STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary's D'Youville Pavilion	102 Campus Ave Lewiston, ME 04240

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of the facility's incident report, record reviews, interviews, and internal investigation, the facility failed to ensure staff spoke to residents in a dignified manner for 2 of 3 residents reviewed for abuse (R1, R2).Findings: On 9/24/25, the facility reported an incident to the Division of Licensing and Certification, which stated on 9/10/25, staff observed CNA1 (Certified Nursing Assistant) shout at R1 and stated Keep your damn hands to yourself, if you hit me, (I) am hitting you back. Later during the shift, the staff reported CNA1 was heard yelling in R2's room. When the staff entered, CNA1 was observed stating to the resident Why don't you just die already. The staff reported having observed CNA1 yell at residents who are wandering during the night to go back to bed, go to your f***ing room, I am sick and tired of you all. Staff stated no attempt was made to determine if residents needed assistance. Due to R1 and R2's level of cognitive impairment, neither demonstrated an awareness of the incidents. A review of R1's clinical record revealed diagnoses including Alzheimer's Dementia, Anxiety disorder, Restlessness, Agitation and Wandering. A review of the Minimum Data Set (MDS) 3.0 Quarterly Assessment, dated 6/29/25, Section C - Cognitive Patterns, indicated R1 had severe cognitive impairment. R1 required substantial/maximum to dependent assistance on staff for activities of daily living. R1 resident on the facility's secure dementia unit. R1's care plan identified the potential for physical aggression. Interventions included anticipate needs: food, thirst, toileting, comfort (pain); Keep a calm voice, adjust approach if R1 is becoming increasingly agitated. Keep enough distance to not allow R1 to grab, punch, or corner you. You may need to seek another staff for redirection. A review of R2's clinical record revealed diagnoses including Alzheimer's Disease, Dementia with Behavioral Disorder, Bipolar Disorder, Anxiety Disorder, and Insomnia. A review of the Minimum Data Set (MDS) 3.0 Significant Change Assessment, dated 7/17/25, Section C - Cognitive Patterns, indicated R2 had severe cognitive impairment. R2 was totally dependent on staff for assistance with all activities of daily living. R2 resident on the facility's secure dementia unit. R2's care plan identified the potential for physical aggression. Interventions included anticipate needs: food, thirst, toileting, comfort (pain); provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, encourage seeking out of staff member when agitated, engage calmly in conversation. On 9/25/25 at 12:45, in an interview with a surveyor, the unit manager stated CNA1 had been previously coached for unprofessional conduct, including reports of using profanity and an abrasive tone with others. The unit manager stated CNA1 had been receptive to the feedback and coaching. No reports of verbal or physical abuse had been received. A review of the facility's internal investigation noted that the incidents previously occurred on 9/10/25. The correct date of the incidents was 9/12/25. Upon learning of the incidents, the facility immediately suspended CNA1 pending the outcome of the investigation. Providers and family members were notified of the incidents. Multiple staff were interviewed. The facility's investigation identified a pattern that CNA1's behavior seems that he/she gets frustrated with certain residents and yells at them, instead of seeking to understand what the residents need.As a result of the facility's investigation the following corrective actions were taken:Incident reported to the appropriate State AgenciesEducation on resident rights, abuse, neglect, (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and reporting requirements for staff was initiated to be conducted on 9/26 and 9/29the CNA was terminated from the facility