STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205127	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - Scarborough	290 US Rt 1 Scarborough, ME 04074

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on staff interviews, written statements and review of the facility's internal investigation, the facility failed to ensure that 1 of 3 residents reviewed for dignity (Resident #1) was treated with respect during care provided after a fall. Finding: Resident #1 experienced two falls on 5/26/25. The first fall, at approximately 11:25 a.m., was documented as a loss of balance. Staff appropriately used a mechanical lift to assist Resident #1 from the floor in accordance with the facility's no-lift protocol. The second fall, at approximately 4:50 p.m. near the nurse's station, was witnessed by Certified Nursing Assistant #1 (CNA), who observed the Resident #1 fall to his/her right side. CNA #1 responded immediately and held the resident's head until CNA #5 arrived. CNA #1 directed CNA #5 to notify the charge nurse, Licensed Practical Nurse #1. (LPN) CNA #1 reported that when LPN #1 arrived, she told staff that because the fall was witnessed, it did not count as a fall and instructed staff to stand the resident up. CNA #1 recalled a disagreement between RN #1 and LPN #1 regarding the use of a mechanical lift. LPN #1 disregarded the concern and proceeded to lift Resident #1 with CNA #5. CNA #1 stated that the resident provided no more than 10% effort. CNA #1 stated that she observed CNA #5 and LPN #1 pick Resident #1 up off the floor under [his/her] arms. CNA #2 reported observing CNA #5 and LPN #1 grabbing Resident #1 under the arms and drag [him/her] down the hallway to [his/her] room. CNA #2 described staff struggling to get Resident #1 into bed and stated she yelled for them to support him/her by the back of his/her pants to prevent another fall. CNA #2 stated that the resident was not bearing weight, and staff used substantial strength to complete the transfer. CNA #5 stated that LPN #1 said, Come on, let's just pick [him/her] up. CNA #5 acknowledged that lifting the resident manually was against facility protocol, but said he followed orders, stating, I was just following orders from my boss. CNA #5 described the resident as unable to walk, saying, It was more accurate to say that we were dragging [him/her]. Once in the room, CNA #5 reported that the resident pushed downward, appearing to try to return to the floor. LPN #1 responded, [He's/She's] just doing this on purpose. [He/She] does this. Staff then lifted Resident #1 into bed and swung his/her legs up. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 stated the Resident #1 mumbled but did not answer pain questions. She reported Resident #1 initially walked without signs of pain, later refused to continue, and became combative. She stated Resident #1 moaned during care but could not determine whether the pain was in the right or left leg. RN #1 stated she was informed by CNA #5 that the resident had a hard fall. When RN #1 arrived, the resident was still on the floor. Upon confirming it was the second fall of the day, RN #1 asked if the mechanical lift was being used. LPN #1 asked if the fall had been witnessed and if the resident had hit his/her head. When CNA #1 confirmed the fall had been witnessed and there was no head injury, LPN #1 said, Then [he/she] doesn't need the lift. We can just get [him/her] up. On 6/17/25 at 2:55 p.m., during an interview with the surveyor, the Director of Nursing (DON) stated that the facility does not have a formal written policy requiring the use of a mechanical lift after a fall. However, the DON confirmed that it is covered in new employee orientation and is considered part of facility protocol, as the facility operates as a no-lift environment. Staff are expected to use mechanical lifts rather than physically lift residents under normal circumstances, including post-fall .