STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205184	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - So Paris	477 High St South Paris, ME 04281

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 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. 51331 Based on observation and interview the facility failed to promote care for a resident in a manner that maintains dignity and respect when staff failed to respect the residents right to confidentiality for 1 of 1 residents observed (Resident #9). Findings: On 10/7/24 at 9:19 a.m. a surveyor approached the Clinical Resource Nurse (CRN) and asked why Resident #9 was on Enhanced Barrier Precautions. The CRN proceeded to shout down the hall, twice, to the Registered Nurses (RN) Manager, is [Resident #9] on enhanced barrier precautions for [his/her] foley. The CRN then stated, I typically yell louder. On 10/8/24 at 2:32 p.m., during an interview, the above was discussed with the Assistant Director of Nursing who agreed it was a dignity concern.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on facility policy review, record reviews, and interviews, the facility failed to ensure that the resident and/or resident representative written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate and advanced directive, was completed for 2 of 2 residents reviewed for advanced directives. (Resident #30 and #47) Findings: Review of the facility policy Advance Directives, DNR Orders and Health Care Decision Making Policy: AD14. It is the policy of (Facility) to: Provide to all residents at the time of their admission and subsequently, upon request, written information concerning their rights under Maine law to make decisions concerning their health care, including the right to accept or refuse medical treatment and healthcare services, the right to withhold or withdraw life- sustaining treatment, including attempts to resuscitate in the event of cardiopulmonary arrest, the right to execute advanced directives concerning their health care decisions, and the right to designate a representative to exercise the rights of the resident in accordance with Maine law. Resident #30 was admitted to the facility on [DATE]. Review of Resident #30's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 10/9/24 at 11:45 a.m. in an interview with a surveyor, the Licensed Social Worker confirmed that Resident #30 states he/she has an advance directive, but not available, and the clinical record lacked evidence that the facility followed up with Resident #30 to obtain the advance directive. Resident #47 was admitted to the facility on [DATE]. Review of Resident #47's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 10/9/24 at 11:51 a.m., the C - Unit Nurse Manager confirmed Residents #47's clinical record did not include evidence that the residents and/or representatives were asked or offered and refused assistance filling out an advanced directive. 35904

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 37648 Based on observation, record review and interview, the facility failed to follow physician orders for treatment related to enteral feeding tube maintenance/care for 1 of 1 resident reviewed with a Percutaneous Gastrostomy tube (G-tube or PEG-tube). (Resident #48) Finding: On 10/8/24 at 7:51 a.m., during observation of Resident #48's G-tube medication administration and maintenance with the Registered Nurse (RN), the RN removed dirty G-tube split gauze dressing from around the stoma. She then obtained a gauze pad and wet it with the faucet water and preceded to clean the G-tube stoma site, then applied new split gauze. At this time, the surveyor asked why she was cleaning the site with water rather than normal saline. The RN stated she uses water to clean around the site. Review of Resident #48's medical record contained a physician order dated 8/14/24 to Cleanse PEG tube Stoma with NS (Normal Saline) and apply split gauze daily. On 10/8/24 at 10:18 a.m., during an interview with Interim Administer, the above was discussed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51331 Based on record review and interview, the facility failed to identify resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 3 of 3 sampled residents reviewed with a diagnosis of PTSD (Resident #9, #23, and #47) Findings: 1. On 10/9/24, review of Resident #9's medical record contained several providers progress notes dated 11/8/23, 12/6/23, 4/26/24 and 9/6/24 under the section Past Medical History indicate he/she has a diagnosis of Anxiety/PTSD. Review of the facilities Trauma Exposure Checklist dated 4/6/23 states Resident #9 has PTSD due to being a Prisoner of War ([NAME]) in Korea This facility form was signed and completed by the Licensed Social Worker (LSW) indicating it was reported to the Unit B Registered Nurse (RN) Manager. Review of the quarterly interdisciplinary team meeting held on 6/25/24 stated Resident #9 has shown increased signs/symptoms of depression/PTSD (a nightmare/flashback from [NAME] experience). A verbal telephone medication order dated 8/23/24 stated the diagnosis for the mediation was for Anxiety/PTSD. In addition, review of Resident #9's care plan lacked evidence of a trauma informed care plan with identified triggers and interventions to prevent re-traumatization. On 10/9/24 at 11:01 a.m., during an interview, the above was discussed with the Director of Nursing who stated Resident #9 does not have a diagnosis of PTSD. 35904 2. Resident Resident #23 was admitted to the facility on [DATE]. The Trauma Exposure checklist indicates that Resident #23 has a diagnosis of PTSD with no listed triggers. Review of Resident #23's care plan, most updated on 7/15/24, states under care area (mood): potential for anxiety anger depression; Resident Choice: I don't want to be re-traumatized; Approach: Social Services --- screen for suicidal thoughts, assist to identify strengths, support daily decision making, provide emotional support, promote sense of control; Will participate in activities, avoid re-traumatization. On 10/9/24 at 1:09 p.m. in an interview with the Unit Manager C Unit, a surveyor confirmed that Resident #23's care plan lacked evidence of what triggers and what interventions are in place to prevent re-traumatization of the PTSD trauma informed care plan section of Resident #23's care plan. 33639 3. Resident #47 was admitted to the facility on [DATE]. The Trauma Exposure checklist indicates that Resident #47 was exposed to combat, war zone and an unexpected death as a stressful event that remains traumatic for the resident. This facility form was signed and completed by the Licensed Social Worker (LSW) on 5/14/24 indicating it was reported to the Unit Manager. The Trauma Exposure checklist instructs staff to notify the Unit Manager and Social Services Manager for follow-up with any affirmative answers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A social service progress note dated. 5/15/24 indicates that Resident #47's Power of Attorney (POA) reported that the resident has significant PTSD and had been attending group sessions. Documentation provided by the facility on 10/9/24 indicates that Resident #47 has a past medical history of PTSD. On 10/9/24 at 11:47 a.m., during an interview with the LSW, she stated that Resident #47 had a diagnosis of vascular dementia and vascular dementia takes over for the PTSD. Resident #47's care plan lacked evidence of a trauma informed care plan with identified triggers and interventions to prevent re-traumatization.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51331 Based on observations and interviews, the facility failed to ensure expired medications and medical supplies were removed from the supply available for resident use for 2 of 2 medication rooms observe (Unit B and Unit C) for 1 of 3 days of survey. Findings: 1. On 10/7/24 at 2:34 p.m., during observation of Unit B medication room with the Nurse Manager, two surveyors observed a flat with approx. 3/4 full of vacutainers with an expiration date of 9/30/24 available for use on residents. At this time, the Nurse Manager stated the vacutainers are used to collect residents' blood on the unit for the International Normalized Ratio (INR) labs. 2. On 10/7/24 at 2:52 p.m., during observation of Unit C medication room with the Assistant Director of Nursing (ADON), two surveyors observed a tote with over-the-counter medications on the counter containing the following open bottles available for use: One bottle of Calcium 600 plus D5 milligram (mg) with the expiration date of 6/2024, One bottle of daily multi-vitamin with minerals with the expiration date of 6/2024, and One bottle of Aspirin 325mg with the expiration date of 4/2024. At this time, during an interview, the Director of Nursing (DON) and the ADON stated that the tote is for the overflow of opened medications from the medication cart and are to be used first before obtaining a new unopened bottle from supply, confirming the medications are available to be used on residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37648 Based on observations and interviews, the facility failed to serve food in accordance with professional standards for food service safety and failed to follow their own policy and procedure by not delivering food in a sanitary manner for 1 of 2 units observed during dining service and tray pass for 2 of 3 days of survey. (B unit). Findings: Facilities Policy and Procedure for Dining/Meal service, dated 2023 states, All foods should be covered and delivered as soon as possible after plating to maintain food quality and temperature. 1. On 10/7/24 from 12:21 p.m., through 12:49 p.m., 2 surveyors observed the following during the lunch dining service on the B unit in the East dining room: Dietary staff plated the food and handed the uncovered plates to the nursing staff. Nursing staff placed the plates on a tray, added drinks condiments etc. then walked the uncovered food trays through the hallways, to the end of the [NAME] Wing, the [NAME] dining room, the family room and to the end of the East Wing. All trays observed during this dining service were served without being covered to maintain sanitary conditions. 2. On 10/8/24 at 8:44 a.m., 2 surveyors observed the following during the breakfast dining service on the B unit in the East dining room: Nursing staff delivered 2 trays of uncovered food to the end of the [NAME] Wing. In addition, observation of several trays prepped, uncovered and sitting on the dining room island for, approx. 2 mins then delivered to the rooms down the [NAME] Wing hallway, uncovered. 3. On 10/8/24 at 12:14 p.m., 2 surveyors observed the following during the lunch dining service on the B unit in the East dining room: Nursing staff delivered several trays of uncovered food to the end of the [NAME] Wing and the end of the East Wing. In addition, there were no covers available in the dining room for the food to be covered. On 10/8/24 at 12:39 p.m., during an interview with the Interim Administrator and the Director of Nursing (DON) the above was discussed. The DON stated they have never covered the food from the East dining room to the [NAME] dining room, only when they are delivering to rooms. At this time, the Interim Administrator, the DON and a surveyor observed the East dining room with no food covers available. The DON immediately educated staff and plate covers were requested from the kitchen.