STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205146	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastport Memorial Nursing Home	23 Boynton Street Eastport, ME 04631

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, facility reported incident and investigation reviews, and interviews, the facility failed to implement a comprehensive care plan for Resident #1 (R1) for 2 of 2 facility reported incidents of elopement reviewed (5/13/25 and 5/17/25). Findings: On 6/23/25, R1's clinical record was reviewed. R1 had been identified as an elopement risk and wore a wander guard bracelet on his/her ankle which should trigger a secured exit (doors with alarms, security codes, and other locking mechanisms to prevent unauthorized exit) to activate. R1's care plan, dated 11/26/24 and last reviewed on 5/21/25, under the care area of I am at risk for elopement, directed staff to redirect me from exits and at times when I am really upset and trying to leave have available staff sit with me. 1. On 5/13/25, the State Agency received a facility reported incident that indicated R1 was found outside after he/she exited the building unwitnessed. A review of the facility's investigation, dated 5/18/25, indicated that R1 had been redirected from the Sunroom exit door at least 3 times before he/she was able to exit the building. On 6/23/25 at 12:10 p.m., during an interview with a surveyor, Certified Nursing Assistant #1 (CNA1) stated R1 tried to get out the Sunroom exit door and got the door open. Housekeeping was present also and we redirected R1 out of the area and closed the wooden (swinging) Sunroom doors. On 6/23/25 at 2:10 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed that for the 5/13/25 elopement, there was no evidence that anyone sat with R1 during the elopement behaviors and staff just kept redirecting the resident from the area. 2. On 5/18/25, the State Agency received a facility reported incident that indicated the evening of 5/17/25, R1 was found outside when he/she exited the building, unwitnessed. A review of the facility's investigation, dated 5/22/25, indicated there were 3 staff on duty that evening. The DON interviewed the Charge Nurse on duty as part of the investigation who stated that R1 had made multiple attempts to elope that evening, but was able to be redirected. On 6/23/25 at 12:00 p.m., during an interview with a surveyor, CNA2 stated that she heard the alarm going off and she figured it was R1. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205146	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastport Memorial Nursing Home	23 Boynton Street Eastport, ME 04631

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/23/25 at 2:10 p.m., during an interview with the DON, a surveyor confirmed for the 5/17/25 incident at occurred at 9:27 p.m., R1 again was exit seeking that shift, and with only 3 staff present, there was no one able to provide adequate supervision for R1 who figured out how to open the alarmed Smokers door and get outside unwitnessed. There was no evidence that anyone sat with R1 during the elopement behaviors and just kept redirecting the resident from the area. The DON stated that she asked Charge Nurse on why he did not immediately notify her or call her or ask for help for someone to come in and sit with R1 until she calmed down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205146	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastport Memorial Nursing Home	23 Boynton Street Eastport, ME 04631

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on the facility's incident report forms and investigations, facility policy review, and interviews, the facility failed to provide adequate supervision to a resident who was actively exit seeking and was able to leave the facility unwitnessed and/or failed to follow it's own Elopement and Wandering Policy by ensuring secured exits were in working order for 2 of 2 facility reported incidents of elopement reviewed (5/13/25 and 5/17/25) for Resident #1 (R1). Findings: The facility's Elopement and Wandering Policy, reviewed 3/12/25, indicated the following: Environmental Modifications: Secure exits: Doors with alarms, security codes, and other locking mechanisms to prevent unauthorized exit. Door alarms should continue alarming after the door is closed and the alarm should be deactivated by staff entering the code to end the alarm. At any time staff finds that door alarms are not functioning properly, it must be reported immediately to maintenance staff or the Administrator and/or the Director of Nursing. Facility Notification: In the event of a resident's elopement, staff need to inform the Director of Nursing or Administrator immediately. On 6/23/25, R1's clinical record was reviewed. R1 had been identified as an elopement risk and wore a wander guard bracelet on his/her ankle which should trigger a secured exit (doors with alarms, security codes, and other locking mechanisms to prevent unauthorized exit) to activate. 1. On 5/13/25, State Agency received a facility reported incident that indicated a staff member (Housekeeping) taking out the garbage observed R1 walking, without their walker, on the sidewalk outside, towards a parked vehicle. The State Agency received the facility's investigation on 5/19/25 for this incident; a review of the facility's investigation, dated 5/18/25, indicated (via cameras) on 5/13/25, between 9:01 a.m. - 9:51 a.m., R1 was observed 4 times to be pushing on the Sunroom exit door with his/her walker, but was unable to push the door open. R1 was observed and redirected by staff 3 times during those attempts at opening the door. At 10:00 a.m., R1 was at the Sunroom exit door again, pushing on the handle and managed to get the door open with the front wheels of the walker, making it outside. Housekeeping was present and called for assistance from a Certified Nursing Assistant (CNA) and R1 was redirected from the area. Housekeeping then closed the wooden swinging doors to the Sunroom. At 10:12 a.m., R1 opened the wooden swinging doors to the Sunroom, pushed on the Sunroom exit door handle and pushed the door open, exiting the building while holding his/her walker with one hand and pushing the door with the other hand. (R1 exited the building on to concrete steps, stepping off those, and on to the level ground). At 10:16 a. m., staff was observed exiting the building through the Sunroom exit door after receiving notification from Housekeeping who was outside at the dumpster and observed R1 outside, walking without their walker, towards a parked car. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205146	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastport Memorial Nursing Home	23 Boynton Street Eastport, ME 04631

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's investigation concluded that the secure exit (door keypad/alarm system) was not working and therefore when R1 opened the outside door, R1's secure care bracelet did not trigger the exit to be secure or sound an alarm; a loose power connection was found to the the reason the exit was not secured. On 6/23/25 at 12:10 p.m., during an interview with a surveyor, Certified Nursing Assistant #1 (CNA1) stated R1 tried to get out the Sunroom exit door and got the door open, but it did not sound the alarm. Housekeeping was present also and we redirected R1 out of the area and closed the wooden (swinging) Sunroom doors. CNA1 stated that she attempted to contact the Maintenance Supervisor after the first attempt of getting the door opened when the alarm did not sound, but he did not answer so she called the kitchen to see if they could track him down; R1 ended up getting out before the Maintenance Supervisor could make it upstairs to check the door. On 6/23/25 at 2:10 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed that for the 5/13/25 elopement, staff knew that the Sunroom door exit was not secured and left the unsecured door unattended and failed to provide adequate supervision for R1, knowing that R1 was actively exit seeking and was able to open an unsecured exit door and leave the building unwitnessed. 2. On 5/18/25, the State agency received a facility reported incident that indicated that on 5/17/25 at 9:30 p. m., had exited out a side door (Smoker's exit) and down steps; R1 was caught by staff who were made aware of R1's elopement because the alarm was sounding. The facility's investigation, dated 5/22/25, indicated the DON was in the facility on 5/18/25, working on the investigation for R1's 5/13/25 elopement, when she discovered that R1 had eloped again on 5/17/25. She noted that she had not informed immediately of this incident (as directed by Elopement policy) by the Charge Nurse. The facility completed an investigation for this incident by reviewing cameras and conducting interviews that indicated on 5/17/25 at 9:27 p.m., R1 was seen on camera leaving the building through the Smoker's exit and at 9:28 p.m., CNA3 was observed exiting the building to bring R1 back inside. The DON gathered statements from staff that were on duty the evening of 5/17/25. On 5/19/25 at 1:59 p.m., CNA3 reported she heard the door alarm go off at the back door. She went towards the back door, opened the back door and saw R1 going down the steps. CNA3 attempted to redirect R1, however the resident was resistant but she was able to get R1 to turn around and walk towards the ambulance entrance. On 5/21/25 at 6:06 a.m. , Charge Nurse stated that R1 had made multiple attempts to elope that evening, but was able to be redirected; when staff had brought R1 back into the building, they reported to him that R1 had eloped from the building. On 6/23/25 at 12:00 p.m., during an interview with a surveyor, CNA2 stated that she heard the alarm going off and she figured it was R1. CNA3 went out brought R1 back inside. (R1 must of held the door handle down 15 seconds to open the door [per life safety code] but the alarm sounded as it should have.) On 6/23/25 at 12:15 p.m., during an interview with a surveyor, Family Member stated that R1's wandering behavior is not new for the resident and that she has been this way for at least 4 years. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205146	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastport Memorial Nursing Home	23 Boynton Street Eastport, ME 04631

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/23/25 at 2:10 p.m., during an interview with the DON, the surveyor confirmed that for the 5/17/25, R1 again was exit seeking that shift, and with only 3 staff present, there was no one able to provide adequate supervision for R1 who figured out how to open the alarmed door and get outside at 9:27 p.m. The DON stated that she asked Charge Nurse on why he did not immediately notify her or call her or ask for help for someone to come in and sit with R1 until she calmed down. The DON stated that education was provided to Charge Nurse about immediate notification of resident elopements to either the DON or Administrator.