

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

RECEIVED

PRINTED: 11/25/2024
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 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 000	Initial Comments Federal Recertification Survey Survey Date: 11.19.2024 Maine Veterans Home Scarborough, a long-term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness.	E 000			
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dalmon Noting</i>			TITLE <i>Administrator</i>		(X6) DATE <i>12/9/2024</i>

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.

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

RECEIVED

PRINTED: 11/25/2024
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 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 024	Continued From page 1 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to have a plan to utilize volunteers for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 11.19.2024, between 9:00 AM and 1:00 PM, a surveyor, with the Maintenance Director and Administrative Assistant present, observed the following: 1. The was no evidence in the emergency preparedness plan for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. The surveyor confirmed this finding with the Maintenance Director and Administrative	E 024			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 024	Continued From page 2	E 024			
E 037	Assistant at the time of the observation.	E 037			
SS=F	EP Training Program CFR(s): 483.73(d)(1)				
	§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing				

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 037	Continued From page 3 hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.	E 037			

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

PRINTED: 11/25/2024
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 01 B. WING _____		RECEIVED JAN 14 2025 (X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 037	Continued From page 4 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new	E 037			

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

PRINTED: 11/25/2024
FORM APPROVED

RECEIVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 037	Continued From page 5 and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH	E 037			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING BY		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 037	Continued From page 6 must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d).] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to provide Emergency Preparedness training annually in accordance with 42 CFR 483.73 Finding: Based on interview and documentation review on 11.19.2024, between the hours of 9:00 AM and 1:00 PM, this surveyor accompanied with the Maintenance Director and Administrative Assistant observed the following: 1. No documentation of initial training in emergency preparedness policies and procedures to all individuals providing services under arrangement consistent with their expected roles. The surveyor confirmed this finding with the Maintenance Director and Administrative Assistant	E 037			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING BY: 107-14-200		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 037	Continued From page 7 at the time of the observation.	E 037			
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based	E 039			

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

PRINTED: 11/25/2024
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 01 B. WING _____		RECEIVED 11/19/2024 (X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 8 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or	E 039			

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

RECEIVED

PRINTED: 11/25/2024
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 01 B. WING BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 9 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the	E 039			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING BY		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 10 hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the	E 039			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 11 [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.	E 039			

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

PRINTED: 11/25/2024
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 01 B. WING		RECEIVED 11/19/2024	(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 12 *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d):] (2) Testing. The ICF/IID must conduct exercises	E 039				

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING BY: --		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 13 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not	E 039			

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

PRINTED: 11/25/2024
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 01 B. WING _____ BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 14 accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group	E 039			

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

PRINTED: 11/25/2024
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 01 B. WING BY: 11/19/2024		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 15 discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at \$403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the long term care facility failed to participate in a full-scale exercise of the Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding:	E 039			

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

PRINTED: 11/25/2024
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 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
E 039	Continued From page 16 Based on interview and documentation review on 11.19.2024, between the hours of 9:00 AM and 1:00 PM, this surveyor accompanied with the Maintenance Director and Administrative Assistant observed the following: 1. A full-scale exercise or table top has not been conducted at this facility, they could provide only 1 real world incident on 04.04.2024 with AAR. Previous one was performed on 10.14.2023	E 039			
K 000	The surveyor confirmed this finding with the Maintenance Director and Administrative Assistant at the time of the observation. INITIAL COMMENTS Federal Recertification Survey: Date: 11.19.2024 Maine Veterans Home Scarborough, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211			

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

PRINTED: 11/25/2024

FORM APPROVED

RECEIVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ BY: _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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
K 211	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the aisles, passageways, corridors, exit discharges, exit locations, and accesses free of all obstructions to full use in case of emergency in 1 of 1 resident care wings per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.2.1, and 7.1.10.1 Finding: On 11.19.2024, between 09:00 AM and 1:00 PM, this surveyor, observed the following finding with the Maintenance Director present. 1. A med cart was plugged into a corridor outlet, not in use and stored in the egress corridor. The surveyor confirmed this finding with the Maintenance Director at the time of the observation and review.	K 211			
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
K 222	Continued From page 18 rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS	K 222			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ BY _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
K 222	Continued From page 19 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on Observations the facility failed to ensure doors at the means of egress meet the requirement of NFPA 101 life safety code 2012 edition 19.2.2.2.5.1, 19.2.2.2.6 for locking. Findings: On 11.19.2024, between 9:00 AM and 1:00 PM, a surveyor, with the Maintenance Director present, observed the following: A Unit cooridor exit door leading to patio and dining room exit door and B Unit corridor exit door leading to patio were locked and the inspector could not exit the building unless staff unlocked the door. The doors are marked "Push until alarm sounds door can be opened in 30 seconds". When panic bar was pressed no alarm sounds and doors did not unlock after 30 seconds. This effected 2 of 4 of the wings. The surveyor confirmed these findings with the Maintenance Director at the time of the observation.	K 222			
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance	K 324			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
K 324	Continued From page 20 with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long-term care facility failed to maintain the grease filter arrangement so that all exhaust air passes through the grease filters per NFPA 101, Life Safety Code, 2012 Edition, Sections 9.2.3, and 19.3.2.5.1. Also reference NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 6.2.3.3. Finding: On 11/19/2024, between 09:00 AM and 1:00 PM,	K 324			

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

RECEIVED

PRINTED: 11/25/2024
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 01 BY: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
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	
K 324	Continued From page 21 this surveyor, observed the following finding with the Maintenance Director present. 1. The grease filter in the commercial cooking hood above the steamer was dented and damaged that leaves a space between the filters that allow grease laden vapors to pass around the filters and in the ductwork. The surveyor confirmed this finding with the Maintenance Director at the time of the observation and review.	K 324			
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors	K 363			

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

PRINTED: 11/25/2024
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ BY: _____	(X3) DATE SURVEY COMPLETED 11/19/2024
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
K 363	Continued From page 22 meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the long-term care facility failed to maintain the resident room doors in the corridor to resist the passage of smoke in one of three resident care wings per NFPA 101, Life Safety Code, 2012 Edition, Section 19.3.6.3. Finding: On 11/19/2024, between 09:00 AM and 1:00 PM, this surveyor, observed the following finding with the Maintenance Director present. 1. Resident room door C6 did not latch, as the latching mechanism did not line up with the hole in the striker plate on the frame. The surveyor confirmed this finding with the Maintenance Director at the time of the observation.	K 363		



MAINE VETERANS' HOMES

caring for those who served

An independent nonprofit organization serving Maine's Veterans and families

12/9/2024

RECEIVED

DEC 11 2024

BY: _____

Dear Mr. Day,

As a result of the statement of deficiencies (SOD) received on 11/25/2024 and request for revision 12/5/2024 via email, please see the attached plan of correction.

E024 Policies/Procedures – Volunteers and Staffing No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. EOP manual contains reference to existing policies EM03 Emergency Preparedness and EM06 Volunteer Policy which both identify emergency preparedness plan for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Maintenance Director or designee will complete random monthly audits of table of contents of EOP Manual x3 months with results being reported to the facility's QAPI committee. Completion date: 11/19/2024

E037 EP Training Program No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. All contract labor staff will complete training for emergency preparedness policies and procedures at initial onboarding and annually to ensure staff knowledge of emergency procedures. A tracking system will be implemented for completed training for all contract labor staff. The DON or designee will complete random audits monthly of the training process x 3 months with results being reported to the facility's QAPI committee. Completion Date: 12/3/2024

E039 EP Testing Requirements No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. An actual event in the prior 12 months was recorded and maintained in a separate binder and not in the EOP manual. The facility does have a documented After Action Report and Education for an elopement/lost resident completed 6/26/2024 which is now in the EOP manual. The template for facility QAPI minutes includes documentation of Professional Policy Review and have now added a line for dates of Emergency Plan Exercises to be reviewed at quarterly QAPI meetings to ensure compliance with conducting exercises to test the emergency plan at least twice per year. The Administrator or designee will complete random audits to review dates of exercises x 3 months with results being reported to the facility's QAPI committee. Completion Date: 12/4/2024

K211 Means of Egress – General No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. Med cart was immediately removed from the egress corridor and relocated to an approved charging area. Staff re-educated on the importance of maintaining clear egress pathways and adhering to storage policies. Maintenance Director or designee

AUGUSTA

35 Heroes Way
AUGUSTA, ME 04330
1-888-684-4464

BANGOR

44 HOGAN ROAD
BANGOR, ME 04401
1-888-684-4665

CARIBOU

163 VAN BUREN ROAD
CARIBOU, ME 04736
1-888-684-4667

MACHIAS

32 VETERAN WAY
MACHIAS, ME 04654
1-877-866-4669

SCARBOROUGH

290 US ROUTE 1
SCARBOROUGH, ME 04074
1-888-684-4666

SOUTH PARIS

477 HIGH STREET
SOUTH PARIS, ME 04281
1-888-684-4668

CENTRAL OFFICE

460 CIVIC CENTER DRIVE
AUGUSTA, ME 04330
1-800-278-9494

WWW.MAINEVETS.ORG



MAINE VETERANS' HOMES

caring for those who served

An independent nonprofit organization serving Maine's Veterans and families

RECEIVED

DEC 11 2024

will complete random audits x3 months to ensure compliance with results being ^{3Y:}reported to the facility's QAPI committee. Completion Date: 12/6/2024

K222 Egress Doors No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. Provide all staff with laminated card identifying codes for A unit corridor exit door leading to patio and dining room exit door. This laminated card will be provided to all existing staff and new hires moving forward. These cards can be kept in current plastic sleeve that staff store their badge in. Random audits will be completed by Administrator or designee x3 months to ensure compliance with results being reported to the facility's QAPI committee. Completion Date: 12/13/2024

For A unit egress doors to patio, vendor on site 12/5/2024 for repair (see attached work order).
Completion date: 12/5/2024

For B unit corridor exit door leading to patio vendor on site 12/5/2024 to repair door. (see attached work order) Maintenance Director or designee will complete random audits x3 months on exit doors to ensure doors at the means of egress meet requirement with results being reported to the facility's QAPI committee. Completion Date: 12/5/2024

K324 Cooking Facilities No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. Order has been placed for a Galvanized Hood Filter (see attached invoice). Tracking number identifies that item is currently in NJ with planned shipment to MA. Maintenance Director or designee will complete random audits x3 months to ensure compliance with results being reported to the facility's QAPI committee. Completion Date: 1/8/2025 or sooner depending on delivery date of item.

K363 Corridor – Doors No residents were harmed by this finding, however some residents and staff had the potential to be impacted by the finding. Resident door C6 was immediately inspected and repaired to ensure it latches properly. Facility staff re-educated on the importance of ensuring doors latch properly for resident safety, privacy and regulatory compliance. Maintenance staff will continue to perform monthly inspections to identify and repair any doors that do not latch. Maintenance Director or designee will complete random audits x3 months to ensure compliance with results being reported to the facility's QAPI committee. Completion Date: 12/6/2024

Thank you for your review of the proposed plan of correction. As stated above the proposed correction date for the statement of deficiencies is 1/8/2025.

Patricia Nutting, Administrator

AUGUSTA

35 Heroes Way
AUGUSTA, ME 04330
1-888-684-4464

BANGOR

44 HOGAN ROAD
BANGOR, ME 04401
1-888-684-4665

CARIBOU

163 VAN BUREN ROAD
CARIBOU, ME 04736
1-888-684-4667

MACHIAS

32 VETERAN WAY
MACHIAS, ME 04654
1-877-856-4669

SCARBOROUGH

290 US ROUTE 1
SCARBOROUGH, ME 04074
1-888-684-4666

SOUTH PARIS

477 HIGH STREET
SOUTH PARIS, ME 04281
1-888-684-4668

CENTRAL OFFICE

460 CIVIL CENTER DRIVE
AUGUSTA, ME 04330
1-800-278-9491

WWW.MAINEVETS.ORG



MAINE VETERANS' HOMES

caring for those who served

An independent nonprofit organization serving Maine's Veterans and families

RECEIVED

DEC 19 2024

BY: _____

12/9/2024

Dear Mr. Cyr,

Please see the attached revised Plan of Correction and supportive documentation.

K324 Please see the attached invoice from HoodFilters.com. Installation date will be dependent on delivery of Hood Filter. Completion date: 1/8/2025 or sooner depending on delivery

K222- Please see the attached work order from A3. Completion date: 12/9/2024

Thank you for your review of this revised Plan of Correction.

Patricia Nutting, Administrator

AUGUSTA

35 Heroes Way
AUGUSTA, ME 04330
1-888-684-4464

BANGOR

44 HOGAN ROAD
BANGOR, ME 04401
1-888-684-4665

CARIBOU

163 VAN BUREN ROAD
CARIBOU, ME 04736
1-888-684-4667

MACHIAS

32 VETERAN WAY
MACHIAS, ME 04654
1-877-866-4669

SCARBOROUGH

290 US ROUTE 1
SCARBOROUGH, ME 04074
1-888-684-4666

SOUTH PARIS

477 HIGH STREET
SOUTH PARIS, ME 04281
1-888-684-4668

CENTRAL OFFICE

460 CIVIC CENTER DRIVE
AUGUSTA, ME 04330
1-800-278-9494

K324

RECEIVED

SEP 18 2014

Patty Nutting,

BY: _____

From all of us at HoodFilters.com, we want to thank you for your order. For reference, your order number is #2106961.

Once it ships, we'll email you tracking information. Please monitor your email for Shipment notifications which will have the tracking numbers and estimated delivery dates. In the meantime, you can view the estimated shipping date by signing into your account. We must be notified within 5 business days of delivery regarding any missing or damaged items. Please reply to this email if you have any questions.

Item	Sku	Qty	Subtotal
16" Tall x 20" Wide Mavrik Galvanized Hood Filter	A6G1620	3	\$87.00
		Subtotal	\$87.00
		Shipping	\$25.95
		Grand Total	\$112.95

Shipping Method:

UPS - Ground

Payment Method:

Credit Card

Billing Information:

Patty Nutting
Maine Veterans Home
460 Civic Center Dr
460 Civic Center Dr
Augusta, Maine, 04330
United States
T: (207) 289-3418
josephlepauloue@mainevets.org

Shipping Information:

Joe LePauloue
Maine Veterans Home
290 US Route One
290 US Route One
Scarborough, Maine, 04074
United States
T: (207) 289-3418

K222

Patty K. Nutting

From: Joseph Lepauloue
Sent: Monday, December 9, 2024 10:05 AM
To: Patty K. Nutting
Subject: FW: <External>Re: Ticket # 238019 / mvhomes / Egress Doors

RECEIVED

BY: _____

Thanks

Joe

From: A3 Customer Service <help@a3communications.com>
Sent: Monday, December 9, 2024 10:02 AM
To: Joseph Lepauloue <josephlepauloue@MaineVets.org>
Subject: <External>Re: Ticket # 238019 / mvhomes / Egress Doors

Zachary Van Velkenburg

12/9/2024 10:01 AM



Good morning,

Please see the notes below from the technician.

Did walk through and discussed issue with all three doors. Began troubleshooting. Discovered that door one in B unit was working properly. Had maintenance person place crash bar in locked position to eliminate occasional alarm from movement of door. Tightened mag lock at door two in A unit and disconnected alert wire running to nurse station. Tested. Discovered after several tests that door three in A unit is also working properly. Customer will remove emergency sticker from doors two and three in A unit.

Thank you,
Zach

--REPLY above this line to respond--

Summary:

Egress Doors

Status: Assigned*
Ticket # 238019
Company: Maine Veterans' Home - Scarborough
Contact: Joseph Lepauloue
Phone: (207) 883-7184
Address: 290 US Route 1
Scarborough, ME 04074

Discussion

Joseph Lepauloue

12/3/2024 9:47 AM

Could I please get a service technician to look at (3) Egress Doors.

A Unit cooridor exit door leading to patio and dining room exit door and B Unit corridor exit door leading to patio were locked and the inspector could not exit the building unless staff unlocked the door. The doors are marked "Push until alarm sounds door can be opened in 30 seconds". When panic bar was pressed no alarm sounds and doors did not unlock after 30 seconds. This effected 2 of 4 of the wings.

RECEIVED

BY: _____

These are findings from a recent State Fire Marshal inspection.

Thanks

Joe

Joe LePauloue
Facilities Manager
Maine Veterans Home
290 U.S. Route 1

Scarborough, Maine 04074
207-289-3418 Desk
207-232-8812 Cell