STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205126	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - Augusta	35 Heroes Way 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.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, the facility failed to ensure that a resident's physician and representative were notified immediately of a significant change in the resident's medical condition and failed to follow its own policy and procedure for Notification of Change in Resident Condition or Treatment plan for 2 of 5 residents reviewed for significant changes. (Resident's #47 and #110).The facilities Notification of Change in Resident Condition or Treatment Plan policy dated 8/20/24 states under Family Notification.The resident's representative will be notified if the resident chooses and/or: there is a change in the resident's physical, mental or psychosocial status. The resident is involved in an accident or occurrence. Except in medical emergencies, representative notifications will be made within 24 hours. 1 Resident #110 had diagnoses to include dementia and chronic kidney disease. Review of Resident #110's progress note dated 6/19/25 at 05:15 states Observed on floor, un-witnessed in residents room attempting to self-transfer. Further review of Resident #110's clinical record lacked evidence the Residents record lacked evidence the resident representative or provider was notified of this fall. During an interview on 10/2/25 at 2:00 p.m., Medical Doctor (MD) stated that she did not believe she was notified of Resident #110's fall that she can recall. During an interview 10/2/25 at 1:00 p.m., the Director of Nursing (DON) confirmed the resident representative was not notified of residents fall on 6/19/25 but believes the provider was notified in writing and is trying to locate the note. DON failed to provide this information by the end of survey. 2. Review of resident #47's medical record contained the following nursing documentation: Nursing note dated 4/29/25 at 7:58 p.m., states observed sitting on bathroom floor - able to use call bell, call bell in reach . Family: needs to be called, will let day shift know in the morning. Nursing note dated 5/14/25 at 8:35 p.m., states observed on floor- gripper socks on, using bedside table as walker.Family: will alert next shift family needs notified. Nursing note dated 6/13/25 at 3:32 pm. states observed on floor, un-witnessed, attempting to self transfer. Resident stated (he/she) was attempting to get something out of (his/her) closet and slipped and fell on (his/her) bottom, Staff found (him/her) seated on the floor next to (his/her) bed.Family: not notified. Further review of Resident #47's medical record lacked evidence of the family being notified of the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above 3 falls. On 10/2/25 at 11:46 a.m., during an interview, the Freedom Bay Registered Nurse Manager was unable to find documentation where the family was notified of the above falls.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 4 wings (Freedom Bay (FB) and Eagle's Landing (EL) and a common area for 3 of 3 facility tours.Findings: 1. On 9/30/25 at 9:13 a.m., on EL-[NAME] outside of Resident rooms [ROOM NUMBERS], a surveyor observed a cushion of the couch was ripped creating an uncleanable surface. At this time, in an interview with a surveyor, the Facility Manager confirmed the finding.2. On 10/01/2025 at 12:55 p.m., on EL - Delta in resident room [ROOM NUMBER], a surveyor observed a floor mat that was dirty, had stains and had ripped material along the side edges. At this time, in an interview with a surveyor, RN #1 confirmed the finding. 3. On 10/2/25 from 8:15 am to 9:00a.m., a surveyor conducted an Environmental Tour with the Facilities Manager in which the following findings were observed:Freedom Bay -Alpha- Resident room [ROOM NUMBER] - The caulking around the base of the toilet was dirty.- Resident Rooms 3 - The caulking around the base of the toilet was dirty.- Resident Rooms 4 - The caulking around the base of the toilet was dirty.- Resident Rooms 8 - The caulking around the base of the toilet was dirty.- Resident #24's Broda chair ripped/torn on back left side of chair.- The common area bathroom, next to the Belgrade Room, had dirty caulking around the toilet. The small floor grate in front of the toilet had dirt build up in it. The counter top was faded/stained behind the sink. - Delta -2 restroom-caulking dirty around toilet. On 10/2/25 at 9:00a.m., in an interview with a surveyor, the Facilities Manager confirmed the findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of the facility's Food Storage and Protection policy/procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall fan, a food disposal unit, and the floor; and failed to ensure foods were labeled in the walk-in refrigerators, the walk-in freezer and the dry storage area for 2 of 2 observations on 1 of 4 days of survey (9/29/25). In addition, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 1 of 1 kitchen tours (9/29/25).Findings:The facility's Food Storage and Protection policy/procedure noted: Policy: Food shall be stored, prepared, served, transported and distributed with protection from potential contamination including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs, and sneezes, flooding, drainage, leakage, and condensation. All foods removed from the original package or container shall be stored in a clean and sanitized container and labeled and dated. Leftovers must be labeled with the date the item was produced. and the name of the product before being put in storage.This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one-inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils.1. Initial Kitchen Tour on 9/29/25 From 8:45 a.m. to 9:15 a.m., in a tour with a surveyor, the facility Food Service Director observed the following findings:- The dish room wall fan was dusty/dirty. - The food disposal unit had dried food particles and dried liquid residue on it.- The floor had food and debris on the floor under the equipment and the stoves. - The reach-in freezer had three and one-half large bags of breaded patties, 10 large bags of French fries, and 7 large bags of waffle fries that were not labeled.- The walk-in freezer had 2 larges bags of breaded patties, 6 large bags of tater tots and 4 bags of sub rolls that were not labeled. - The dry storage room had 3 large bags of cereal that were not labeled. - A surveyor food preparation sink, next to the ice machine, had no required air gap installed.On 9/29/25 at 9:15 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings. 2. On 9/29/2025 at 10:48 a.m., a surveyor observed the Freedom Bay Unit reach-in freezer which contained one large bag of bread, one large bag of breaded patties and two individual pie crusts that were not labeled.On 9/29/25 at 10:50 a.m., in an interview with a surveyor, a kitchen staff member confirmed the findings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record review and interview the facility failed to ensure that a resident's drug regimen was free from unnecessary medication by prescribing an antipsychotic medication (a drugs that treats symptoms that happen with schizophrenia and other conditions that involve psychosis) without adequate indications for 1 of 5 reviewed for unnecessary medications (#107).Finding:Resident #107's current electronic medical record contained a Physician order dated 5/5/25 for Olanzapine (antipsychotic medication used to treat mental health conditions such as schizophrenia and bipolar disorder) 5 milligrams daily at hour of sleep for the indicated use (diagnosis) of encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition).On 10/1/25 at 12:02 p.m., during an interview, the Registered Nurse Manager of Freedom Bay Delta House stated the diagnosis of encephalopathy was incorrect and the provider is updating the diagnosis. At 12:19 p.m., the physician order for Olanzapine had a diagnosis of behavioral disorders associated with dementia paranoia and delusions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of hearing aids for 1 of 1 sampled resident reviewed for communication difficulty and/or sensory problems. (Resident #3) (R3)Findings:Review of facility policy Care Area Assessments and Plan of Care dated 6/3/25 states .residents will have an individualized interdisciplinary Plan of Care that identifies the care and services necessary to maintain the highest practicable physical, mental and psycho-social well-being ensuring resident wishes for treatment and care are well defined and honored.Resident #3 was admitted to the facility in August 2025. Review of Resident #3's Comprehensive Minimum Data Set (MDS) dated [DATE] noted in section B-Hearing that R3 had and used a hearing aid. R3's current care plan, updated 9/2/25, lacked evidence that a hearing aid care plan was developed/initiated for R3.On 10/2/25 at 9:55 a.m., in an interview with a surveyor, RN #2 stated that she thought R3 had only one hearing aid but not sure and was not sure what ear it was in.On 10/2/25 at 9:55 a.m., a surveyor observed R3 sitting at a dining room table eating breakfast. The resident had a hearing aide in his/her left ear. On 10/2/25 at 10:13 a.m., in an interview with a surveyor, the Director of Nursing (DON) stated that R3 can't manage the hearing aid by himself/herself and would need staff assistance to help use it. On 10/02/2025 at 10:50 a.m., in an interview with 3 surveyors present, the Liberty Island Unit Manager confirmed that the resident's hearing aid and use/ storage had not been care planned for.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to assess and monitor a resident after unwitnessed falls and failed to follow their own Neurological Assessments policy and procedure by obtaining neurological assessments after the unwitnessed falls for 1 of 5 residents reviewed for falls. (Resident #47).FindingsThe facilities Neurological Assessments policy dated 5/8/24 states, A neurological assessment will be completed and documented in ECS after any incident or fall in which a head injury is suspected. In the case of an unwitnessed fall, the resident will be considered to have hit their head unless he/she can reliably state he/she did not. Assessments will be completed every 15 minutes for the first hour after the fall; every 30 minutes for the subsequent 4 hours; every shift for the next 72 hours.Review of resident #47's medical record contained the following nursing documentation:A nurses note dated 5/14/25 at 8:35 p.m., states, observed on floor- gripper socks on, using bedside table as walker. Neurochecks (neurological assessments) initiated as per facility policy. Review of the neurological assessments revealed only one of the 15 minute checks was completed on 5/14/25 at 8:50 p.m., and no evidence of the 30 minute checks being completed. The next documented neurological assessment was on 5/15/25 at 2:02 a.m. A nurses noted dated 5/26/25 at 5:05 pm states, observed on floor, unwitnessed. Resident states, [He/she] was trying to go to a different chair. Neuros initiated. Review of the neurological assessments lacked evidence of the 15 minute and 30 minute neurological assessments were completed with the next documented neurological assessment on 5/27/25 at 3:40 a.m.On 10/02/25 at 11:46 a.m., during an interview, the Freedom Bay Registered Nurse Manager stated confirmed the neurological assessments were not completed for the falls on 5/14/25 and 5/26/25