

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/17/2025
NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - SCARBOROUGH			STREET ADDRESS, CITY, STATE, ZIP CODE 290 US RT 1 SCARBOROUGH, ME 04074		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/17/25, an unannounced on-site visit was conducted at Maine Veterans Home-Scarborough for the purpose of an investigation of a facility reported incident #ME00051787. It was determined that Maine Veterans Home-Scarborough was not in substantial compliance with 42 CFR 483, Sub-part B-Requirements for Long Term Care Facilities.	F 000			
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, written statements and review of the facility's internal investigation, the facility failed to ensure that 1 of 3 residents reviewed for dignity (Resident #1) was treated with respect during care provided after a fall. Finding: Resident #1 experienced two falls on 5/26/25. The first fall, at approximately 11:25 a.m., was documented as a loss of balance. Staff appropriately used a mechanical lift to assist Resident #1 from the floor in accordance with the facility's no-lift protocol.	F 557			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/09/2025

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.

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F 557	Continued From page 1 The second fall, at approximately 4:50 p.m. near the nurse's station, was witnessed by Certified Nursing Assistant #1 (CNA), who observed the Resident #1 fall to his/her right side. CNA #1 responded immediately and held the resident's head until CNA #5 arrived. CNA #1 directed CNA #5 to notify the charge nurse, Licensed Practical Nurse #1. (LPN) CNA #1 reported that when LPN #1 arrived, she told staff that because the fall was witnessed, it "did not count" as a fall and instructed staff to stand the resident up. CNA #1 recalled a disagreement between RN #1 and LPN #1 regarding the use of a mechanical lift. LPN #1 disregarded the concern and proceeded to lift Resident #1 with CNA #5. CNA #1 stated that the resident provided no more than 10% effort. CNA #1 stated that she observed CNA #5 and LPN #1 "pick Resident #1 up off the floor under [his/her] arms." CNA #2 reported observing CNA #5 and LPN #1 "grabbing Resident #1 under the arms and drag [him/her] down the hallway to [his/her] room." CNA #2 described staff struggling to get Resident #1 into bed and stated she yelled for them to support him/her by the back of his/her pants to prevent another fall. CNA #2 stated that the resident was not bearing weight, and staff used substantial strength to complete the transfer. CNA #5 stated that LPN #1 said, "Come on, let's just pick [him/her] up." CNA #5 acknowledged that lifting the resident manually was against facility protocol, but said he followed orders, stating, "I was just following orders from my boss." CNA #5 described the resident as unable	F 557			

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F 557	Continued From page 2 to walk, saying, "It was more accurate to say that we were dragging [him/her]." Once in the room, CNA #5 reported that the resident pushed downward, appearing to try to return to the floor. LPN #1 responded, "[He's/She's] just doing this on purpose. [He/She] does this." Staff then lifted Resident #1 into bed and swung his/her legs up. LPN #1 stated the Resident #1 mumbled but did not answer pain questions. She reported Resident #1 initially walked without signs of pain, later refused to continue, and became combative. She stated Resident #1 moaned during care but could not determine whether the pain was in the right or left leg. RN #1 stated she was informed by CNA #5 that the resident had a "hard fall." When RN #1 arrived, the resident was still on the floor. Upon confirming it was the second fall of the day, RN #1 asked if the mechanical lift was being used. LPN #1 asked if the fall had been witnessed and if the resident had hit his/her head. When CNA #1 confirmed the fall had been witnessed and there was no head injury, LPN #1 said, "Then [he/she] doesn't need the lift. We can just get [him/her] up." On 6/17/25 at 2:55 p.m., during an interview with the surveyor, the Director of Nursing (DON) stated that the facility does not have a formal written policy requiring the use of a mechanical lift after a fall. However, the DON confirmed that it is covered in new employee orientation and is considered part of facility protocol, as the facility operates as a "no-lift" environment. Staff are expected to use mechanical lifts rather than physically lift residents under normal circumstances, including post-fall .	F 557			

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