STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205129	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Home	3402 Aroostook Road Eagle Lake, ME 04739

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on review of the Nursing Facility Reportable Incident Form submitted to the Division of Licensing and Certification on 11/13/23, the facility's internal investigation, written statements, and interviews the facility failed to ensure that 1 of 3 residents (Resident #1 [R1]) was free from physical abuse and 2 of 3 residents were free of verbal abuse (R1, and R3). Findings: A review of clinical record states R1 was admitted to the facility on [DATE] with diagnoses to include Huntington's Disease (a hereditary disease that causes degeneration of the brain cells causing progressive dementia, decreased coordination, impaired decision making, irritability, and depression). A review of the Nursing Facility Reportable Incident form submitted to the Division of Licensing and Certification on 11/13/23 at 4:05 p.m. states, there was an allegation that on 11/13/23 at 2:20 p.m. a Certified Nursing Assistant (CNA) #1 was being rough and rude to R1 while washing his/her hair . A review of a follow up letter submitted to the Division of Licensing and Certification on 11/17/23 at 4:06 p.m., states: - According to CNA2, a witness, CNA1 got frustrated with R1 and informed him/her that if he/she does not stop moving around he/she was not going to change him/her and leave him/her in bed. CNA1 was getting mad and forceful. When CNA1 was done washing R1's hair she grabbed his/her hair into a ponytail and yanked it so hard, R1 burst out crying. - In an interview with R1, he/she stated, CNA1 is mean to me. R1 stated yes when asked if his/her hair was pulled after his/her hair wash. A review of R1's Care Plan with a Problem Onset date of 6/14/23 states, Impaired communication/difficulty communicating needs effectively r/t (related to) Huntington's Disease-frequently yells and/or becomes impatient when unable to communicate a need or staff takes longer than anticipated. Goal My needs will be met daily. Approaches Redirect/reorient as needed. Speak to me slowly and clearly while facing me. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of written statement by CNA1 states, went into wash R1's hair .I washed it & rinsed it I had a little water left I did what I've seen others do pour the little bit on [his/her] hair then had CNA2 take out the basin with the water in it I grabbed his/her hair & put his/her head up so I can put the towel on & under his/her hair. He/she was crying to the point I couldn't understand him/her I asked him/her nicely I spoke so he/she could hear me .we changed him/her & he/she still seemed upset asked him/her if I could brush his/her hair & if he/she wanted a ponytail he/she said yes as he/she was in his/her chair he/she was upset we did everything he/she wanted I said nicely stay calm that way you can go to Mass if you're not [Activities] might not be able bring you so you don't disturb people in there. In a telephone interview with a surveyor on 6/7/24 at 1:19 p.m., CNA1 stated, regarding incident with R1 on 11/13/23, You have to wash it in his/her bed (referring to R1's hair), I lifted his/her head, I think it hurt him/her. I was not trying to pull his/her hair, but I was trying to rinse it all the way. He/she was expressing that I had hurt him/her. I wanted to get all the soap out, so his/her hair wouldn't be a mess , regarding allegation that she told R1 he/she couldn't go to Mass (a church service), CNA1 stated, I just explained to him/her .tried to explain to him/her to help him/her calm down. A review of written statement by CNA2 dated 11/13/23, states, On November 13th, 2023 I, CNA2 and another CNA named CNA1 went into R1's room because he/she needed help with a transfer and help with washing R1's hair which made CNA1 very irritated due to not having the right basin to wash his/her hair . CNA1 very upset and agitated and she would say hurtful things to R1 as in . if you keep moving I'm not going to wash your hair and if you don't stop moving around so much I'm not going to wash your hair or change you and you can just stay on the bed and she would get very rough with her as in pushing her to the wall to get the Hoyer pad out from under him/her and R1 would try to express himself/herself and move around a lot more and that would make CNA1 more mad and forceful . CNA1 would dump water over his/her head and forehead and was getting it over his/her eyes, which was making R1 very upset and he/she would move around a lot more and it was making CNA1 ever more upset and she would make threats and saying if you don't stop moving I'm going to leave you here because that's what (Staff) said to do. She grabbed his/her hair into a ponytail and yanked it up so hard it made R1 burst out crying and screaming and she continued to yell and berate him/her telling him/her it's all his/her fault and saying you have no consideration for what I'm doing for you. A review of Employee Counseling Form dated 11/15/23. CNA1 received an employment termination notice as a result of CNA1's actions and behaviors reported and witnessed. On 5/29/24 at 1:26 p.m. in an interview with the Administrator, a surveyor confirmed the above findings. A review of Employee Counseling Form dated 11/20/23. Registered Nurse (RN) received a written warning that on 11/13/23 she was the Charge Nurse working. She heard CNA1 say to a resident, Don't be such an asshole and then walk away. Regarding the allegation that CNA1 swore at a resident, she said, I never swore at other residents. This surveyor asked if she said to R3, - don't be such an asshole- CNA1 stated, Oh yeah, I remember, I think he/she ran over my toe. We were in the dining room - You rolled over my toe you have to be careful; I need my feet-. CNA1 stated, If I did, it might of slipped out, like an impulse. I wouldn't have meant it. A surveyor confirmed this finding at this time. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of written statement by CNA2 dated 11/13/23, states, On November 13th, 2023 I, CNA2 and another CNA named CNA1 went into R1's room because he/she needed help with a transfer and help with washing R1's hair which made CNA1 very irritated due to not having the right basin to wash his/her hair . CNA1 very upset and agitated and she would say hurtful things to R1 as in . if you keep moving I'm not going to wash your hair and if you don't stop moving around so much I'm not going to wash your hair or change you and you can just stay on the bed and she would get very rough with her as in pushing her to the wall to get the Hoyer pad out from under him/her and R1 would try to express himself/herself and move around a lot more and that would make CNA1 more mad and forceful . CNA1 would dump water over his/her head and forehead and was getting it over his/her eyes, which was making R1 very upset and he/she would move around a lot more and it was making CNA1 ever more upset and she would make threats and saying if you don't stop moving I'm going to leave you here because that's what [staff] said to do. She grabbed his/her hair into a ponytail and yanked it up so hard it made R1 burst out crying and screaming and she continued to yell and berate him/her telling him/her it's all his/her fault and saying you have no consideration for what I'm doing for you. A review of Employee Counseling Form dated 11/20/23. Registered Nurse (RN) received a written warning that on 11/13/23 she was the Charge Nurse working. She heard CNA1 say to a resident, Don't be such an asshole and then walk away. A review of Employee Counseling Form dated 11/15/23. CNA1 received an employment termination notice as a result of CNA1's actions and behaviors reported and witnessed.

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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 - Minimal harm or potential for actual harm 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** 35904 Based on record review, review of the facility incident report, and interviews, the facility failed to lock and/or alarm doors to prevent a resident identified as an elopement risk from leaving the building unnoticed. A nearby neighbor, who was driving near the facility called the facility to let staff know that a Resident might be away from the facility and near another health care building. The failure to have locked, and/or alarmed doors, resulted in an avoidable elopement with injury for 1 of 1 resident reviewed (Resident # 2 [R2]). Findings: R2 was admitted to the facility on [DATE] with diagnoses to include neurocognitive disorder with Lewy bodies (a form of dementia). Review of R2's Care Plan dated 3/18/24 includes, Problem onset: 6/28/23, I have a history of wandering into unsafe situations. Goal & Target Date: I will not wander into unsafe situations; Approaches: reviewed 3/14/24; Staff will attempt to redirect me to an activity I enjoy. Staff will locate me when the door alarms go off in the building. If I elope from facility, implement facility protocol for locating residents. If I am wandering away from unit, stay with me, converse and gently persuade me to walk back to designated area., and Problem onset: 12/29/2022, I am at risk for falls due to poor safety awareness, some unsteadiness on feet. Goal & Target Date: I will not experience any injuries related to falls (6/15/24). Review of R2's Reportable Incident Form, Mercy Home dated 5/8/24 indicated that on 5/8/24 at approximately 5:10 a.m., we received a call that there was a resident next to Fish River Office. After checking, we realized it was R2. R2 had an unwitnessed elopement, and superficial abrasions to forehead and nose. Review of R2's Reportable Incident Form, Mercy Home, 5 day follow up dated 5/10/24, 8. Identified 2 doors exiting day room leading to the service hallway do not alarm. - kitchen entrance and nurse's station entrance. It is assumed resident was able to leave building through one of these two exits. On 5/29/24 at 2:19 p.m., during an interview with the Director of Nursing, a surveyor confirmed that R2 eloped from the facility unnoticed on 5/8/24 and was returned to the facility on [DATE] at 5:10 a.m. On 6/13/24 at 10:47 a.m., during an interview with a surveyor, the Registered Nurse stated that he didn't know R2 had left until he received the phone call from the neighbor. There were two Certified Nursing Assistants (CNA) #1, and #2 (that went by vehicle to go get him/her. On 6/13/24 at 12:25 p.m., during an interview with a surveyor, a CNA1 stated, it was brought to our attention that the resident was outside. We went and got R2 from an area near another building, it was across a street. R2 was sitting on the side of the road, blood on his forehead and nose, and his/her knees were dirty. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 12:57 p.m. in a telephone interview with a surveyor, the Administer stated the facility was able to determine through video surveillance footage that R2 exited the building from the loading dock. On 6/13/24 at 1:41 p.m. in electronic communication from the Administrator, R2 was out on the loading dock at 4:52 a.m. On 6/13/24 at 5:00 p.m. in an interview with CNA2, she stated she last saw R2 in the dining room at around 4:45 a.m., she cannot be sure of exact with the time. R2 left the building unnoticed on 5/8/24 at approximately 4:52 a.m. according to video surveillance footage per the Administrator. The resident exited from the loading dock and was out of the facility until approximately 5:10 a.m., 18 minutes. R2 did sustain an abrasion to his/her forehead and abrasion to his/her nose. R2 was assessed, treated, and monitored, there were no lasting effects to R2.