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	04/15/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, review of the facility internal investigation, interviews, and video surveillance, the facility failed to notify the State agency of a resident's elopement within 24 hours of the incident; and failed to provide the State agency with a 5 day follow up report for 1 of 1 investigated incident of neglect. (#1) Finding: The Department of Licensing and Certification [State Agency] received an anonymous complaint which stated R1 was found outside on the ground in wet/snowy conditions in the early morning hours of March 21, 2026. A review of a Late Entry note for March 21, 2026, stated R1 had went out of [his/her] room into the stairwell . [he/she] was observed by staff and brought back to [his/her] room, and states that R1 continued to be restless. A review of a Fall/Details note stated on March 21, 2026, R1 was in bed at 5:00 a.m., and at 5:30 a.m. R1 was noted to not be in [his/her] room, at 5:40 a.m., R1 was found outside lying on the grass. A review of facility records included nursing documentation, video surveillance, written staff statements and interviews confirmed that on March 21st, 2026, R#1 exited the unit through an exit door and was later found outdoors on facility grounds. Documentation and staff interviews confirmed the facility was aware of the incident at the time it occurred. A review of the facility's investigation revealed a Sentinel Event Root Cause Analysis (SERCA) which states R1 was found outside in the patio space at 5:38 a.m. wearing a flannel shirt and jeans.the SERCA identified contributing factor and root causes as, staff did not re-evaluate resident when [his/her] behaviors change, Roam alert not implemented by nurse on duty with first wandering incident and stated that the facility .did not have an elopement policy in place at the time. On April 8th, 2026, at 1:52 p.m., during an interview, the Administrator and Director of Nursing (DON) confirmed the incident was not reported to the State Agency because the resident was found on facility property and the facility did not consider the event an elopement. The DON stated the incident was initially treated as a fall. The DON further stated the facility did not have a formal elopement policy or procedure at the time. (See F-689 for details)

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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(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	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** Based on record review, review of the facility internal investigation, interviews, and video surveillance, the facility failed to ensure a resident was free from an avoidable accident and environmental hazards. Specifically, Resident #1 [R1] exited their assigned unit onto an exterior courtyard/patio area without staff knowledge. The resident remained outdoors, inadequately dressed for the weather, for approximately 30 minutes before being discovered face down on the snow-covered ground. This failure created an immediate jeopardy situation.Findings: The Department of Licensing and Certification [State Agency] received an anonymous complaint which stated R1 was found outside on the ground in wet/snowy conditions in the early morning hours of March 21, 2026. A review of R1's clinical records stated R1 was admitted in March 2026 following an evaluation in the emergency department after a fall at home resulting in fractured ribs. Diagnoses included Alzheimer's disease and dementia complicated by psychosis. During the emergency department evaluation, the resident's family expressed concerns regarding increased confusion, sundowning behaviors, agitation, hallucinations, delusional thoughts, memory thoughts, mobility limitations, and falls. A review of a Late Entry note for March 21, 2026, stated R1 had went out of [his/her] room into the stairwell . [he/she] was observed by staff and brought back to [his/her] room, and states that R1 continued to be restless. A review of a Fall/Details note stated on March 21, 2026, R1 was in bed at 5:00 a.m., and at 5:30 a.m. R1 was noted to not be in [his/her] room, at 5:40 a.m., R1 was found outside lying on the grass. A review of the nursing admission assessment identified a Brief Interview for Mental Status (BIMS) score of 8 out of 15 indicating severe cognitive impairment. The assessment identified chronic confusion, short term memory loss, and need for cues. Additional findings included history of falls, mobility limitations, need for assistance with personal care, and dementia with psychotic disturbance. An elopement risk assessment was conducted upon admission, which indicated R1 had a score of zero, identifying the resident as not at risk for elopement despite a history of Alzheimer's disease and dementia. A review of the facility's investigation revealed a Sentinel Event Root Cause Analysis (SERCA) which states R1 was found outside in the patio space at 5:38 a.m. wearing a flannel shirt and jeans.the SERCA states contributing factor and root causes as, staff did not re-evaluate resident when [his/her] behaviors change, Roam alert not implemented by nurse on duty with first wandering incident and stated that the facility .did not have an elopement policy in place at the time. A review of written statements from staff obtained was completed, revealing the following: -The Unit secretary stated concerns with placing R1 in room [ROOM NUMBER] because there is no lock on the door (referring to the exit door across the hallway from room [ROOM NUMBER]). -The CNA on duty at the time of admission stated that she expressed concerns to the unit secretary placing R1 in room [ROOM NUMBER] the door across from patients did not lock. and stated that R1s [family member] reported R1 might try to get up.and [he/she] might forget where [he/she] is going and stated I assured [family member] that I would pass along to the night CNA and states that she did pass along this information. -The Clincal Resource Nurse (CRN) stated that the unit secretary did contact them reporting concerns with R1 being placed in room [ROOM NUMBER] at the end of the hall because of R1s diagnoses. The CRN states that they came down to the unit and found R1 to be lying in bed and answering questions appropriately with bouts of confusion and there were no signs of R1 wanting to leave the unit. -The Registered Nurse (RN) stated she admitted R1 to the facility and to the unit, she states assessments were completed including an elopement assessment. This resident did not trigger as an elopement risk -The Licensed Practical Nurse (LPN) on duty the night/early morning of the incident stated R1 sat with nursing staff most of the night., and for most of the night R1 was very insistent on going to move [his/her] truck off the street she describes R1 as hallucinating throughout the shift, taking to people who were not there. At 5:30 a.m. staff begin looking for R1 and at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	approximately 0540 [5:40 a.m.] the resident was observed out in the courtyard. she describes that R1 was face down on the ground. -The CNA on duty the night/early morning of the incident stated that R1 kept getting out of bed, so confused, and that she went to check on him at about 0535 (5:35 a.m.) and [he/she] was not in [his/her] room or bathroom Surveyor reviewed the unit video surveillance dated 3/20/26 at approximately 8:00 p.m. to 3/21/26 at approximately 5:56 a.m., with the Administrator and Director of Nursing (DON). The following was observed:-On 3/20/26 at approximately 11:02 p.m. through 3:32 a.m. on 3/21/26, R1 can be seen several times wandering in the hallway. -At approximately 5:02 a.m., R1 is observed opening the exit door across from his/her room and exiting through the door. R1 was not seen for several minutes but does return and goes back into his/her room. Staff were not observed to be in the area or having knowledge that R1 had exited through the door. -At approximately 5:08 a.m., R1 is observed opening the exit door across from his/her room, opening the door and exiting the unit. He/She does not return. Staff were not observed to be in the area or having knowledge that R1 had again exited through the door.-At approximately 5:34 a.m., staff identify that R1 is not in his/her room and can be seen looking for him/her.-At approximately 5:38 a.m., video of the courtyard/patio area, staff can be seen outside, and R1 is observed to be lying on the snow-covered ground.-At approximately 5:56 a.m. R1 is seen being transported back into the facility by staff-he/she is noted to be wearing a long sleeve shirt, pants, and socks. Staff do cover the resident with a blanket.Further review of the video surveillance shows that staff placed a rolling linen cart in front of the exit door to prevent R1 from further exiting through the door.A review of archived records from Accu Weather states on March 20, 2026, the overnight temperature was recorded as 20 degrees Fahrenheit.During an interview and environmental tour with the Administrator and Director of Nursing, (DON) surveyor observed room [ROOM NUMBER] located directly across from the exit door. The Administrator stated that a resident wearing a wander guard would not be able to exit through the first door. R1 had not been identified as an elopement risk and was not wearing a wander guard. R1 was able to open the first exit door and proceed through the second exit door into an enclosed outdoor courtyard/patio which locked after exit and prevented reentry. After the incident both the first and second exit doors had been configured to alarm when opened. During an interview with the DON on 4/8/26 at 1:52 p.m., she stated the incident was not reported to the State Agency because the resident was found on facility property and the facility did not consider the event and elopement. During a later interview the DON stated the incident was initially treated as a fall. The DON stated that the resident received an immediate assessment, vital signs were obtained, telehealth was contacted, and the resident was not sent to the emergency department due to no apparent injuries at that time. The DON further stated the facility did not have a formal elopement policy or procedure at the time. Based on the above information, Immediate Jeopardy (IJ) was called on 4/9/26 for the facility's failure to ensure a resident who was known to be wandering and had exited through an unsecure door was monitored and supervised. 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.