| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205126 | A. Building<br>B. Wing | 10/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Maine Veterans Home - Augusta | 35 Heroes Way<br>Augusta, ME 04330 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531<br><br>Based on facility policy review, record reviews, and interviews, the facility failed to ensure that the resident and/or resident representative was provided with written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, or appoint a surrogate, was completed for 9 of 13 residents reviewed for advanced directives. (Resident [R] , R70, R78, , R12, R5, R42, R101, R61, R80 and R94).<br><br>Findings:<br><br>Review of facility policy Advanced Directives, DNR (Do Not Resusitate) Orders and Health Care Decision Making undated states Provide to all residents at the time of their admission, and subsequently upon request, written information concerning their rights under Maine Law to make decisions concerning their health care, including the right to accept or refuse medical treatment, .the right to execute advance directives concerning their health care decisions, and the right to designate a representative to exercise the rights of the resident .MVH (Maine Veterans Home) staff shall, at the time of residents admission: Document whether or not the resident has executed an advance directive; document the type of advance directive the resident has .Request a copy of the advance directive for inclusion in the resident' medical record; Document the name, address, telephone number and legal status of any person designated by the resident as the resident's authorized decision maker, such as a healthcare power of attorney agent, agent under the mental health treatment declaration, guardian, or healthcare surrogate; In the event that the resident is incapacitated at the time of admission or at the start of care and is unable to receive information or articulate whether he or she was executed an advance directive, MVH staff shall give the advance directive information required under this Policy to the residents authorized representative or a family member .MVH staff shall ensure that the above information is documented on the Advance Directive Documentation Form and placed in a prominent part of the resident's current medical record .<br><br>1. R70 was admitted to the facility on [DATE]. A review of Resident #70's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical/ surgical treatment and/or formulate an advance directive or appoint a surrogate.<br><br>(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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. R78 was admitted to the facility on [DATE]. A review of Resident #78's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical/ surgical treatment and/or formulate an advance directive or appoint a surrogate.<br><br>During an interview on 10/22/24 at 11:12 a.m., Social Worker (SW) indicated that residents/representatives should be asked for Advanced Directives (AD) upon admission, and if they have one its scanned into the electronic medical record (EMR). If a resident doesn't have one, they are offered the information/help to fill one out, if they refuse or are offered, it is all supposed to be documented in the EMR. During a follow up interview on 10/22/24 at 1:28 p.m., SW confirmed he reviewed residents clinical records, did not show evidence they were asked or offered opportunity to fill out an advanced directive.<br><br>During an interview on 10/23/24 at 1:56 p.m., a surveyor and Clinical director and DON (Director of Nursing) confirmed not all residents/representatives were asked/offered opportunity to fill out an advanced directives upon admission<br><br>17282<br><br>3. R12 was admitted to the facility on [DATE]. Review of R12's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.<br><br>During an interview with a surveyor on 10/23/24 at 2:00 p.m., the Licensed Social Worker confirmed he reviewed R12's clinical record did not show evidence they were asked or offered an Advanced Directive.<br><br>32540<br><br>4. R5 was admitted to the facility on [DATE]. A review of R5's clinical record lacked evidence that the facility provided resident and/or resident's representative with written information concerning the right to accept or refuse medical/ surgical treatment and/or formulate an advance directive or appoint a surrogate.<br><br>5. R42 was admitted to the facility on [DATE]. A review of R42's clinical record lacked evidence that the facility provided resident and/or resident's representative with written information concerning the right to accept or refuse medical/ surgical treatment and/or formulate an advance directive or appoint a surrogate.<br><br>6. R101 was admitted to the facility on [DATE]. A review of R101's clinical record lacked evidence that the facility provided resident and/or resident's representative with written information concerning the right to accept or refuse medical/ surgical treatment and/or formulate an advance directive or appoint a surrogate.<br><br>On 10/23/24 at 1:56 p.m. during an interview, the Clinical Director and DON confirmed that not all residents/representatives were asked/offered opportunity to fill out an advanced directives upon admission<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 37440<br><br>7. R61 was admitted to the facility on [DATE]. Review of R61's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.<br><br>8. R80 was admitted to the facility on [DATE]. Review of R80's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.<br><br>9. R94 was admitted to the facility on [DATE]. Review of R94's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.<br><br>On 10/23/24 at 1:56 p.m. during an interview, the Clinical Director and DON confirmed not all residents/representatives were asked/offered opportunity to fill out an advanced directives upon admission. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>42531<br><br>Based on record review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notices (SNFABN) Form 10055, which included appeal rights and liability of payment, were provided at least 2 days prior to the resident's last covered day, for 1 of 3 residents whose Medicare Part A services were discontinued, and remained in the facility (Resident [R]56).<br><br>Findings:<br><br>R56, who remained in the facility, had a SNFABN which indicated his/her last day of Skilled services was on 7/16/24. R56 was not provided the SNFABN until 7/16/25, the day the services ended.<br><br>During an interview on 10/22/24 at 11:11 a.m., Social Worker confirmed R56 was not provided a SNFABN notice at least 2 days prior to last covered day. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531<br><br>Based on record review, interviews, and facility policy, the facility failed to update goals and interventions on the resident's current comprehensive care plan for the areas of mood/behavior for 1 of 1 residents reviewed for behaviors (Resident #9[R9]).<br><br>Findings:<br><br>Review of facility policy Care Area Assessments and Plan of Care dated 5/24/24 states .residents will have and individualized interdisciplinary Plan of Care that identifies the care and services necessary to maintain the highest practicable physical, mental and psychosocial well-being ensuring resident wishes for treatment and care are well defined and honored.<br><br>1. R9 was admitted on [DATE] and has diagnoses to include senile dementia, epilepsy with behaviors, delusional disorder, adjustment disorder, and depression.<br><br>Review of R9's care plan updated 7/14/24 states Behavior: Potential for disruptive behavior identified wanderer. Related to dementia schizoaffective disorder with highs and lows of behaviors and paranoia manifested by hitting, pushing, punching staff, pacing exit seeking. wandering. agitation, refusing care, pushing over furniture, physically threatening others, paranoia, less trusting of some staff. APPROACH: perform behavioral check sheet assessment every hour, check sheet is located in residents room follow medication combination orders listed on sheet .<br><br>Observations of R9's room on 10/21/24 at 2:14 p.m., and 10/23/24 at 8:10 a.m., No behavior monitoring sheets were observed in room.<br><br>During an interview on 10/23/24 at 12:30 p.m., Unit Manager Freedom Bay (UM1) confirmed R9 had not been receiving hourly behavioral checks and were changed to every shift in September, and his/her care plan had not been updated to reflect their current behavior monitoring.<br><br>37440 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531<br><br>Based on observations, interviews, and facility policy, the facility failed to follow professional standards of practice with usage of Personal Protective Equipment (PPE) and to provide a sanitary environment to help prevent the development and transmission of disease and infection related to hand hygiene during a medication pass on 1 of 3 days of survey. In addition, the facility failed to post enhanced barrier precautions (EBP's) pertaining to Resident's with urinary Foley catheters, and multi drug resistant organisms [MDRO] for 3 of 3 days of survey (10/21/24, 10/22/24 and 10/23/24) (Resident #34 [R34]).<br><br>Findings:<br><br>1.Review of facility policy Medication Administration-General Guidelines dated 10/17 states Handwashing and Hand Sanitization: the person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: before beginning a medication pass, prior to handling medication, after coming into direct contact with a resident, .Hand sanitization is done with an approved hand sanitizer.; between hand washings, when returning to the medication care or preparation area . If breaking tablets is ultimately necessary to administer the proper dose, hands are washed with soap and water or alcohol gel [and examination gloves work] prior to handling tablets .<br><br>During an observation of medication pass on Freedom Bay unit on 10/22/24 between 7:49 a.m., and 8:23 a. m., the following was observed:<br><br>At 7:49 a.m., Certified Nursing Assistant Medication Technician (CNA-M) was observed in room [ROOM NUMBER] administering a medication underneath the tongue of a resident with an oral syringe with an ungloved right hand. A laptop was observed on the counter. CNA-M was then observed leaving room [ROOM NUMBER], with the empty syringe walking by hand sanitizer located on the wall next to exit door, left the room and proceeded to walk to the end of the hall and into the medication room where another hand sanitizer was located on top of the shelf by the door. CNA-M then picked up a clear plastic cup with her left hand, and while still holding empty syringe in her right hand walked back down the hall and around the corner to the kitchenette. CNA-M then placed the plastic cup on the counter with her left hand, opened the refrigerator door with her right hand containing the empty syringe and removed a bottle of cranberry juice with her left hand. She then moved the empty syringe from her right hand to her left hand and used her right hand to pick up the juice and poured it into the plastic cup and put the juice back in the refrigerator. CNA-M then picked up the plastic cup with her right hand, empty syringe in her left and proceeded to walk back into room [ROOM NUMBER] and assisted resident to drink the juice. CNA-M then took the empty plastic cup in her right hand and the empty syringe in her left hand and again walked past the hand sanitizer on the wall by the exit door and proceeded to walk to the end of the hall and back to the medication room, where she disposed of the syringe, threw the plastic cup in the trash and began to wash her hands. CNM-M then returned to room [ROOM NUMBER] and retrieved her laptop from the counter by the door.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At 8:03 a.m., 2 surveyors observed CNA-M in common area where Resident #41, (who resided in room [ROOM NUMBER]) was sitting and asked him/her if he/she was ready for morning medications. CNA-M was then observed placing the lap top she just obtained from room [ROOM NUMBER] and placed it on the counter in room [ROOM NUMBER]. At this time, a surveyor attempted to obtain hand sanitizer from the dispenser located on the wall by the door entrance, but it was empty. A surveyor then said out loud that the sanitizer was empty. CNA-M began to open the medication cupboard and started removing pills from prepared pill packs and placed them in a medicine cup without using hand hygiene prior. CNA-M then dropped a pill on the counter, reached over and removed a glove from a glove box located on the counter, donned (put on), picked up the pill and placed it in the medication cup. She then doffed (removed) the glove and threw it in the trash can located next to the counter, then reached over to the hand sanitizer located on the wall next to the door and rubbed her hands together. The surveyor again indicated the hand sanitizer was empty. CNA-M said That's ok. At this time CNA-M's phone rang, she put her right hand in her pocket and retrieved the phone answered it and returned it to her pocket. She then picked up the medication cup with her right hand, and the laptop with her left and left the room, walked up the hall to the medication room and retrieved a plastic cup, tucked the laptop under her left arm and came back down the hall to the kitchenette and placed the laptop and medication cup on the counter next to the refrigerator. CNA-M then opened the refrigerator with her right hand, removed cranberry juice, and poured it in the plastic cup. She then replaced the juice in refrigerator, picked up the juice in her left hand covering the top lip of the cup, picked up the cup of juice with her right and walked around the corner toward Resident #41. At this time a surveyor asked what her intent was at this point, CNA-M indicated she was going to give resident his/her medications. A surveyor expressed their concerns regarding hand hygiene, as she did not use hand hygiene prior to preparing medication, did not practice hand hygiene prior to doffing gloves, and pretended to use hand sanitizer after doffing gloves, answered the phone, and her hands were touching the lip of the medication cup. CNA-M stated, You're absolutely right She then walked around the corner, down the hall and to the medication area, put the pills and cup of juice on the counter, washed her hands, picked up the pills and juice back up and returned to give the resident his/her medications. She then picked up the laptop, walked out of room and went directly into room [ROOM NUMBER].<br><br>At 8:23 a.m., CNA-M was observed entering room [ROOM NUMBER] and placed the laptop on the counter just inside the door. CNA-M opened medication cabinet and began to remove medications from bottles and pill packets. CNA-M then removed 2 gloves from the box on the counter and donned them without using hand sanitizer and started to pull apart capsules to remove the medications and pored them inside a medication cup. At this time a surveyor asked what the policy was for doffing and donning gloves. CNA-M stated she was not sure and would have to ask her supervisor and continued to pull apart the remaining capsules. She then doffed the gloves and used hand sanitizer. At this time 2 surveyors confirmed with CNA-M that she did not use and sanitizer prior to preparing the medications or donning gloves. At this time 2 surveyors confirmed with CNA-M she did not use hand sanitizer prior to donning gloves.<br><br>During an interview with 2 surveyors on 10/22/24 at 8:33 a.m., Cares Demetia Specialist (CNS) confirmed the expectation is that staff use hand sanitizer before and after the use of gloves, before and after entering the rooms and before and after preparing and administering medications.<br><br>37440<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. In reviewing the facility policy on infections regarding transmission based precautions, the following was noted: methods of implementing and control, page 17 of the facilities infection control policy-the CDC has provided guidance for enhanced barrier precautions, which falls between standard and contact precautions, and requires gown and glove use for certain residents during specific high contact resident care activities that have been found to increase risk for multi drug resistant organism(MDRO) transmission. Enhanced barrier precautions-definition: Barrier Precautions expands the use of personal protective equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. Examples of high contact resident care activities requiring gown and glove use for enhanced barrier precautions include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line/urinary catheter/feeding tube/tracheostomy/ ventilator, wound care: any skin opening requiring a dressing.<br><br>Implementation: when implementing contact precautions or enhanced barrier precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: post clear signage on the door or wall outside of the resident's room indicating the type of precautions and required PPE (e.g., gown and gloves). For enhanced barrier precautions, signage should also clearly indicate the high contact resident care activities that require the use of gown and gloves.<br><br>R34 was admitted on [DATE] with diagnoses including multiple drug resistant organism (MDRO)and a Urinary tract Infection. Regarding continence, the resident has an ileostomy. R34's Minimum Data Set(MDS) dated [DATE] noted the following: Bed mobility - 02,substantial/maximal assistance/03, supervision or touching assistance; Locomotion with wheelchair- 02, substantial/maximal assistance; Dressing - 01, dependent, Eating - 05, set up and clean up assistance; Toileting - 02, substantial/maximal assistance; Personal Hygiene - 04, supervision or touching assistance; Bathing-03, partial/moderate assistance and Continence - Ostomy.<br><br>On 10/21/24 at 1:30 p.m., a surveyor observed Liberty Island resident room [ROOM NUMBER] entrance lacked signage indicating to visitors, staff and residents the type of precautions needed to enter the room.<br><br>On 10/22/24 at 2:35 p.m., a surveyor observed Liberty Island resident room [ROOM NUMBER] entrance lacked signage indicating to visitors, staff and residents the type of precautions needed to enter the room.<br><br>On 10/22/24 at 02:30 p.m., in an interview, Certified Nursing Assistant (CNA) #1 stated that the R34 was on contact precautions. She stated and confirmed that there was no signage at the room entrance indicating to visitors, staff and residents the type of precautions needed to enter the room because a nurse manager told her one was not needed.<br><br>On 10/22/24 at 02:44 p.m., in an interview, Liberty Island Nurse Manager confirmed that the resident was on contact precaution and that there was no signage at the room entrance indicating to visitors, staff and residents the type of precautions needed to enter the room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/22/24 at 02:55 p.m., in an interview with the Director of Nursing, a surveyor discussed that R34 was on contact precautions and that there was no signage at the room entrance indicating to visitors, staff and residents the type of precautions needed to enter the room.<br><br>On 10/23/24 at 8:07 a.m., a surveyor observed Liberty Island resident room [ROOM NUMBER] entrance lacked signage indicating to visitors, staff and residents the type of precautions needed to enter the room.<br><br>On 10/23/24 at 12:30 p.m., in an interview with a surveyor, the Liberty Island Nurse Manager and the Administrator confirmed that there was no signage at the room entrance indicating to visitors, staff and residents the type of precautions needed to enter the room. |