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 _____	C 06/26/2023

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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F 000	INITIAL COMMENTS On 6/26/23, an unannounced on-site visit was conducted at Maine Veterans Home - Caribou for the purpose of investigating a facility reported incident #ME00043043 and complaint #ME000043042. It was determined that Maine Veterans Home - Caribou was in past non-compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to supervise 1 of 1 residents (Resident #1) when the resident, who was wearing a secure care bracelet, was let outside while in their wheelchair by a staff member and left unsupervised. Because of the facility's failure, the resident while in their wheelchair left the paved sidewalk, rolled down a slight incline on a grassy hill which resulted in the wheelchair tipping over the parking lot curb and the resident sustained a forehead laceration that required sutures, facial abrasion, bruises, knee pain and left wrist pain. Finding:	F 689	Past noncompliance: no plan of correction required.	

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

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F 689	Continued From page 1 On 6/23/23, a facility reported incident and a complaint were received by the Division of Licensing and Certification that indicated that on 6/21/23 at 4:30 p.m., Resident #1 asked a staff member to go outside to which the staff member let Resident #1 outside and left him/her unsupervised. Resident #1 left the paved sidewalk, rolled down a slight include on a grassy hill and the wheelchair tipped over the parking lot curb which resulted in the resident hitting his/her head. Staff that were outside tending to a facility event (barbeque/cookout) immediately ran to assist the person in the tipped over wheelchair. On 6/21/23 at 4:45 p.m., Resident #1 arrived at the Emergency Room and was treated for a 2.0 centimeter forehead laceration with moderate tenderness and swelling that required 4 sutures, a large abrasion with controlled bleeding of the upper central forehead, and both knees had a small abrasion located on each patella [kneecap]. On 6/21/23 following the incident, a "Fall Scene Investigation Report" was completed by the Charge Nurse (CN) that indicated at 4:30 p.m., "[Resident #1's] wheelchair hit curb, flipping [Resident] out of chair into parking lot." A Huddle and Staffing was completed at 5:00 p.m., which the discussion was about what happened and what can we (facility) do to prevent future falls. It was noted that, "[Resident] was outside unattended and that [Resident #1] told employee (Activities Aide) that the CN said the resident can go outside - this was not verified with CN before letting resident outside. [Resident] was wearing secure care at time of fall." The cause of the fall, was "outside unattended." Interventions initiated, "not to be outside without supervision, secure care, education to staff." The investigation	F 689		

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F 689	Continued From page 2	F 689		

section included relevant health history that could have contributed to falls of dementia and history of falls.

On 6/22/23, Resident #1 was re-examined by a Primary Care Provider. Resident #1 complained of left hand/wrist and knee pain since the fall. X-ray images were ordered for the left knee and left wrist due to pain and were negative for fractures.

On 6/26/23 at 9:05 a.m., the surveyor observed Resident #1 who was in a wheelchair and seated at a table with his/her brother. The surveyor observed Resident #1 with bruising to both eyes and a large bandage to the forehead. The left arm was also wrapped with an elastic-like bandage and the surveyor observed a staff member place a pillow under Resident #1's left arm. The surveyor asked Resident #1 what happened. Resident #1 stated, "I fell off the step outside" as he/she was looking out the door they had been let out. The surveyor also asked Resident #1 if he/she usually went outside by him/herself and the resident replied, "no".

On 6/26/23, a review of Resident #1's current care plan indicated the resident was care planned for care areas of "behavior of wandering related to dementia with exit seeking behaviors" on 1/26/23 and "potential for falls" on 11/9/22.

The facility policy, "Elopement Alert System", last reviewed 5/23/23, included the following procedure: "When a resident is found to be an elopement risk the resident will be fitted for the alert system (secure care). Residents with an alert system desiring to leave will be allowed to do so with resident representative, family, staff or

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F 689	Continued From page 3	F 689		

other visitors and that facility staff are responsible for responding to door alarms to ensure resident safety."

On 6/26/23 at 8:10 a.m., during an interview with a surveyor, the Administrator stated that there were four staff outside tending to a staff barbeque (herself included) and they watched this person in a wheelchair roll (down the slight incline of a hill). As soon as the wheelchair tipped over, they ran to assist the person. The Administrator stated, "At first, we didn't know that it was our resident and thought it could be someone from the hospital going to their car. Resident #1 has a laceration across his/her forehead but no broken bones."

On 6/26/23 at 9:30 a.m., during an interview with a surveyor, the Activities Supervisor (AS) stated that Resident #1 is not 100% cognitively with it and that the resident moves about the facility slow, not strong or quick and gets pushed from place to place usually, but can move about on his/her own. When asked about the secure care alarm system, AS stated that you have to enter a code to deactivate it and the alarm will not go off once you enter a code even if the resident wears a secure care.

On 6/26/23 at 10:10 a.m., during an interview with a surveyor, the CN stated, "Resident #1 was alert to person, place, and time but forgets his/her own limitations and gets confused to his/her own abilities. Resident #1 thinks he/she can walk sometimes. Resident #1 never talked to me about going outside, he/she was in activities and the music thing was all done before he/she went outside." After the incident the CN stated she told the Activities Aide (AA), "we don't let any

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residents outside without supervision." AA told the CN that Resident #1 told her that he/she had permission to go outside by the nurse, which he/she did not.

On 6/26/23 at 11:07 a.m., during a telephone interview with a surveyor, AA stated that Resident #1 said to her, "I want to go out. I asked Resident #1 if he/she had permission and Resident #1 told me that he/she could go out anytime he/she wanted." AA stated she asked Resident #1 three times if he/she had permission, all to which Resident #1 told AA, yes. AA stated that Resident #1 had never lied to her before so she had no reason not to believe the resident. AA stated she entered the code and Resident #1 kicked open the door and that she helped Resident #1 out the door in the wheelchair and locked the wheels. AA stated that no sooner then she turned her back, the Administrator came running in the door. The surveyor asked AA if she would normally let a resident outside unsupervised. AA stated that is not her normal duty which is why she questioned Resident #1 about the permission part several times. AA stated, "I figured that if Resident #1 said that he/she had permission 3 times, I figured it must be fine, but it was not and he/she lied to me." The surveyor asked AA about the Resident Monitoring System and secure care bracelets. AA stated, "when they talked to me the next day, I was asked if I knew he/she had a bracelet .....I thought everyone had a bracelet. I thought that once they were put in there, they all had it ... ...I don't know why I had to enter the code to get out ... ...I thought you had to enter a code to just get out. I didn't even know what that was until I asked the next day. I didn't know that is what it was called. I assumed that because they put

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F 689	Continued From page 5 bracelets on, they all had them." AA stated that she completed orientation in November 2022, when she was hired per-diem, but does not remember this. On 6/26/23 at 11:30 a.m., during an interview with a surveyor, the Staff Development Coordinator (SDC) stated she was the one that completed the orientation with AA and that she did go over the Resident Monitoring Systems which included the secure care. The SDC also stated that she tells the new staff if they have any questions to always go to their Charge Nurse or Supervisor. She stated that the "New Employee Orientation Classroom Checklist" was signed by the employee and herself after orientation was completed. As a result of the this isolated incident, the following corrective actions were initiated: - On 6/21/23, Resident was assessed immediately by Charge Nurse and sent to Emergency Room; - On 6/21/23, the Charge Nurse, educated the evening shift staff (1:45 p.m. - 10:15 p.m.), after the incident, by informing staff of the following: Residents are not to go outside by themselves and while in an outdoor setting, residents need supervision by a staff member or a family member that has gotten permission by a nurse. The Charge Nurse also shared this information with the oncoming nurse, who was relieving her at 6:15 p.m. - On 6/22/23, the Charge Nurse, educated the day shift (6:15 a.m. - 2:15 p.m.) during report that Residents are not to go outside by themselves	F 689		

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F 689	Continued From page 6 and while in an outdoor setting, residents need supervision by a staff member or a family member that has gotten permission by a nurse. - On 6/22/23, Primary Care Provider also evaluated Resident #1 and additional x-rays were ordered which were negative; - Neuro checks and wound care were completed as ordered for Resident #1; - Activities Aide was suspended pending investigation and was terminated 6/26/23; - A mass email was sent to staff on 6/26/23 reminding staff about the practice of residents going outside; - The facility will provide education on Elopement Alert System and the Elopement Risk Assessment and develop a Resident Outdoor Protocol with staff education on the steps involved, both to start immediately with a target date of completion of July 8th.	F 689		