemiplegia, right leg below the knee amputation, major depressive disorder, and a cognitive communication deficit. Resident has a wander guard placed on his/her left ankle for safety. Review of quarterly Minimum Data Set (MDS) dated [DATE] indicates Resident #1 had a Brief Interview for Mental Status (BIMS) of 11 of 15 and self ambulates in wheelchair. Review of Resident #1's care plan initiated 8/5/21, last revised on 9/12/22 states the following: -Focus: (initiated 7/5/22) The resident has depression with suicidal ideation tendencies due to feeling a sense of loss, missing family and wanting to return back to the community. Goal: [Resident #1] will demonstrate effective coping behavior as evidenced by a decrease in emotional distress. Interventions: Arrange for psych [psychiatry] consult . -Focus: [Resident #1] has impaired cognitive function/dementia or impaired thought process r/t difficulty making decisions, Long term memory loss, short term memory loss. -Focus: (initiated 3/8/22) [Resident #1] is at a High Risk for elopement Recent attempts to leave premises/ unit. Goal: [Resident #1] will be safely housed on designated unit over the next 3 months without incident. Interventions 1:1 as needed, wanderguard placed R) [right] ankle. Review of Resident #1's entire clinical record lacked evidence that the above interventions were put into place. During an interview on 9/22/22 at approximately 3:10 p.m. The Director of Nursing confirmed above concerns.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interviews and document reviews, the facility failed to provide adequate supervision to a resident who was a known elopement risk with a history of suicidal ideation. This failure resulted in the resident exited the facility on two occasions and was found in and by the road for 1 of 3 residents reviewed for elopement (Resident #1). This failure created an immediate jeopardy situation. Findings: On 9/13/22 the Department of Licensing and Certification received a complaint from an anonymous source indicating that he/she saw a Facebook (social media) post indicating that a resident was seen beside the road trying to wheel him/herself into traffic in an attempt to kill him/herself. Resident #1 was admitted to facility on 9/13/21 with diagnoses to include, seizure disorder, hemiplegia, right leg below the knee amputation, major depressive disorder, malignant bladder cancer and a cognitive communication deficit. Resident #1 was placed Hospice services for end- of- life care on 6/29/22 and has a wander guard placed on his/her left ankle for safety. Review of quarterly Minimum Data Set (MDS) dated [DATE] indicates Resident #1 had a Brief Interview for Mental Status (BIMS) of 11 of 15 indicating moderate impairment. Resident #1 self ambulates in wheelchair. Review of Resident #1's care plan initiated 8/5/21, updated 9/12/22 states the following: -Concern initiated 3/8/22 states [Resident] is at a High Risk for elopement Recent attempts to leave premises/unit. Goal: [Resident #1] will be safely housed on designated unit over the next 3 months without incident. Interventions: 1:1 as needed. Wander guard placed (R) ankle. -Concern initiated 9/16/21 states [Resident #1] has impaired cognitive function/dementia or impaired thought process related to/ Difficulty making decisions, long term memory loss. Short term memory loss. During an interview on 9/21/22 at approximately 2:15 p.m., Resident #1 indicated that the first time he/she got out (7/13/22) nobody was watching me or the back door (Kennebec Unit), so I just put the code in, went around the building to the front to head to the road with the intent on killing myself, but the nurse got to me first and wouldn't let me go in the road and I was mad. When asked how he/she got the code to the back door, he/she replied, I watch, and I see. This writer then asked Resident #1 how he/she was able to get the front door open on 9/10/22 to assist Resident #3 out of the building. He/she lifted his/her left leg and pointed to a wander guard on his/her ankle and replied, I have my ways, but they changed the code, I can't go out alone. At this time writer asked how he/she got out of the building on 9/11/22. He/she replied [LPN] let me out to sit outside and nobody was watching so I beet feet to the road and I will do it every time. At this time Resident #1 again stated, the second they turn their backs on me, I will beet feet right to the road. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/21/22 at 12:25 p.m. Maintenance Director (MD) indicated the Kennebec Unit door does not have a wander guard alarm on it and in order for someone to get out they must know the code. MD further indicated that the front door has a wander guard alarm so resident should not have been able to open the door to get out on 9/10/22 and somehow, resident was able to get the door open and move fast enough to get to the door fast enough to keep it open. During a phone interview on 9/21/22 at 3:13 p.m., Registered Nurse (RN) indicated that on 7/13/22 Resident #1 used a security code to leave the Kennebec Unit and leave the building and was found outside, in front of the building heading toward the busy road and indicated to her that it was his/her desire to kill himself/herself. RN indicated that she had to physically restrain wheelchair with Resident #1 in it to prevent resident from going into oncoming traffic. RN indicated she called the Director of Nursing (DNS) who came in and it took 1.5 hours to get Resident #1 back into the building. RN further indicated that the Kennebec Unit door only needs a code, but the front door has a separate code and Resident #1 knew them both. RN further stated on 9/10/22 Resident #1 was caught assisting Resident #3 (who is also an elopement risk and wears a wander guard) out the front door when she heard the alarm sound. RN indicated that she saw Resident #1 holding the door open for Resident #3 and was able to get them both back inside and then called the Administrator who informed her that he and Resident #1 had a man-to-man talk, and he/she promised the Administrator that he/she would not let anyone else out. At this time RN indicated that the Administrator told her that he gave Resident #1 the code to the front door. During a phone interview on 9/21/22 at 3:07 p.m. Licensed Practical Nurse (LPN) indicated that on 9/11/22 he let Resident #1 outside with the understanding that he/she would stay under the awning. LPN observed him/her under the awning x2 and went to obtain some blood sugars. When he returned Resident #1 was gone. LPN indicated that on his way out the door [passerby 2] was coming inside to get him and he and passerby 1 had to psychically pick up the wheelchair with Resident #1 in it out of the road and into the building for safety. At this time LPN indicate that residents with wander guards were not normally allowed outside alone, but management said he could go under the awning. During an interview on 9/22/22 at 12:25 p.m., [NAME] by (1) indicated that while driving by the facility on 9/11/22 between 5-5:15 p.m., he/she saw [Resident #1] in the busy road and it seemed that he/she was deliberately trying to wheel him/herself in front of oncoming traffic and cars had to drive around the resident. [NAME] by 1 stopped his/her car and ran to resident, who was actively attempting to wheel out into the busy traffic and had to physically restrain the wheelchair. At this time [NAME] by (2) stopped to help and went into the facility and got Licensed Practical Nurse (LPN) to come help. LPN and [NAME] by 1 physically picked up Resident #1 in his/her wheelchair and moved resident into the facility for safety. During an interview on 9/21/22 at 10:02 a.m., Director of Nursing indicated that Resident #1 has expressed the desire to go to his/her brother/sister's house in [NAME] and the wander guard was put on him/her in March of 2022 and if we don't let him/her go outside well have a huge fight on our hands. At this time DNS confirmed that as of 9/21/22 staff have not received education regarding recognizing signs of/or what to do when a resident elopes. after Resident #1's 2 elopement attempts. During an interview on 9/21/22 at 3:45 p.m., the Administrator indicated that anyone with a wander guard on is not allowed outside unsupervised. At this time a surveyor confirmed with Administrator that Resident #1 was found unattended on 2 occasions attempting to go into the road. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on the above information, IJ was called on 9/22/22 for the facility's failure to provide adequate supervision to a resident with a history of suicidal ideation, that had left the faciity on two occasions and was found in/by the road. The facility's failure to provide these services constituted an immediate jeopardy situation. Please see F-0000 Initial comments related to the IJ removal plan. Review of facility policy titled Elopement dated 3/13 states Elopement: the unauthorized absence of a resident from the facility who is unable to make decisions due to mental capacity or guardianship .Resident will be accounted for at all times .A risk evaluation will be done on all new admissions and with a change of condition. A photo of residents that are identified at risk will be place at reception desk .if a resident is found off the facility premises, an A/I [accident/incident] will be completed and the Department of Health will be notified (as appropriate). A completed body audit will be conducted, upon the return of the resident who was found off the premises. The MD will be notified with the findings and will determine if the resident will need further medical assistance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interviews and document review, the facility failed to ensure that a resident who had signs of suicidal ideation received the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning for 1 of 3 residents reviewed for mood/behavior (Resident #1). Findings: On 9/13/22 the Department of Licensing and Certification received a complaint from an anonymous source indicating that he/she saw a Facebook (social media) post indicating that a resident was seen beside the road trying to wheel him/herself into traffic in an attempt to kill him/herself. Resident #1 was admitted to facility on 9/13/21 with diagnoses to include, seizure disorder, hemiplegia, right leg below the knee amputation, major depressive disorder, malignant bladder cancer and a cognitive communication deficit. Resident #1 was placed Hospice services for end-of-life care on 6/29/22 and has a wander guard placed on his/her left ankle for safety. Review of quarterly Minimum Data Set (MDS) dated [DATE] indicates Resident #1 had a Brief Interview for Mental Status (BIMS) of 11 of 15 indicating moderate impairment. Resident #1 self ambulates in wheelchair. During an interview on 9/21/22 at approximately 2:15 p.m., Resident #1 indicated the first time I had the code, second time the nurse let me out and wasn't watching. He/she indicated his/her intent was to head to the road to kill himself/herself and the nurse stopped him/her. Twice I tried to kill myself and twice I failed. At this time Resident #1 indicated that the second they turn their backs on him/her, he/she would beet feet right to the road. During a phone interview on 9/21/22 at 3:13 p.m., Registered Nurse (RN) indicated that on 7/13/22 Resident #1 was found outside of the building heading toward the busy road and indicated to her that it was his/her desire to kill himself/herself. RN indicated that she had to physically restrain wheelchair with Resident #1 in it to prevent resident from going into oncoming traffic. During an interview on 9/22/22 at 12:25 p.m., [NAME] by 1 indicated that on 9/11/22 between 5-5:15 p.m., he/she saw [Resident #1] in the road and it seemed that resident was deliberately trying to wheel him/herself in front of oncoming traffic. [NAME] by indicated that [Resident #1] stated, I don't want to fucking live anymore. [NAME] by physically restrained the resident's wheelchair to prevent resident from going in front of oncoming traffic. Facility staff and passerby physically picked up Resident #1 in his/her wheelchair and moved him/her into the facility for safety. Review of Resident #1's clinical record revealed nursing note dated 7/4/22, states [pt] was at door trying to get out, nurse asked what going on, [he/she] reply wants to get out of [here], to kill [himself/herself], Nurse asked resident to please talk to Director of Nursing or Administrator in morning to discuss. Will continue to monitor. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's clinical record revealed progress noted dated 7/4/ states [pt] was [overhear] by another [res] that [he/she] was going to get out and get a gun to kill [himself/herself], brought to nurse attention, nurse asked [pt] [he/she] said yes [he/she] said it when asked why [no response] . Review of Resident #1's clinical record revealed social service note dated 7/5/2022 states The writer reached out to [Resident #1] today due to resident expressing [he/she] wanted to buy a gun and shoot [himself/herself] . [He/she] has no current plan and feels safe in his environment with no indication of self harm .[he/she] is unhappy and wants to return into the community." Review of Resident #1's clinical record lacked evidence that Resident #1 received mental health treatment/services regarding this incident. During an interview on 9/22/22 at 2:50 p.m. Social Worker (SW) indicated that she met with Resident #1 on 7/5/22 and at that time he/she did not have any plan in place and had no suicidal ideation and did consult with the doctor. The facility did not refer him/her to a psyche provider because he/she was already getting Hospice support and someone from hospice is here almost daily and didn't feel the need to discuss this with the medical provider. SW was not aware of Resident #1's elopement on 7/12/22. SW further indicated that after the 9/11/22 incident she asked Resident #1 if he/she wanted to see a psychiatric practitioner and he/she said, absolutely not. States she did not document this discussion or look into it any further. When asked if other placement had been discussed SW indicated she did not consider having him/her involuntarily committed or a placement in a facility more sufficient for residents needs as she felt he/she was safe in the facility, and she didn't think he/she would be happy anywhere else. During an interview on 9/22/22 at 9:07 a.m., Nurse Practitioner (NP) indicated that he was not made aware of Resident #1's statement of self harm made on 7/4/22 and that he should have been consulted. Review of Resident #1's care plan initiated 8/5/21, updated 9/12/22 states the following: -Concern initiated 7/5/22 states Focus: The resident has depression with suicidal ideation tendencies due to feeling a sense of loss, missing family and wanting to return back to the community. Goal:[Resident #1] will demonstrate effective coping behavior as evidenced by a decrease in emotional distress. Interventions: Arrange for psych consult, follow up as indicated Concern initiated 10/7/21 states [Resident#1] is at risk for a mood problem. Goal: [Resident #1] will have improved mood state . Intervention: Monitor/record/report to MD prn acute episode feeling or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt .Monitor/record/report to MD prn(as needed) mood patterns s/sx(signs and symptoms) of depression, anxiety, sad mood as per fatuity behavior monitoring protocols. Review of Resident #1's Hospice Care Meeting held on 7/14/22 lacked evidence that Residents recent statement of suicidal ideation was discussed. Further review of Resident #1's clinical record lacked evidence he/she received the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility provided Business Associate Agreement dated 6/22/22 for psychiatry services. Further review indicated contracted psychiatrist resigned her contract with the facility on 5/11/22. During an interview on 9/22/22 at 2:15 p.m. Administrator indicated that National Health Care ended their contract with the facility on 5/11/22 and they do not currently have any psyche provider (3 months 10 days) and if there was an immediate need the facility would notify the Medical Director or the Nurse Practitioner and confirmed that the Medical Director or Nurse Practitioner were not consulted regarding the above concerns. At this time Administrator confirmed that Resident #1 did not receive the care and services necessary to reach and maintain the highest level of mental and psychosocial functioning. Facility failed to provide behavior monitoring protocols by the end of survey on 9/22/22 at 3:45 p.m. Based on the above information, Immediate Jeopardy (IJ) was called on 9/22/22 for the facility's failure to ensure that a resident who had signs of suicidal ideation received care and services. The facility's failure to provide these services constituted an immediate jeopardy situation. Please see F-0000 Initial comments related to the IJ removal plan. Review of Facility assessment dated [DATE] states .[NAME] Center will use a competency-based approach that focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practical physical, mental and psychological well-being Mental health and behavioral health: Manage the medical conditions and medications related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairments, care of individuals with depression, trauma/PTSD, other psychiatric diagnosis, intellectual or developmental disability. There is a licensed clinical Psychiatrist on Consult who visits weekly as needed.