STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205151	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - Caribou	163 Van Buren Rd Suite 2 Caribou, ME 04736

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33242 Based on observations, record review, and interview, the facility failed to maintain the dignity of 1 resident (Resident #29 [R29]) related to urinary collection bags during 2 of 3 days of survey (1/7/25 and 1/8/25). Findings: R29's care plan under Self Care Deficit included an approach, dated 5/25/23, references that R29 has a Foley Catheter and to cover bag to maintain dignity when out of room. 1. On 1/6/25 at 12:15 p.m. two surveyors observed R29's Foley catheter bag under his/her Tilt in Space wheelchair while R29 was in the dining room at lunch time. The blue covering of the Foley Catheter bag was riding up bottom to top and urine was visible at the bottom of the bag. 2. On 1/7/25 at 11:35 p.m. two surveyors observed R29's Foley catheter bag under his/her Tilt in Space wheelchair while resident was in the doorway of his/her room, facing the hallway. The blue covering of the Foley Catheter bag was riding up from the bottom to the top and urine was visible at the bottom of the bag. 3. On 1/7/24 11:46 p.m., a surveyor observed R29 in the dining room at lunch time sitting in his/her Tilt in Space wheelchair. The blue covering of the Foley catheter bag was riding up and urine was visible at the bottom of the bag. The surveyor confirmed this finding with Staff Development Coordinator at this time.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 32540 Based on interview and record review the facility failed to ensure that a resident's choice in bathing was being followed for 1 of 1 sampled resident reviewed for Choices (Resident #30 [R30]). Finding: On 1/6/25 at 9:30 a.m., during an interview with a surveyor, R30 stated that he/she does not get their shower every week, stating that it is more like once a month that they are able to go into the shower. R30 stated that staff are saying they just don't have time to do showers. Upon review of the scheduled whirlpool list R30 is scheduled on Monday. Certified Nursing Assistant (CNA) documentation shows that R30 has received 2 showers since November 1st, 2024, to current day (1/7/25). Documentation shows that R30 received a shower on 11/11/24 and 12/9/24 supporting R30's statement of only receiving a shower once a month. R30 was scheduled to receive his/her shower on 1/6/25 during this survey, there is no evidence that R30 received a shower. During an observation of the whirlpool and shower room with a CNA there was no evidence showing that the shower/whirlpool room was used (floors in shower were dry, whirlpool tub was dry). On 1/7/25 at approximately 1:30 p.m. during an interview with the Director of Nursing Services and review of CNA documentation for R30's showers, the surveyor confirmed that R30 has not had his/her showers weekly as scheduled, with 2 scheduled days being documented that R30 had refused bathing.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record reviews and interviews the facility failed to ensure a care plan was resident centered, updated, and implemented for 2 of 14 residents reviewed on survey (Resident #6 [R6] and [R33]). Findings: 1. Clinical record review indicated R6 transitioned to hospice level of care on 12/13/24. The care plan identified the following: -A care area identified on 1/5/24 and revised on 12/31/24, indicated the Potential for Constipation. The approach indicated Keep fluids in reach and encourage fluid intake. -A care area identified on 1/5/24 and revised on 12/31/24, indicated the Potential for Fluid volume [deficit] manifested by Dry mucous membranes. The approaches listed included Encourage fluid intake and Offer fluids frequently, Keep fluids within reach. - A care area last revised on 12/31/24, identified verbally and physically disruptive behaviors related to dementia, manifested by outbursts and agitation. Approach for this care area, indicated Provide auditory or tactile stimulation for excess vocalization and Use headset to provide music or puzzles for distraction when behaviors are increased . Do not leave Hoyer sling underneath R6 when Hoyer is not being used. -A care area identified on 1/5/24 and revised on 12/31/24, identified Mood Disturbance manifested by agitation. Approach to this care area directed staff to decrease environmental stimulation, and provide temporary isolation as indicated. On 1/6/25 at 9:44 a.m., a surveyor observed R6 resting in a chair at bedside. The Hoyer sling was observed under the resident. There were no fluids observed within reach. On 1/7/25 at 11:52 a.m., a surveyor observed R6 sitting in a chair at bedside. The Hoyer sling was observed under the resident. There were no fluids observed within reach. At 1:07 p.m., during an interview with a surveyor, a staff member stated that leaving the Hoyer pad under the resident is easier due to R6 being easily agitated. On 1/7/24 at 3:36 p.m., during an interview with a surveyor, the Director of Nursing Services (DNS) stated the care plan should be updated to allow the Hoyer sling to remain under R6 for comfort purposes, clarified R6 responds better to reduce stimulation, and stated that staff offer fluids but may not be documenting each attempt. At this time the surveyor confirmed R6's care plan was not updated and implemented to meet R6's needs. 2. Clinical record review indicated R33 was admitted on [DATE]. On 9/23/24 the provider ordered 240 milliliters (ml) of House Supplement (CIB) to be given at breakfast, lunch and dinner. R33's weights were as follows: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 9/7/24, R33 weighed 98.6 pounds (lbs). - On 10/3/24, R33 weighed 98.4 lbs. -On 11/4/24, R33 weighed 87.6 lbs. -On 12/2/24, R33 weighed 86.6 lbs. -On 1/1/25, R33 weighed 86.6 lbs. R33 had a 12.17 percent weight loss in less than 6 months. On 1/8/25 at 2:28 p.m., during an interview with a surveyor and the Director of Nursing Services (DNS), R33's care plan was reviewed. The care plan indicated a care area of Potential for Alteration in nutrition on 10/26/24, with a goal that R33 will consume 50 percent to 75 percent of meals and maintain a weight of 95 lbs to 105 lbs. This care area was revised on 12/13/24 indicating Alteration in Nutrition with a goal that R33 would consume 25 percent to 50 percent of meals and maintain a body weight of 85 lbs to 95 lbs. The care plan did not address the use of CIB with meals, resident preferences for meals, or weight monitoring parameters , and was not revised when the care area and goals were changed to prevent further weight loss. At this time the surveyor confirmed R33's care plan was not resident centered, or updated for the monitoring, and treatment of unintended weight loss.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review and interviews, the facility failed to address significant weight loss for 1 of 1 sampled residents reviewed for nutrition (Resident #33 [R33]). Finding: On 1/8/25, a clinical record review was done for R33. The record indicated R3 was admitted on [DATE]. On 9/23/24 the provider ordered 240 milliliters (ml) of House Supplement Carnation Instant Breakfast (CIB) to be given at breakfast, lunch and dinner. R33's weights were as follows: - On 9/7/24, R33 weighed 98.6 pounds (lbs). - On 10/3/24, R33 weighed 98.4 lbs. -On 11/4/24, R33 weighed 87.6 lbs. -On 12/2/24, R33 weighed 86.6 lbs. -On 1/1/25, R33 weighed 86.6 lbs. R33 had a 12.17 percent weight loss in less than 6 months. On 10/26/24 at 1:13 p.m., a dietary note indicated the resident had an involuntary 5 percent weight loss. A goal was set to have no weight loss and continue to maintain a weight of 95 lbs to 105 lbs for three months. On 12/13/24 at 8:36 a.m., the dietary note identified alteration in nutrition and change the goal to maintain a body weight of 85 lbs to 95 lbs for three months. On 1/8/25 at 1:15 p.m., during an interview with a surveyor, 2 staff reviewed resident charts but were unable to find food preferences. They stated the dietary details come on the meal tray on a slip, but they do not have access otherwise. On 1/8/25 at 1:30 p.m., during an interview with a surveyor, the Dietary Manager (DM) stated that she meets with residents within the first 7 days of admission. She will mark off resident's preferences and take the slip back to the kitchen. Residents will be sent a meal avoiding dislikes. If a resident does not like the meal, they are offered an alternative (soup and sandwich). If a resident does not eat the food, the DM will sometimes come meet with the resident to ask what else they might like but is unable to do this with residents who are cognitively impaired. DM stated, she does not notify the physician of weight loss but addresses it at interdisciplinary team meetings for care planning. DM stated she does not communicate food preferences to staff. At this time the surveyor confirmed that the weight goals were changed for R33, but no interventions were initiated to prevent further weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 2:28 p.m., during an interview with a surveyor and the Director of Nursing Services (DNS), R33's care plan was reviewed. The care plan indicated that on 10/26/24 the care plan identified a care area Potential for Alteration in nutrition with a goal that resident will eat 50 percent to 75 percent of meals and maintain a weight of 95 lbs to 105 lbs. This was revised on 12/13/24 indicating Alteration in Nutrition with a goal that R33 would consume 25 percent to 50 percent of meals and maintain a body weight of 85 lbs to 95 lbs. The approach did not address the use of CIB with meals, R33's preferences for meals, or weight monitoring parameters, and was not revised when the care area and goals were changed. At this time the surveyor confirmed R33's care plan was not resident centered or updated to prevent further unintended weight loss. The DNS stated, residents with weight loss are reviewed weekly in a meeting, it is run by the Staff Development Coordinator (SDC). On 1/8/25 at 3:08 p.m., during an interview with a surveyor, the SDC stated, we monitor weights for residents on supplements, to make sure weights are done. The SDC does not notify the provider of weights discussed in the meeting. The SDC reviewed the previous meeting notes and stated R33 was not on the list for monitoring. At this time the surveyor confirmed R33 was not monitored for significant weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32540 Based on observations, record reviews and interviews, the facility failed to have complete orders that contained the specific amount of liters per minute (LPM) for the use of oxygen and the facility failed to ensure that one oxygen concentrator was operated and maintained per manufacturer's directions for 2 of 3 residents reviewed with oxygen (Resident #19 [R19 and R1]). Findings: 1. On 1/6/24 at 12:00 p.m. R19 was in the dining room using his/her oxygen concentrator with a flow rate of 3 liters using a nasal cannula. The surveyor observed that the oxygen concentrator was missing the side filter. A surveyor asked RN #1 to observe the oxygen concentrator with the surveyor and acknowledged the side filter was missing. On 1/7/25 at 8:50 a.m. an observation of R19's oxygen concentrator was observed and showed the side filter was still missing. At this time the surveyor confirmed the side filter was missing with the RN MDS Coordinator. The RN MDS Coordinator cut a filter to replace the missing side filter after the observation was made. On 1/7/25 during a review of the manufacturer's manual for the Rhythm Healthcare oxygen concentrator that R19 was using the manual reads on page 17, section 5.2, do not operate the concentrator without the filter installed. The Administrator was shown the manufacturer's manual that instructed to not operate the concentrator without the filter installed. On 1/7/25 during a clinical record review R19 had an order dated 11/15/24 to apply humidified oxygen via nasal cannula to keep O2 sat (saturation) above 88%. The order does not contain a specific flow rate (the amount of oxygen to be delivered) making the order incomplete. 33242 2. On 1/6/25, R1's clinical record was reviewed and it was noted that R1 had a medical diagnosis that included chronic obstructive pulmonary disease. The current physician order entered into the electronic record on 9/14/24 was, Apply humidified Oxygen via Nasal Cannula to keep O2 sat above 88%. On 9/21/24, R1 was transferred to the hospital and returned with an order for oxygen to be administered at 2 liters per minute (LPM) to keep saturation (sats) above 90% but this was not the current order and was not entered into the clinical record. On 1/6/25 at 11:49 a.m., a surveyor observed R1's oxygen concentrator set at 3 LPM. On 1/7/25 at 12:27 p.m., during an interview with a surveyor, the Director of Nursing Services stated that the physician orders for oxygen should include the amount of liters to administer and will follow up on the oxygen orders. The surveyor confirmed the oxygen orders did not include the amount of liters to administer during this interview.