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	12/19/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on facility policy review, controlled substance (Narcotic Bound) book and interviews, the facility failed to ensure that each nurse signed the controlled substance book after each shift count for 5 out of 5 medication/treatment carts observed.Findings:The facilities Management of Controlled Substances policy and procedure last reviewed 11/12/24 under section 6.5.1 states A count of Scheduled II drugs will be done at the change of shift, or when there is an exchange of keys, by two people who are authorized to administer medications, one of who must be a licensed nurse, utilizing the bound book from which no pages are removed. Accuracy of the count will be acknowledged with the two signatures of the staff members who performed the count and section 6.5.1.1 states, Count of the Schedule 3-5 drugs will be done at the change of each shift, or when there is an exchange of keys, by two people who are authorized to administer medications, utilizing the bound book from which no pages are removed. Accuracy of the count will be acknowledged with the two signatures of the staff members who preformed the count. 1. On 12/15/25 at 8:25 a.m., observation of the Narcotic Bound Book for Unit B nurse treatment cart containing Schedule II drugs with the Registered Nurse #1 (RN#1). The shift count sign off had multiple missing entries for narcotic reconciliation: on 8/2/25 day shift, 8/20/25 night shift, 10/21/25 day shift, 11/9/25 both evening and night shifts, 11/10/25 day shift, 11/12/25 day shift, 11/19/25 day shift, 11/21/25 evening shift and 11/27/25 evening shift. At this time, the RN#1 stated both the nurse coming on and the nurse going off are to count the narcotics and both sign the back of the narcotic book at the change of each shift.2. On 12/15/25 at 9:23 a.m., observation of the Narcotic Bound Book for Unit B Medication cart, containing Schedule 3-5 drugs, with the Certified Medication Technician (CNA-M) #1. The change of shift count had multiple missing entries for the narcotic reconciliation; on 10/11/25 night shift, 10/24/25 evening shift, 11/3/25 day shift, 11/10/25 day shift, 11/11/25 evening and night shift, 11/19/25 day shift, 11/23/25 night shift, 11/24/25 day shift and 12/3/25 day shift. At this time, the above missing entries were discussed with the CNA-M #1.3. On 12/15/25 at 9:52 a.m., observation of the Narcotic Bound Book for Unit C Medication cart, containing Schedule 3-5 drugs, with the Registered Nurse (RN) #2. The change of shift count had multiple missing entries for the narcotic reconciliation; on 11/4/25 day shift, 11/23/25 day shift, 11/24/25 evening shift, 12/1/25 evening and night shift, 12/2/25 day shift and 12/9/25 day shift.4. On 12/15/25 at 10:00 a.m. observation of the Narcotic Bound Book for Unit C nurse treatment cart, containing Schedule II drugs, for rooms C1 through C16 with the Licensed Practical Nurse (LPN) #1. The change of shift count had multiple missing entries for the narcotic reconciliation; on 7/31/25 evening shift, 11/2/25 night shift and 12/9/25 day shift.5. On 12/15/25 at 10:05 a.m. observation of the Narcotic Bound Book for Unit C nurse treatment cart, containing Schedule II drugs, for rooms C17 through C32 with the RN #3. The change of shift count had multiple missing entries for the narcotic reconciliation; on 8/8/25 day shift, 8/27/25 evening shift, 10/26/25 night shift, 11/2/25 night shift, 11/3/25 night shift and 11/4/25 day shift.On 12/15/25 at 12:57 p.m., during an interview, the above missing change of shift signatures for the narcotic reconciliation was discussed with the Director of Nursing.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a dish machine, a food disposal, fans, mixers, a shake machine and dessert dishes; and failed to ensure a large sugar bin was labeled and dated. Additionally, the facility failed to ensure that kitchen staff members with facial hair wore facial hair protection.Findings: On 12/15/25 from 8:10 a.m. to 8:50 a.m., a surveyor did an initial kitchen tour with the Food Service Director in which the following findings were observed: -The sides and top of the dish machine had a build-up of dried liquid residue and chemical residue. -The food disposal had dried food particles and dried liquid residue on it. -A large standing floor fan was dusty/dirty.-A shelf-top mixer had dried food particles on the unit and base.-A large standing floor mixer had dried food particles and dried liquid residue on the unit and base.-A commercial shake machine had dried food particles and dried liquid residue on the unit and base.-There were approximately one hundred stacked clear plastic dessert cups that had dried liquid residue and chemical residue on them. -A large bin of sugar was not labeled and dated.-Two male kitchen workers, observed to have facial hair, were not wearing facial hair protection. On 12/15/25 at 8:50 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure that a Minimum Data Set, Version 3.0 (MDS) was accurately coded for 1 of 1 resident reviewed for hospice (Resident #4). Resident #4's clinical record stated he/she was admitted into hospice for end of life care on 5/17/25. A Significant Change Assessment, with an Assessment Reference Date (ARD) of 5/23/25, and completed on 5/27/25; Section Treatments/Procedures:0: lacked evidence that Resident #4 was admitted to hospice.Review of facility provided Reason for Significant Change dated 5/20/25 states : [Resident #4] opened to Hospice under [Hospice] on 5/17. A significant change MDS has been scheduled. During an interview on 12/16/25 at 1:18 p.m., with 5 surveyors present. the Director of Nursing confirmed Resident #4's Significant Change MDS was initiated, but was not triggered for hospice.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure an expired medication was removed from the supply available for use in 1 of 5 medication/treatment carts observed (Unit C nurse treatment cart for rooms C1 through C16).Finding:On [DATE] at 10:00 a.m. during observation of the Unit C nurse treatment cart for rooms C1 through C16 with the Licensed Practical Nurse (LPN) #1, the cart contained an open Lantus insulin pen dated [DATE] with manufactures instruction to Use within 28 days after initial use. At this time LPN#1 confirmed the insulin had expired and retrieved a new insulin pen.