

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 200024		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2026	
NAME OF PROVIDER OR SUPPLIER CENTRAL MAINE MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 MAIN STREET , LEWISTON, Maine, 04240			
(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
A0000	INITIAL COMMENTS Glossary/Definitions: CFR = Code of Federal Regulations CMS = Centers for Medicare & Medicaid Services CoP = Condition of Participation IJ = Immediate Jeopardy Immediate Jeopardy = Immediate Jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. This report is the result of an unannounced complaint survey for complaint #53926, #53939, #53958, #53999 and #54032 completed on 08/26/2026, at Central Maine Medical Center, an acute care hospital, to evaluate compliance with Title 42 CFR, Part 482, CoPs: Governing Body (§482.12), Infection Prevention and Control and Antibiotic Stewardship Programs (§482.42), Medical Staff (§482.22), Nursing Services (§482.23), Outpatient Services (§482.54), and Physical Environment (§482.41). It was determined that Central Maine Medical Center was not in substantial compliance with the requirements of 42 CFR, Title 42, Part 482 CoPs: Governing Body (§482.12), Infection Prevention and Control and Antibiotic Stewardship Programs (§482.42) and Physical Environment (§482.41). On 08/21/2026 at 3:57 PM IJ was identified regarding the hospital's failure to address sterile			A0000			

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 reverse for further 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
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A0000	Continued from page 1 surgical instrument trays being contaminated with an unidentified orange/yellow colored substance. During interviews with sterile processing department staff, they confirmed this had been a known issue since 2023. The IJ template was given to the hospital on 08/21/2026 at 3:57 PM. A removal plan was submitted by the hospital on 08/21/2026 at 10:02 PM. The IJ removal plan was approved by the State Agency on 08/22/2026 at 8:22 AM; and the IJ was resolved on 08/24/2026 at 2:54 PM after the State Survey Agency verified onsite that the hospital implemented corrective actions addressing the IJ. IJ was identified at: - Infection Prevention and Control and Antibiotic Stewardship Programs (§482.42) Conditional Level Deficiencies Identified: - Governing Body (§482.12) - Infection Prevention and Control and Antibiotic Stewardship Programs (§482.42) - Physical Environment (§482.41)	A0000			
A0747	INFECTION PREVENTION CONTROL ABX STEWARDSHIP CFR(s): 482.42 The hospital must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program.	A0747			

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A0747	Continued from page 2 This CONDITION is NOT MET as evidenced by: Based on document reviews, observations and interviews, the hospital failed to ensure that processes were in place to prevent and control infections. Specifically, in the Sterile Processing Department ("SPD"), the hospital failed to address sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance. During interviews with central sterile processing staff, they confirmed this had been a known issue since 2023. It was determined that the hospital's failures constituted an Immediate Jeopardy situation. Immediate Jeopardy ("IJ") is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment or death as a result of the hospital's noncompliance with one or more health and safety requirements. Standard: §482.42(a)(3) also known as A-0750 - Based on document reviews, observations and interviews, the hospital failed to ensure that processes were in place to prevent and control infections. Specifically, in the SPD, the hospital failed to address sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance. During interviews with central sterile processing staff, they confirmed this has been a known issue since 2023. In addition, the hospital failed to provide a clean and sanitary environment in the Perioperative Area. It was determined that the hospital's failure to ensure surveillance and a clean environment in the SPD constituted an immediate jeopardy situation. See A-0750 for details. Standard: §482.42(c)(1) Leadership Responsibilities (Governing Body) also known as A-0770 - Based on document reviews, observations, and interviews, the hospital's Governing Body failed to ensure that the hospital addressed sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance as well as ensure that systems were in place to maintain a clean and sanitary patient environment. See A-0770 for details. Standard: §482.42(c)(2)(ii) Infection Control Professional Documentation also known as A-0773 - Based on document reviews, observations, and interviews, the hospital's Infection Preventionist failed to provide documented evidence that they addressed the sterile surgical instrument trays being		A0747				

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A0747	Continued from page 3 contaminated with an unidentified orange/yellow colored substance as well as ensure that systems were in place to maintain a clean and sanitary patient environment. See A-0773 for details. Please see A-0000 Initial Comments for details related to the IJ template, removal plan, and abatement of the IJ. The hospital's failure to address the issue over a period of at least three (3) years, and the risks associated with the use of contaminated surgical instruments during patient surgeries has resulted in noncompliance with this Condition of Participation.	A0747					
A0043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is NOT MET as evidenced by: Based on document reviews, observations, and interviews, it was determined that the Condition of Participation for Governing Body was not met. The Governing Body failed to provide effective oversight of hospital operations, which resulted in the following deficient practices: the failure to implement the infection prevention and control program; the failure to maintain a clean and sanitary environment; the failure to address infection control findings; the failure to maintain facilities, supplies, and equipment ; the failure ensure OR surgical tables were free of rust and chipped paint; the failure to ensure that expired supplies were removed from patient care areas/perioperative areas; the failure to provide documented evidence of temperature and humidity levels in surgical areas; and the failure to ensure supplies used during surgical procedures were sterile. Condition: §482.41, also known as A-0700 - Based on document reviews, observations, and interviews, the hospital failed to meet the Condition of Participation of Physical Environment as evidenced by the following: the failure to maintain facilities, supplies, and equipment; the failure ensure OR	A0043					

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A0043	Continued from page 4 surgical tables were free of rust and chipped paint; the failure to provide documented evidence of temperature and humidity levels in surgical areas,; Standard: §482.41(d), also known as A-0722 - Based on observations and interviews, the hospital failed to ensure patient care areas were maintained in a sanitary and serviceable condition, free of damage, rust or evidence of water intrusion for six (6) out of seven (7) ORs observed (OR #2, OR #3, OR #4, OR #7, OR #8, OR #11); one (1) out of one (1) perioperative departments observed (the Sterile Processing Department), the cardiac catheterization lab, two (2) out of two (2) cardiac operating rooms observed, the Emergency Department, hospital units M4, T3, West 3/Rehab, M2 and common areas. See A-0722 for details. Standard: §482.41(d)(2), also known as A-0724 - Based on observations, interviews, and document reviews, the hospital failed to ensure expired supplies were removed from circulation in four (4) ORs observed (OR #5 - OR #7, and OR #9) and the inpatient unit M2. The hospital failed to ensure that facilities and equipment were maintained, and free of rust damage and chipped paint for a surgical table (Asset Tag #04322), a mobile imaging table (Asset Tag #17539) and a sink outside of the ORs. See A-0724 for details. Standard: §482.41(d)(4), also known as A-0726 - Based on observations, interviews, and document reviews, temperature and humidity in the Operating Rooms ("OR") was not consistently monitored and documented for one (1) of one (1) OR temperature and humidity log reviewed ("Old Cysto Room"). See A-0726 for details. Condition: §482.42, also known as A-0747 - Based on document reviews, observations and interviews, the hospital failed to ensure that processes were in place to prevent and control infections. Specifically, in the Sterile Processing Department, the hospital failed to address sterile surgical instrument trays that were contaminated with an unidentified orange/yellow colored substance. During interviews with central sterile processing staff, they confirmed this has been a known issue since 2023. See A-0747 for details. Standard: §482.42(a)(3) also known as A-0750 -			A0043			

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A0043	Continued from page 5 Based on document reviews, observations and interviews, the hospital failed to ensure that processes were in place to prevent and control infections. Specifically, in the SPD, the hospital failed to address sterile surgical instrument trays that were contaminated with an unidentified orange/yellow colored substance. During interviews with central sterile processing staff, they confirmed this has been a known issue since 2023. In addition, the hospital failed to provide a clean and sanitary environment in the Perioperative Area. It was determined that the hospital's failure to ensure surveillance and a clean environment in the SPD constituted an immediate jeopardy situation. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment or death as a result of the hospital's noncompliance with one or more health and safety requirements. See A-0750 for details. Standard: §482.42(c)(1) Leadership Responsibilities (Governing Body) also known as A-0770 - Based on document reviews, observations, and interviews, the hospital's Governing Body failed to address sterile surgical instrument trays that were contaminated with an unidentified orange/yellow colored substance as well as ensure that systems were in place to maintain a clean and sanitary patient environment. See A-0770 for details. Standard: §482.42(c)(2)(ii) Infection Control Professional Documentation also known as A-0773 - Based on document reviews, observations, and interviews, the hospital's Infection Preventionist failed to provide documented evidence that they addressed the sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance as well as ensure that systems were in place to maintain a clean and sanitary patient environment. See A-0773 for details. The Governing Body's failure to maintain sufficient oversight over the hospital's Infection Prevention and Control and Antibiotic Stewardship Program has led to the contamination of surgical instruments going unaddressed for at least three (3) years, and the Governing Body's failure to ensure the physical environment and equipment within the hospital were maintained in a serviceable condition has resulted in noncompliance with this Condition of Participation.			A0043			

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A0700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is NOT MET as evidenced by: Based on document reviews, observations, and interviews, the hospital failed to maintain the facilities and equipment in its Operating Rooms ("OR"), the sterile processing department, cardiac operating and procedure rooms, the emergency department, inpatient units M4, West 3/Rehab, M2, and common areas. The hospital failed to remove expired supplies from circulation and failed to ensure temperature and humidity was monitored in the ORs. Condition: §482.41, also known as A-0700 - Based on document reviews, observations, and interviews, the hospital failed to meet the Condition of Participation of Physical Environment as evidenced by the following: the failure to maintain the facilities, supplies, and equipment; the failure ensure OR surgical tables were free of rust and chipped paint; the failure to provide evidence that expired supplies were removed from circulation in the ORs; and the failure to provide documented evidence of temperature and humidity levels in surgical areas. Standard: §482.41(d), also known as A-0722 - Based on observations and interviews, the hospital failed to ensure patient care areas were maintained in a sanitary and serviceable condition, free of damage, rust or evidence of water intrusion for six (6) out of seven (7) ORs observed (OR #2, OR #3, OR #4, OR #7, OR #8, OR #11); one (1) out of one (1) perioperative departments observed (the Sterile Processing Department), the cardiac catheterization lab, two (2) out of two (2) cardiac operating rooms observed, the Emergency Department, hospital units M4, T3, West 3/Rehab, M2 and common areas. See A-0722 for details. Standard: §482.41(d)(2), also known as A-0724 - Based on observations, interviews, and document reviews, the hospital failed to remove expired supplies from circulation in four (4) ORs observed (OR #5 - OR #7, and OR #9) and the inpatient unit M2. The hospital failed to ensure that facilities and			A0700			

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A0700	Continued from page 7 equipment were maintained, and free of rust damage and chipped paint for a surgical table (Asset Tag #04322), a mobile imaging table (Asset Tag #17539) and a sink outside of the ORs. See A-0724 for details.		A0700				
	Standard: §482.41(d)(4), also known as A-0726 - Based on observations, interviews, and document reviews, temperature and humidity in the OR was not consistently monitored and documented for one (1) of one (1) OR temperature and humidity log reviewed ("Old Cysto Room"). See A-0726 for details.						
A0722	FACILITIES CFR(s): 482.41(d) (d) Standard: Facilities. The hospital must maintain adequate facilities for its services. This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the hospital failed to ensure patient care areas were maintained in a sanitary and serviceable condition, free of damage, rust or evidence of water intrusion for six (6) out of seven (7) Operating Rooms ("OR") observed (OR #2, OR #3, OR #4, OR #7, OR #8, OR #11); one (1) out of one (1) perioperative departments observed (the Sterile Processing Department), the cardiac catheterization lab, two (2) out of two (2) cardiac operating rooms observed, the Emergency Department ("ED"), hospital units M4, T3, West 3/Rehab, M2 and common areas. Findings: A document provided by the hospital titled, "M4 Findings", indicated that the hospital identified the following issues on 03/03/2026: - "...Multiple door frames damaged throughout unit. Piece of floor missing. Please remediate. Housekeeping walls also with splashes, penetrations, and wall separation..." A document provided by the hospital titled, "SPD Findings", indicated that the hospital identified the following issues on 05/05/2026: - "...The flooring that was replaced has started to		A0722				

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A0722	Continued from page 8 come up, causing a trip hazard. Tape has been placed over it, but tape is not allowed within SPD for infection control reasons..." - "...Floors throughout the department need intensive cleaning..." A document provided by the hospital titled, "[Environment of Care] EOC Rounds OR SPD 03/10/2026", indicated that the hospital identified the following issues between 03/10/2026 and 03/12/2026: - "...Holes, chips and nicks on walls throughout the area..." - "...The corner wall in bay [OR] 3 has plaster knocked off..." - "...Extensive repairs needed for walls. Wall across from OR 8 by the soiled utility room has multiple holes and chips. OR 9 &10 have multiple holes in walls..." A document provided by the hospital titled, "SPD Findings", indicated that the hospital identified the following issues on 05/05/2026: - "...The flooring that was replaced has started to come up, causing a trip hazard. Tape has been placed over it, but tape is not allowed within SPD for infection control reasons..." - "...Floors throughout the department need intensive cleaning..." Operating Rooms: On a tour of the Operating Rooms with the Director of Perioperative Services and Sterile Processing Department Manager ("SPD Manager") on 08/18/2026 at approximately 10:30 AM, the following was identified: - On 08/18/2026 at 10:32 AM, the survey team observed small holes in the floor in OR #2; - On 08/18/2026 at 10:35 AM, the survey team observed a crack in the corner of the floor next to the door in OR #3; - On 08/18/2026 at 10:40 AM, the survey team observed that in the hallway outside of OR #11, there			A0722			

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A0722	Continued from page 9 was a tube from the ceiling draining into a covered bucket. The survey team opened the bucket in the presence of hospital staff and observed a brown liquid had accumulated in the bottom of the bucket; and - On 08/18/2026 at 10:42 AM, the survey team observed a rusty air vent in the hallway ceiling and a crack along the wall in the corner of the hallway leading to the ORs. These findings were confirmed at the time of observation by the Director of Perioperative Services and SPD Manager. Sterile Processing Department: On a tour of the Sterile Processing Department with the Director of Perioperative Services and SPD Manager on 8/18/2026 at 11:30 AM, the following was identified: - On 08/18/2026 at 11:30 AM, the survey team observed signs of water leaking on the floor below wall-mounted washing machine units in the Sterile Processing Department. - On 08/18/2026 at 11:32 AM, the survey team observed damaged floor tiles that appeared to have previously had adhesive tape applied to the tiles in the Sterile Processing Department. - On 08/18/2026 at 11:35 AM, the survey team observed a large gouge on the wall adjacent to the washing machines in the Sterile Processing Department. These findings were confirmed at the time of observation by the Director of Perioperative Services and the SPD Manager. Hospital Units: During a tour conducted of the hospital units starting on 08/19/2026 at 1:15 PM with the Director of Acute Care Nursing, the following was identified: - On 08/19/2026 at 1:21 PM, the survey team observed door frames with gouges and at 1:24 PM observed cracks in the soiled utility room floor on M4;			A0722			

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A0722	Continued from page 10 - On 08/19/2026 at 1:45 PM, the survey team observed damage to the medication room door frame and at 1:51 PM observed cracks in the utility room floor of T3; - On 08/19/2026 at 2:23 PM, the survey team observed a bucket on the floor in the hallway across from room 304 that had drainage tubing coming down from the ceiling into the bucket this was on the inpatient Rehab Unit - West 3/Rehab; - During an in-person interview on 08/19/2026 at 2:31 PM, with Registered Nurse #1, he/she stated the bucket that was on the floor in the hallway across from room 304 was due to an ongoing leak and stated that it happens when it rains; and - On 08/19/2026 at 1:17 PM, the survey team observed in the T3 kitchen, that an upper kitchen cabinet to the right of the sink had a door with broken hinges. The survey team observed the door was not labeled to indicate it was broken, and that the cabinet appeared to still be full of supplies. These findings were confirmed at the time of observation by the Director of Acute Care Nursing. Emergency Department: A tour of the ED was conducted at 8:30 AM on 08/21/2026 with the ED Nurse Director, during which the following was identified: - On 08/21/2026, the survey team observed a water stain on a ceiling tile in corridor between the green and blue pods; - On 08/21/2026, the survey team observed chairs in the ED waiting room had torn upholstery; and - On 08/21/2026, the survey team observed damage along the external wall covering the baseboard heating unit in the waiting area, as well as the bottom plastic component of the baseboard heating was damaged and was hanging freely from the rest of the assembly. These findings were confirmed at the time of observation by the ED Nurse Director. Common Areas:			A0722			

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A0722	Continued from page 11 During a tour of common areas conducted with the Vice President of Operations and Executive Director of Facilities Management starting on 08/21/2026 at 9:15 AM, the following was identified: - The survey team observed cracks in the floor on the ground floor hallway of the Memorial Wing; - The survey team observed a broken cove base on the 3rd floor by the elevator; and - The survey team observed peeling paint and wall damage in stairwell 10 of the West Wing. These findings were confirmed at the time of observation by the Executive Director of Facilities Management. Cardiac Operating and Procedure Rooms: On a tour of the Cardiac Operating Rooms, Cardiac Catheterization Lab and the surrounding patient care area with the Director of Perioperative Services and the Registered Technologist in Radiography starting at approximately on 08/24/2026 at 10:03 AM, the following was identified: - On 08/24/2026 at 10:05 AM, the survey team observed missing, chipped paint and/or damage to the walls of the area with patient bays outside of the Cardiac Catheterization Lab; - On 08/24/2026 at 10:07 AM, the survey team observed damaged doors and doorways, including gouges, damage, chipped/missing paint, including white paint that was chipped and missing on the white double doors in the OR area near OR #8; and The Director of Perioperative Services confirmed these findings at the time of observation. Operating Rooms: The survey team conducted observations of OR #1, OR #2, OR #4, OR #8, and the surrounding patient care area on 8/24/2026 at 10:36 AM. These observations were accompanied by the Director of Perioperative Services, and the survey team's observations revealed the following: - On 08/24/2026 at 10:36 AM, the survey team observed damaged doors and doorways, including			A0722			

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A0722	Continued from page 12 gouges, damage, and chipped/missing paint for OR #1, #2, #4, and #8; - The survey team that in the hallway outside of OR #1, #2, #4 and #8, the layers of drywall in the walls were visibly separating at the corners; - On 08/24/2026 at 10:42 AM, the survey team observed a visible orange substance on the floors in the corners of the room by the two white doors leading into the area where the operating rooms are located; - On 08/24/2026 between 10:36 AM and 10:45 AM, the survey team observed screws, plastic fasteners and adhesive strips protruding from or affixed to the walls in the walls of ORs #1, #2, #4, and #8; and - On 08/24/2026 at 10:45 AM, the survey team observed rust on the floor by the sink located outside of the operating rooms. The Director of Perioperative services confirmed this sink was used by surgical staff to scrub in prior to surgeries. The Director of Perioperative Services confirmed these findings at the time of observation. The Director of Perioperative Services indicated they were aware of many of these findings prior to the date of the survey but indicated that the issues had not yet been fixed. Kitchen: During a tour of the kitchen and cafeteria conducted with the Executive Director of Facilities Management starting on 8/24/2026 at 1:30 PM, the following was identified: - On 08/24/2026 at 1:44 PM, the survey team observed cracked floors in the kitchen around the stoves; and - On 08/24/2026 at 1:46 PM, the survey team observed the ceiling tiles in the kitchen area where trays are sanitized were sagging due to excessive exposure to moisture-On 08/24/2026 at 1:50 PM observed cracks in the floor of the cafeteria. These findings were confirmed at the time of observation by the Executive Director of Facilities Management.			A0722			

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A0724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and document reviews, the hospital failed to ensure expired supplies were removed from circulation in four (4) Operating Rooms ("OR") observed (OR #5 - OR #7, and OR #9) and the inpatient unit M2. The hospital additionally failed to ensure that facilities and equipment were maintained, and free of rust damage and chipped paint for a surgical table (Asset Tag #04322), a mobile imaging table (Asset Tag #17539) and a sink outside of the ORs. Findings: The hospital's policy "Expired & Near Expired Product," approved on 10/28/2025 states in part, that the facility must "Remove expired product for disposal." The hospital's "Process Service Request" (undated) which specifies timeframes for response to work orders documents that the longest response time for a routine work order would be two hundred and forty (240) hours or (30 days). A list of "Open Work Orders" listed forty-three (43) incomplete work orders over 30 days old dating back to 3/19/2026. A list of "Open Cosmetic Work Orders" listed fifty-five (55) incomplete work orders dating back to 01/28/2026. A document provided by the hospital titled, "[Environment of Care] EOC Rounds OR SPD [Sterile Processing Department] 03/10/2026," indicated that the hospital identified the following issues between 03/10/2026 and 03/12/2026: "...Sterile items must remain in their packaging until patient use. It has come to our attention that a number of sterile items are routinely being opened prior to the patient entering the OR, thus exposing the patient to potential contamination. For example, the masks on the anesthesia equipment are being opened and attached to the tubing at the end of the prior case and left in opened packaging until the			A0724			

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A0724	Continued from page 14 next patient..." On a tour of the ORs with the Director of Perioperative Services and the Sterile Processing Department Manager ("SPD Manager") on 08/18/2026 at approximately 10:50 AM, the following issues were identified: - On 08/18/2026 at 11:21 AM, the survey team observed that in OR #5, there was an opened, undated bottle of sterile water and a syringe on a counter; - On 08/18/2026 at 11:36 AM, the survey team observed that in OR #6, there was an unlocked neonatal cart with medications; - On 08/18/2026 at 11:25 AM, the survey team observed that in OR #7, there was an open, undated bottle of sterile water on a cart and [Electroencephalogram] Index Monitoring System packages with expiration dates of 12/06/2025, 09/08/2025, and 11/23/2025; - On 08/18/2026 at 11:51 AM, the survey team observed that in OR #9, there were open tubing and hemostats in the anesthesia cart and laryngeal mask airways with expiration dates of 11/2024, 05/2026, and 07/2026. The cart was unlocked and included medications. The Perfusionist confirmed that this cart was routinely left unlocked; and - On 08/18/2026 at 10:56 AM, the SPD Manager showed the survey team a towel from a sterilization tray that was observed to be contaminated unidentified discoloration and staining. The SPD Manager stated, "This is typical." These findings were confirmed with the Director of Perioperative Services and the SPD Manager at the time of observation. During observations on 08/19/2026 at 9:42 AM on the inpatient unit M2, the survey team observed a Safety System with Y Adapter (an over the needle intravenous catheter designed to reduce needle stick injuries) in a supply cabinet in the medication storage area of M2. The Safety System with Y Adapter was observed to have expired on 04/30/2026. On a tour of the ORs on 08/24/2026 with the			A0724			

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A0724	Continued from page 15 Director of Perioperative Services at 10:30 AM, the following was identified: - On 08/24/2026 at 12:01 PM, the survey team observed a surgical table (Asset Tag #04322) with a rusted pedal and a panel with adhesive tape; - On 08/24/2026 at 12:03 PM, the survey team observed a mobile imaging table (Asset Tag #17539) with rust and chipped paint; and - On 08/24/2026 at 12:07 PM, the survey team observed rust on the floor by the sink used to prepare for surgeries outside of the ORs. These findings were confirmed with the Director of Perioperative Services at the time of observation. During an interview on 08/24/2026 at 12:04 PM, the Biomedical Site Lead stated that there had been no work orders to Biomed to address the two (2) procedure tables.		A0724				
A0726	VENTILATION, LIGHT, TEMPERATURE CONTROLS CFR(s): 482.41(d)(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and document reviews, temperature and humidity in the Operating Rooms ("OR") was not consistently monitored and documented for one (1) of one (1) OR temperature and humidity log reviewed ("Old Cysto Room"). Findings: The hospital's "Temperature and Humidity in the Operating Room" policy, approved 10/28/2025, states in part," The temperature and humidity of each operating room will be recorded on a daily basis during normal operating hours." On a tour of the ORs with the Director of Perioperative Services and Sterile Processing Department Manager at 10:30 AM on 8/18/2026, the following was identified: - A review of temperature and humidity logs		A0726				

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A0726	Continued from page 16 revealed the hospital failed to document temperature and humidity on 08/01/2026 and 08/02/2026 for the OR identified as "Old Cysto Room"; and - A review of the Fluid Warmer Temperature Charts for ORs #6 - #11 revealed the hospital failed to document fluid warmer temperatures on 08/01/2026 and 08/02/2026. These findings were confirmed with the Director of Perioperative Services at the time of observation.		A0726				
A0750	INFECTION CONTROL SURVEILLANCE, PREVENTION CFR(s): 482.42(a)(3) The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and This STANDARD is NOT MET as evidenced by: Based on document reviews, observations and interviews, the hospital failed to ensure that processes were in place to prevent and control infections. Specifically, in the Sterile Processing Department ("SPD"), the hospital failed to address sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance. During interviews with central sterile processing staff, they confirmed this has been a known issue since 2023. In addition, the hospital failed to ensure that the hospital provided a clean and sanitary environment in the Perioperative Area. It was determined that the hospital's failure to ensure surveillance and a clean environment in the SPD constituted an immediate jeopardy situation. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment or death as a result of the hospital's noncompliance with one or more health and safety requirements. Central Maine Healthcare "Maintaining Integrity of Sterile Packaging" policy, last approved 05/28/2025, states in part: "Physical integrity of sterilized items is violated when a package is: 1) torn 2) dropped 3) wet 4) damaged ... Hospital sterilized items follow event-related sterilization guidelines and will be considered sterile as long as the integrity of the package is not compromised. ... I. Inspection of Sterile Packages A. All sterile packages must be		A0750				

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A0750	Continued from page 17 inspected before use. B. Do not use if the package is torn, has been wet, soiled or dropped. ... Any packaging for which package integrity is in question, either from contamination, compression, or excessive humidity, shall be removed from patient use and either discarded or returned to SPD for reprocessing " In addition, "Storage Parameters A. Central Medical and Surgical Supply areas, such as those in SPD (Sterile Processing Department) or the Perioperative Departments are required to maintain parameters outlined per AAMI, ASHRAE, and AORN [Association of periOperative Registered Nurses] which includes positive air pressure in relation to adjacent areas, minimum total air exchanges of 4 per hour, maximum relative humidity of 30 - 60% and temperature range of 72 to 78 F." Association of periOperative Registered Nurses ("AORN") Guidelines for Perioperative Practice 2026 edition, in part states "Immediately before presenting items to the sterile field, inspect the packaging and item for sterility of the contents; package integrity; product integrity (e.g., discoloration or particulate formation in medications and solutions). Inspect rigid sterilization containers for intact external locks, secure latch filters, valves, and tamper-evident devices, and for the correct color change to external chemical indicators before they are opened onto a clean, flat, and dry surface. Before the instruments are placed on the sterile field, the scrub person should inspect the inside surface of the container for debris, moisture, contamination, or damage and consider the contents to be contaminated if debris, moisture ..., or damage is present. If there are any filters in the bottom of the container, an unscrubbed person should inspect the integrity of 23 the filters " On 08/21/2026, two (2) tours of the Perioperative Department were conducted. Four (4) sterile surgical instrument trays that were marked ready for use were opened by the Sterile Processing Department Manager ("SPD Manager") in the presence of the survey team and the Director of Perioperative Services and all four (4) were observed to be contaminated inside with an unknown orange/yellow substance. This was confirmed to be the same staining that has been observed by staff since 2023. When asked about the prevalence of the contaminated surgical trays, the SPD Manager stated "[All the trays] are all like that." When asked how many trays had been returned from			A0750			

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A0750	Continued from page 18 the Operating Room ("OR") to be reprocessed due to being contaminated inside with the unknown orange/yellow substance, he/she stated, None, no one turns the trays away. We would have to close the doors due to the prevalence of the issue. He/She stated, "[I have] never received a tray back due to contamination." This was also confirmed by Director of Perioperative Services. The Director of Perioperative Services was asked about the surgical site infection rate, but he/she could not answer and stated the Infection Preventionist would have that information. The Director of Perioperative Services and the SPD Manager reiterated that no trays have been returned to the SPD due to the contamination, as there would be no surgeries if they returned all the trays that were stained. On 08/21/2026 at 9:10 AM, a tour of the decontamination area with the Director of Perioperative Services and the SPD Manager was conducted. This tour revealed the following: The ultrasonic machine had discoloration to the metal at the bottom of the reservoir; the primary manual instrument cleaning sink had a large pipe with evidence of a leak below the end of the pipe. Per the SPD Manager, the floor had been cleaned overnight, and the evidence of the leak had occurred since that cleaning; The floor in the front of the instrument washers showed evidence of a large floor patch and evidence of gross soiling. There was water seeping a pooling along the long edge of the patch; ceiling tiles were observed to be displaced within the ceiling's grid support system to such an extent that it would allow air from within the ceiling to circulate into the restricted area, the ceiling's grid support system in this area was additionally observed to be rusted; Dirty light lens' were noted; Air handling vents dirty and dusty; and There was blue colored matter hanging from the ceiling above the middle instrument washer. The Director of Perioperative Services and the SPD Manager confirmed the findings at the time of the observation. On 08/21/2026 from 10:45 AM to 12:50 PM, two (2) surveyors conducted a tour of OR #3, #5, #7, #9 - #11, The "Y Area", Sub Sterile Areas/Rooms,			A0750			

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A0750	Continued from page 19 Equipment Storage Areas, Hallway, Anesthesia Supply Room, and the "OR Core". At 10:58 AM, OR #3 and Sub Sterile #3 was found to have: -Broken wall handle guard going into OR #3; -Open pipes that "are leftovers from the sterilizer that was removed about six (6) months ago" per the Director of Perioperative Services; -Dust and debris under the warming blankets with tape adhesive on the doors; -The cabinets were rusty and had tape adhesive; -Cove base (a specialized type of trim installed at the junction where a wall meets a floor) was in disrepair, with tape holding it together; -A biohazard box rubbing on the wall and marking it up with adhesive on the wall above the biohazard box; -A medical device that uses controlled high-frequency electrical current or thermal energy to cut tissue and stop bleeding by sealing blood vessels, generator and foot pedal were dirty; -Arm board of OR table had tape adhesive; -Intravenous ("IV") pole with pump had rust; -Dusty and debris on the anesthesia keyboard; -Former X-Ray machine was broken; and -Open hole in frame of door to the OR. At 11:18 AM OR #5 was found to have: -There was a black substance and tape adhesive on			A0750			

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A0750	Continued from page 20 the OR door; -The white board had adhesive on it; -The cabinet door handle was broken, and the bottom of the cabinet was rusted; -There was adhesive on cabinets, casters are rusted on metal tables; -Part of the base on the OR table was rusted; -There was a tear in the mattress of the OR table; and -There was adhesive and a brown substance on the anesthesia tower. At 11:25 AM, The OR Core was found to have: -Broken ceiling vents; -The cystoscopy cart had rust; -Four (4) chipped fluid warmer bases; -A machine used in gynecological procedures had a chipped stand, and the holder in the [Endometrial Ablation Machine] was stained with some orange substance; -The fluid management system for gynecology had a chipped base and tape adhesive; -The coagulator had tape adhesive; -The bed extender that holds the different positioners (a specialized devices used to safely and effectively position patients on the operating table during surgical procedures) had adhesive on many of the positioners;	A0750					

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A0750	Continued from page 21 -The pyxis, the refrigerated component, was chipped and dirty in the vent and the facing was coming off; -There was a dirty step stool; -There was a dirty green cart with supplies; -There was a dirty vent; and -There was a hole in the wall. At 11:31 AM, the Anesthesia Supply Room was found to have: -The "Travel 3" cart had a rusted top, with a laryngeal mask airway that had an unknown substance on it; -The lilac-colored supply cart had tape adhesive on it along with dirty bins on top with debris inside and was soiled and rusty in the charcoal bin; -A dirty step stool; -"Cart #6" had broken plastic on it; -The blue cart had a few drawers that were broken and it was confirmed that they keep medications for anesthesia in the cart; -There were dirty gas lines for the wall plate as well as the extra hoses for anesthesia machine; -The "green gaming chair" for staff was in disrepair; -The anesthesia technician counter had dust; -The anesthesia counter cabinet had broken drawers;	A0750					

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A0750	Continued from page 22 -The floor of the cabinet was chipped and had rusted equipment with dirty drawers and a box of orange oval mints/candies inside one of the drawers; -There was a broken and unsecured vent; -There was a dirty vent; -There was a substance on the bottom of the cart that held sodium chloride bottles that was unable to be identified; -There was a dirty tray with bags of fluid that were prepared to be used; -The ortho headlamp black case had dust; and -A headrest container had dust and dirt on the cover. At 11:54 AM, OR #6 which is primarily used for cesarean sections was found to have: -A blue cart with porous handles and a rusted base; -A baby cart with tape adhesive on it; -Cabinets had rust along with tape adhesive; -The sharps container had dust and debris; and -A rusted stool. At 11:58 AM OR #7 was found to have: -A black substance on the door; -A rusted stool;			A0750			

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(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	
A0750	Continued from page 23 -A dirty step stool; -The feet of the OR tables had rust; -A machine used in operating rooms to collect and dispose of surgical fluid waste and clear surgical smoke machine was dirty; -The pad on the OR table had tape adhesive; -A medical device that uses controlled high-frequency electrical current or thermal energy to cut tissue and stop bleeding by sealing blood vessels had chipped paint; -IV poles had chipped paint; -The filter on the anesthesia tower had dust; and -There was a clear bag taped to a wall that was ripped and had tape adhesive [the Director of Perioperative Services stated that he/she did not know what that was used for in this OR]. At 12:03 PM, the Sub Sterile room between OR #6 and #7 was found to have: -An open drain next to the sterilizer; -A second blanket warmer that had dust, debris and tape adhesive; -A broken vent; and -The clean sequential compression device supplies and isolation gowns unit had dust and dirt. From 12:08 PM to 12:16 PM The "Y Area" was found to have: -A surgical oncology cart and a dilation and evacuation cart had tape adhesive on both carts with	A0750					

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A0750	Continued from page 24 rusty wheels and a broken piece on the surgical oncology cart; -A pediatric cart with tape adhesive; -A trauma cart with tape adhesive; -A wall with a hospital wall guard that was broken; -The cove base (a specialized type of trim installed at the junction where a wall meets a floor) had an area that was ripped and dirty; -The scrub sink pedals were dirty; -The bins that hold suture supplies were broken; -The lead apron holder was chipped, had missing end caps and was rusted; -The suture tower had tape adhesive and was broken in one area; -A sterile robot kit, ready for use, was pulled and opened randomly ... an orange/yellow substance on the cloth under the instruments of the tray was observed; -The cardiac positioners (a specialized devices used to safely and effectively position patients on the operating table during surgical procedures) had dirt and tape adhesive; -Multiple positioners (a specialized devices used to safely and effectively position patients on the operating table during surgical procedures) with tape adhesive and ripped in areas; -Green and tan supply cart, containing foley catheters, umbilical tape, etc. had tape adhesive; and -Wound vac supplies cabinet had tape adhesive .			A0750			

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A0750	Continued from page 25 OR #11, which is primarily used for bariatric surgery was found to have: -A black substance on the door; -The cove base below the OR supply cabinet doors (a specialized type of trim installed at the junction where a wall meets a floor) was broken - the cove base was peeling away from the wall; -The cabinets had a significant amount of tape adhesive; -The yellow chair that the OR surgical staff sits in was in disrepair; -The keyboard contained dirt and dust; -There were brown spots of some type of substance on the floor; -A third blanket warmer contained a significant amount of dirt, dust and debris; -The fluid warmer had a significant amount of dirt, dust and debris; -A dirty foot pedal for the vascular ablation machine; and -Positioners (a specialized devices used to safely and effectively position patients on the operating table during surgical procedures) had dust on them. At 12:25 PM, OR #9, which is primarily used for heart surgeries was found to have: -A black substance on the door; -A medical device that uses controlled high-frequency electrical current or			A0750			

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A0750	Continued from page 26 thermal energy to cut tissue and stop bleeding by sealing blood vessels, had dirt and tape adhesive; -The vents had dust; -A writing surface that pulls out of the countertop was missing the blue laminate and the porous wood structure was exposed; -A medical device that uses controlled high-frequency electrical current or thermal energy to cut tissue and stop bleeding by sealing blood vessels had chipped paint; -The profusion machine base was dirty; -The profusion cart had a bin on top that stored 5CC and 10CC syringes contained plastic/silicone toys with dust and debris along with debris on the bottom of the bin; -[The anesthesia cart] had a plastic organizer with syringes and needles had plastic/silicone toys with dust; and -The anesthesia keyboard had dirt and debris. At 12:39 PM, OR #10, which is primarily used for vascular surgeries was found to have: -Missing laminate on the workstation pull out; -A significant opening in the wall [the Director of Perioperative Services stated that there were plans in place to remove the cabinet, but it has not happened]; -Chipped paint on the wall; -The suction machine had dust; -The anesthesia tower had dirt; and			A0750			

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A0750	Continued from page 27 -A dusty vent. At 12:48 PM, a hallway outside of OR #11 was found to have: -The cove base (a specialized type of trim installed at the junction where a wall meets a floor) was missing a piece; and -The bottom of wall covering was pulling away from the wall. -All the above items could not be or were not properly cleaned and sanitized and these findings were confirmed by the Director of Perioperative Services and the SPD Manager.		A0750				
A0770	LEADERSHIP RESPONSIBILITIES CFR(s): 482.42(c)(1)(i) Standard: Leadership responsibilities (1) The governing body must ensure all of the following: (i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities. This STANDARD is NOT MET as evidenced by: Based on document reviews, observations, and interviews, the hospital's Governing Body failed to ensure that the hospital addressed sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance as well as ensure that systems were in place to maintain a clean and sanitary patient environment. Findings: The "CMHC [Central Maine Health Care] Infection Prevention Plan FY2025", with a final approval date of 07/15/2024, states in part, "OBJECTIVES ... 5.		A0770				

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A0770	Continued from page 28 Utilizing current guidance documents, references, published evidence based an industry standard best practices to develop policies and procedures designed to prevent and control the transmission of communicable diseases, including, but not limited to those from the Centers for Disease control and Prevention & World Health Organization. ... 8. Reinforcing patient safety by upholding accreditation standards and federal state mandates related to the environment of care and infection prevention throughout the continuum." In addition, it states in part, "From a CMMC [Central Maine Medical Center] and system wide perspective, the Infection Prevention Committee or its appropriate members have authority delegated from organizational leadership to institute infection prevention measures, studies, enforced policies, and act on a suspected or defined problem when indicated by findings or through surveillance mechanisms. ... The Quality, Value, & Community Health Committee (QVHC) retains ultimate authority and responsibility for the quality of patient care and performance of staff. Data and recommendations from the QVHC are elevated to the Board of Directors." Finally, in part it states, "The System Director of Infection Prevention: a. Provides strategic oversight and sets direction for the Infection Prevention and Control Program. ... c. Provides administrative oversight for the review of surveillance activities and development of action plans based on high-risk or trending observations in conjunction with key stakeholders." "FY2025 has identified following areas as high risk through the IP Risk Assessments", in part, "CMMC Perioperative Services Environmental Contamination/Compliance." The "CMH [Central Maine Healthcare] Infection Prevention and Control Plan FY2026", with a final approval date of 09/18/2025, states in part, "OBJECTIVES ... f. Utilizing current guidance documents, references, published evidence based an industry standard best practices to develop policies and procedures designed to prevent and control the transmission of communicable diseases, including, but not limited to those from the Centers for Disease control and Prevention & World Health Organization. ... i. Reinforcing patient safety by upholding			A0770			

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A0770	Continued from page 29 accreditation standards and federal state mandates related to the environment of care and infection prevention throughout the continuum." In addition, it states in part, "From a CMMC and system wide perspective, the Infection Prevention Committee or its appropriate members have authority delegated from organizational leadership to institute infection prevention measures, studies, enforced policies, and act on a suspected or defined problem when indicated by findings or through surveillance mechanisms. ... The Quality, Value, & Community Health Committee (QVHC) retains ultimate authority and responsibility for the quality of patient care and performance of staff. Data and recommendations from the QVHC are elevated to the Board of Directors." Finally, in part it states, "The System Director of Infection Prevention: i. Provides strategic oversight and sets direction for the Infection Prevention and Control Program. ... iii. Provides administrative oversight for the review of surveillance activities and development of action plans based on high-risk or trending observations in conjunction with key stakeholders." "FY2026 has identified following areas as high risk through the IP Risk Assessments", in part, "CMMC Perioperative Services Environmental Contamination/Compliance." On 08/18/2026, the CMMC Board Meeting Minutes were reviewed for the following dates that were provided: 07/02/2025, 08/06/2025, 09/03/2025, 10/01/2025, 11/05/2025, 01/07/2026, 02/04/2026, 02/13/2026, 03/04/2026, 04/15/2026, 05/27/2026, 06/24/2026, and 07/2026. In the minutes provided, there was no discussion related to infection control concerns in the perioperative and sterile processing department. On 08/26/2026 at 2:43 PM, a virtual interview was conducted with the President and Chief Medical Officer [of a healthcare company], and Governing Body Chairman. He/She stated in part, the following: I sit as the Chair of the Board for CMMC. Regarding concerns in the perioperative and sterile processing department of this magnitude, I learned			A0770			

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A0770	Continued from page 30 about it during this survey. It came to my knowledge last week [due to the survey findings]."		A0770				
A0773	Upon further review of the CMMC Board Meeting Minutes, the President and Chief Medical Officer [of a healthcare company], and Governing Body Chairman has been absent for three (3) of five (5) meetings. IC PROFESSIONAL DOCUMENTATION CFR(s): 482.42(c)(2)(ii) [The infection preventionist(s)/infection control professional(s) is responsible for:] (ii) All documentation, written or electronic, of the infection prevention and control program and its surveillance, prevention, and control activities. This STANDARD is NOT MET as evidenced by: Based on document reviews, observations, and interviews, the hospital's Infection Preventionist failed provide documented evidence that they addressed the sterile surgical instrument trays being contaminated with an unidentified orange/yellow colored substance as well as ensure that systems were in place to maintain a clean and sanitary patient environment. Findings: The "CMHC [Central Maine Health Care] Infection Prevention Plan FY2025", with a final approval date of 07/15/2024, states in part, "OBJECTIVES ... 5. Utilizing current guidance documents, references, published evidence based an industry standard best practices to develop policies and procedures designed to prevent and control the transmission of communicable diseases, including, but not limited to those from the Centers for Disease control and Prevention & World Health Organization. ... 8. Reinforcing patient safety by upholding accreditation standards and federal state mandates related to the environment of care and infection prevention throughout the continuum." In addition, it states in part, "From a CMMC and system wide perspective, the Infection Prevention Committee or its appropriate members have		A0773				

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A0773	Continued from page 31 authority delegated from organizational leadership to institute infection prevention measures, studies, enforced policies, and act on a suspected or defined problem when indicated by findings or through surveillance mechanisms. ... The Quality, Value, & Community Health Committee (QVHC) retains ultimate authority and responsibility for the quality of patient care and performance of staff. Data and recommendations from the QVHC are elevated to the Board of Directors." Finally, in part it states, "The System Director of Infection Prevention: a. Provides strategic oversight and sets direction for the Infection Prevention and Control Program. ... c. Provides administrative oversight for the review of surveillance activities and development of action plans based on high-risk or trending observations in conjunction with key stakeholders." "FY2025 has identified following areas as high risk through the IP Risk Assessments", in part, "CMMC Perioperative Services Environmental Contamination/Compliance." The "CMH [Central Maine Healthcare] Infection Prevention and Control Plan FY2026", with a final approval date of 09/18/2025, states in part, "OBJECTIVES ... i. Reinforcing patient safety by upholding accreditation standards and federal state mandates related to the environment of care and infection prevention throughout the continuum." In addition, it states in part, "From a CMMC [Central Maine Medical Center] and system wide perspective, the Infection Prevention Committee or its appropriate members have authority delegated from organizational leadership to institute infection prevention measures, studies, enforced policies, and act on a suspected or defined problem when indicated by findings or through surveillance mechanisms. ... The Quality, Value, & Community Health Committee (QVHC) retains ultimate authority and responsibility for the quality of patient care and performance of staff. Data and recommendations from the QVHC are elevated to the Board of Directors." Finally, in part it states, "The System Director of Infection Prevention: i. Provides strategic oversight and sets direction for the Infection Prevention and			A0773			

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A0773	Continued from page 32 Control Program. ... iii. Provides administrative oversight for the review of surveillance activities and development of action plans based on high-risk or trending observations in conjunction with key stakeholders." "FY2026 has identified following areas as high risk through the IP Risk Assessments", in part, "CMMC Perioperative Services Environmental Contamination/Compliance." On 08/26/2026, the 2023, 2024, 2025 and 2026 Environment of Care Rounds related to the perioperative area was reviewed and indicated the following: On 04/24/2023, Infection Preventionist #1 documented, in part, the following: -Some of the air vents are not secured to the ceiling; -Rust was observed on several IV stands as well as rolling wheels on IV poles, equipment stand, an old X-ray holder; -In several ORs, there are new anesthesia chairs that are cloth covered; -In OR #3 there is tape on the arm rest of the operating room table; -There is dust on top of anesthesia machines; and -Floors in the hallway were dirty. On 08/09/2024, Infection Preventionist #2 documented, in part, the following: -Dust was found in multiple areas, on clinical shelving and equipment, on anesthesia cart filters, built up in the corners of the OR room floors, behind the autoclaves in sub sterile rooms, in plastic storage bins, on top of sterilizers and other tall equipment;			A0773			

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A0773	Continued from page 33 -Passthrough room to sub sterile #3 has holes on and in the cabinets; -Chairs need to be replaced in OR and anesthesia office; -Many pieces of equipment which contain rust - these need to be taken out of -Areas of floor require repair due to inability to clean properly, looks dirty -Many areas have penetration via peeling paint, holes, broken molding; -All OR rooms have cabinet doors that are rusting on the bottom and need to be cleaned and painted; -OR #3 and the decontamination room outside OR #3 have cabinets that need door handles repaired; -There are multiple areas throughout the department that need paint and repair to the walls; -OR #3 base edge along the floor needs repair all the way around the room; and -Hallways throughout the department need to be painted. There are scuffs, dents on about every wall and some damage to some of the plastic on the walls in the hallways as well. On 11/11/2025, the System Director of Infection Prevention documented, in part, the following: -Flooring with cracks, holes on clean side- stepping on one area in front of the autoclaves actually made dust rise from the open hole. The same was seen with the decontamination area except water seeped through the cracks when pressure was placed on the floor. Floor under the washers on both sides showed evidence of leaking. This entire area needs patching and replacing so it can be adequately			A0773			

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A0773	Continued from page 34 cleaned and not serve as a source of contamination; -Rust on racks and casters of carts cannot be cleaned; and -Mats in decontamination area old, worn and cracking. On 03/10/2026, Infection Preventionist #3 documented in part the following: -Multiple wall dings and penetrations throughout the perioperative unit ... Facilities has been notified; -There is an exposed rusty pipe extending from the wall in the clean equipment area: -The corner wall in bay 3 has plaster knocked off; -Holes, chips and nicks on walls throughout the area; -Extensive repairs needed for walls; -OR #9 and #10 have multiple holes in walls; -The wall laminate in the hall is separating; -The floor [cove base] in OR #3 is peeling up and exposing underlay; -Sub sterile has dirty ceiling vent and open drain in floor; -Sub sterile has laminate under the sink that is partially missing, there are holes in the walls, and a dirty vent; -Sub sterile has open floor drain, open wall, and an open pipe;	A0773					

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A0773	Continued from page 35 -Dust and dirt are still a major issue; -Multiple floors appear unclean. Some floors look clean in areas that are easy to access but have accumulated dust and grime in corners and under equipment. Floor corners need manual cleaning; the mops don't appear to reach the 90-degree corners, and the buildup of dirt is now black and very noticeable; -There is also visible dust in clean areas and on clean equipment; -Multiple clean supply storage bins are dusty in OR #9, the cardiac perfusion rack bins in the hallway between OR #9 and #10 are very dusty; -Inside the perfusion cart drawers in OR #9 is very dirty; -The bottom shelf of most of the supply racks need dusting; -Several areas and pieces of equipment had tape or tape residue. Since items cannot be appropriately cleaned with tape, they must be removed. Some of these areas are: OR #9 has tape/velcro on the anesthesia cart and monitor; -Tape residue on the top side of the lights in OR #7; and -Clean supply room wall has taped paper and tape residue. On 05/05/2026, the Director of Facilities Operations documented, in part, the following from the SPD: -The flooring that was replaced has started to come up, causing a trip hazard. Tape has been placed over it, but tape is not allowed within SPD for infection control reasons; -Some dust on solid shelving and plastic bins. Recommend moving to wire storage bins where			A0773			

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A0773	Continued from page 36 possible, and assigning someone to dust shelving and storage bins weekly; -Some rust on wheel casings; -There was a large amount of blue lint found around the door gaskets and floors of washers; -Floors throughout the department need intensive cleaning, especially around thresholds; and -The floor cove base has pulled away from the wall in the soiled side by the pass-through window. On 06/02/2026, the Infection Prevention Committee Meeting Minutes stated, in part, [System Director of Infection Prevention]: An [Outside Accrediting Agency] had findings that included, material that can no longer be cleaned ... workgroup to address glucometer cleaning, instruments without tape, etching or corrosion and expired supplies in OR airway carts ... Recommend an emergency stash of thermometers, maintained calibrated and/or withing expirations dates OR additional temperature/humidity "guns" similar to facilities' equipment, in a easily accessible area if tracking temperature and humidity is necessary due to HVAC issues ... Concern for numerous pieces of equipment and environmental material that are present in our departments which can no longer be cleaned due to tears, holes, rust, etc. This is an IP issue that was recommended to be presented to PE for standard discussion and moving toward removal and replacement. ..." On 08/25/2026 at 12:30 PM, an interview was conducted with the System Director of Infection Prevention. He/She stated in part, the following: The SPD is an area of concern. I am aware of the brownish staining on the instruments and the conditions of the unit itself. We have documented the issues with the flooring, walls and the tiles on the ceiling [in the perioperative area]. The perioperative area, including SPD, has been an area of concern for years; I have been aware of issues since about 2024. On 08/26/2026 at 2:43 PM, a virtual interview was conducted with the President and Chief Medical		A0773				

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A0773	Continued from page 37 Officer [of a healthcare company], and Governing Body Chairman. He/She stated in part, the following, "I sit as the Chair of the Board for CMMC. Regarding concerns in the perioperative and sterile processing department of this magnitude, I learned about it during this survey. It came to my knowledge last week." Based on observations and interviews, the hospital failed to ensure collected lab specimens were stored in a manner that would prevent contamination of surfaces and the potential spread of infection for one (1) out of one (1) Obstetrics and Gynecology practice observed (Central Maine Obstetrics-Gynecology located at 12 High St. Suite 301 Lewiston, ME). Findings: Central Maine Medical Center's policy titled, "Bloodborne Pathogens Exposure Control Program", last approved 08/24/2024 states in part, "... Biohazard labels are used to identify biohazardous materials such as biomedical waste, blood, specimens, and OPIM [other potentially infectious materials]" On 08/20/2026 at 12:32 PM, during observations of the Central Maine Obstetrics-Gynecology clinic, the survey team observed a a swab specimen in a clear tube with a red top. The survey team observed the tip of the swab was saturated with a tan substance. The swab was observed to be labelled with a patient's name (Patient #21) and was sitting directly on the counter. The swab was not in a biohazard bag. The Vice President of Practice Operations was present during the observation, and he/she confirmed that the swab should not be stored directly on the counter. On 08/21/2026 at 9:11 AM, Medical Assistant ("MA") #1 was interviewed. He/She stated swabs with red tops are used for group B streptococcus (an infectious bacteria) testing at 36 weeks of pregnancy. MA #1 stated these swabs are vaginal-rectal swabs, and they could also be used for yeast swabs which would be a vaginal swab. MA #1 stated the process after the specimens are collected is the specimen is labeled, bagged, and sent to the lab. MA #1 stated the specimens are bagged in a biohazard bag after labelling. MA #1	A0773			

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A0773	Continued from page 38 stated the specimens need to be put in a bag because if they aren't put in a bag the specimen could transfer bacteria or infections. On 08/21/2026 at 9:23 AM, MA #2 was interviewed. He/She stated swabs with the red tops are for group B streptococcus testing and yeast cultures which require the patient's vagina and anus be swabbed. MA #2 stated the patients do the swab themselves usually, then write their name and date of birth on the tube and place it in a metal door in the bathroom. MA #2 indicated staff should take the specimen out of the metal door, place it in a biohazard bag, then send the specimen to the lab. MA #2 was asked why the specimens are placed in a biohazard bag, and he/she stated, "I haven't been told the reason it has to go in the bag." MA #2 was asked if it might be an infection risk and stated, "I would think so... ." On 08/21/2026 at 9:34 AM, MA #3 was interviewed. He/She stated the red top swabs are for group B streptococcus and stated they are vaginal and rectal swabs that patients can either do themselves or providers will. MA #3 stated they let patients know to insert both swabs into the vaginal canal, then both tips into the rectum. MA #3 stated patients will then write their name and date of birth on the tube and stick it in a box, and the medical assistant will label it. MA #3 stated the tube will be put in a biohazard bag either right away or the swab will be put in an area where a patient is not privileged to see. When asked if the specimens need to go in a biohazard bag, MA #3 stated it "Depends on if you have time to bag it." MA #3 indicated there was no risk of an un-bagged specimen spreading contamination because the specimen was, "In a tube."		A0773				
A1081	STANDARD TAG FOR OUTPATIENT SERVICES CFR(s): 482.54 Standard-level Tag for §482.54 Condition of Participation: Outpatient Services If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.		A1081				

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A1081	Continued from page 39 This STANDARD is NOT MET as evidenced by: Based on document reviews and interviews, the hospital failed to provide documented evidence that patient rights information was offered to nine (9) of ten (10) patients seen at the Family Practice/Internal Medicine outpatient practice (Patients #12 - #20). Findings: Prime Healthcare's "Patient Access Registration & Admission Forms", last revised on 04/2025, states in part, "Every patient seeking care, treatment, or services at Prime facilities will be registered or admitted into the computer system, generating a visit/encounter number to create a patient record. Upon completing each registration or admission, all necessary forms will be produced, including informational and educational documents. Additionally, certain documents will require a review of their contents with the patient or their designee, followed by obtaining signatures." "Patient Rights Acknowledgement - This form acknowledges the receipt of Patient Rights and Responsibilities, along with educational and informational materials." "Additionally, in accordance with the standards of The Joint Commission and the "Patient Self-Determination Act (PSDA)" effective December 1, 1991, the form also asks whether the patient has an Advance Healthcare Directive in place. If the patient does not have one. If the patient does not have a written Advance Directive or did not provide us with a copy, and they wish to define their healthcare wishes for this visit/admission, they should inform their nurse or physician. Their wishes can then be recorded in the medical record, or we can provide the patient with a standard document to complete. If someone other than the patient is signing this form, the relationship of the individual signing must be specified. The Admitting or Registration Representative must then sign on the "witness" line and provide the date and time where indicated." The "Bylaws of the Medical Staff of Central Maine Medical Center", last approved by the Governing Body on 03/10/2026, states in part, "General Responsibilities. All members of the Medical Staff with Admitting Privileges shall participate in			A1081			

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A1081	Continued from page 40 providing coverage for patients who are without an available local Physician and who present to the Hospital needing services. This coverage obligation includes both inpatient hospital care and outpatient follow-up care of acute illness and/or injuries ..." On 08/25/2026 from 10:00 AM to 12:00 PM, ten (10) medical records were reviewed with the Practice Manager for Family Practice and Internal Medicine. The following was identified: On 07/07/2026, Patient #14 had an outpatient visit and there was no documented evidence of being provided with information on patient rights. On 07/29/2026, Patient #15 had an outpatient visit and there was no documented evidence of being provided with information on patient rights. On 07/30/2026, Patient #16 had an outpatient visit and there was no documented evidence of being provided with information on patient rights. On 08/21/2026, Patient #12, #13, #17 - #20 had an outpatient visit and there was no documented evidence of being provided with information on patient rights. During an interview on 08/26/2026 at 8:51 AM, with the Regional Performance Improvement Director, they confirmed that the Patient's Rights information was missed by the patient service representatives in the practice. Based on document reviews, and interviews Central Maine Obstetrics-Gynecology ("OB/Gyn"), an outpatient department of the hospital, failed to communicate waitlist expectations and processes to front office staff. This failure has led to front office staff including Medical Assistants and Patient Service Representatives turning pregnant and OB/Gyn patients away for the outpatient OB/Gyn practice located at 12 High St. Suite 301 Lewiston, ME. Findings: The "Bylaws of the Medical Staff of Central Maine Medical Center", last approved by the Governing Body on 03/10/2026, states in part, "General			A1081			

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A1081	Continued from page 41 Responsibilities. All members of the Medical Staff with Admitting Privileges shall participate in providing coverage for patients who are without an available local Physician and who present to the Hospital needing services. This coverage obligation includes both inpatient hospital care and outpatient follow-up care of acute illness and/or injuries ..." On 07/01/2026, an email was sent staff of the OB/Gyn Practice that they would be implementing the following changes on that day, per Physician #1 and Physician #2: [The practice] will no longer schedule the following: - Acute vaginitis/UTIs [urinary tract infections] (unless pregnant) - No new HRT [hormone replacement therapy] - No Annuals - No fertility - No new referrals - No contraception visits - No options consults (planned parenthood or family planning) - No two (2) week post-partum visits No NEW GYN pts from now until Sept 1st [2026] Unless: - Post Menopausal bleeding - Abnormal Pap smears - Pelvic Mass All ER [Emergency Room] follow up, and referrals need to be reviewed by triage and then [Physician #1 and Physician #2] if needed before scheduling Pregnant Patients: - No NOBs [("New Obstetric" - a newly pregnant patient that needs a first visit)] NOBs unless their due date is February [2027] or after. When scheduling NOBs. Each Midwife will have 4 NOBs a week and Each Doc will have 2. Once those numbers have been met, we will stop accepting pregnant [patients] for that month. On 08/21/2026 at 8:51 AM, Patient Service Representative ("PSR") #1 was interviewed and when asked if they were taking new patients, PSR #1 stated that they are not taking any new annual patients for Gynecological services. He/She stated that some providers have left the practice, so he/she was told to give patients the option of other places to receive OB/GYN services because they are not taking any patients who would be delivering before March of 2027. PSR #1 indicated that their understanding was sometimes the clinic says, "No,"		A1081				

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A1081	Continued from page 42 to some patients, but sometimes they accept certain patients. PSR #1 stated, "It's frustrating for me. I turn away the first [patient because] they say no, but, the second [patient], they will say yes." PSR #1 stated patients can't get through on the phone because, "We are very short staffed." PSR #1 stated the clinic has a lot of walk-in patients because patients can't get through on the phone, and he/she stated phone call volumes, "Have gone down really low, I think people are just giving up." PSR #1 stated people are walking in saying they need prescriptions or help but couldn't get through on the phone. On 08/21/2026 at 9:11 AM, PSR #2 was interviewed and when asked if they were taking new patients, PSR #2 stated, as far as he/she knew they were not accepting any new women who are pregnant until February [2027] or after. On 08/21/2026 at 9:23 AM, Medical Assistant ("MA") #2 was interviewed and when asked if they were taking new patients, MA #2 stated, it is limited to new pregnant women to see if it fits in the schedule. MA #2 stated the practice was limiting the number of OB/Gyn patients due to not having enough providers. MA #2 stated the staff were being told different reasons for this every week, and he/she indicated that which patients they are accepting or not accepting has been changing. MA #2 stated patients who need birth control, annual exams, or options talks are being placed on a waitlist unless a nurse practitioner has time to see them, otherwise they turn the patients away. MA #2 stated they [the clinic staff] have tried calling the office phones from their cell phones and he/she stated it didn't work. MA #2 stated they have a lot of people that walk in because they can't get in touch with the office over the phone. On 08/21/2026 at 9:38 AM, MA #3 was interviewed and when asked if they were taking new patients, MA #3 stated that they have had conflicting answers [by practice leadership] and that there is no standardized protocol for which patients are to be accepted or when to see patients. MA #3 stated patients were, "Falling through the cracks every single day." MA #3 stated they have, "100% had to turn patients away." MA #3 stated each midwife, and doctor has so many patients they can see each month, and the providers are consistently overbooked. MA #3 stated it makes, "All of us feel how dangerous the care has become." MA #3 stated the phone lines are a concern for refills and there is			A1081			

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A1081	Continued from page 43 no medication refill option on the phone system. During an interview on 08/25/2026 at 2:08 PM with the Pediatric Hospitalist and Chief of OB/Gyn and Pediatrics, he/she stated he/she went to the OB/Gyn office on 08/24/2026 and met with staff to touch base. He/she stated he/she pulled together everyone in the office for a meeting and stated the concern from the staff was, "We should be taking all patients ... we should not be limiting patients." The Pediatric Hospitalist and Chief of OB/Gyn and Pediatrics stated there was a waitlist in place, and he/she stated some of the PSRs didn't realize that. The Pediatric Hospitalist and Chief of OB/Gyn and Pediatrics stated, "OB patients can't wait."		A1081				