STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bangor Nursing & Rehabilitation Center	103 Texas Ave Bangor, ME 04401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 32540 Based on record reviews, and interviews, the facility failed to provide evidence to show Advance Directives were offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an Advance Directive, for 7 of 14 residents reviewed for Advance Directive. (Resident #19 [R19], R16, R17, R11, R18, R37 and R102) Findings: 1. R19 was admitted to the facility on [DATE]. A review of R19's clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 2. R16 was admitted to the facility on [DATE]. A review of R16's clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 3. R17 was admitted on to the facility on [DATE]. A review of R17's clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 4. R11 was admitted on to the facility on [DATE]. A review of R11's clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. R11's Admission packet did not have the section addressing Advance Directives completed. On [DATE] at 2:00 p.m. during an interview with the Administrator, she stated they looked in the Social Service office and found 2 folders one for POLST and one that had the State of Maine health care Advanced Directives form labeled your right to choose. Per the Administrator there is no evidence in that office or in the resident records to show Advanced directives were offered or reviewed with the resident or the representatives. (continued on next page)

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	The above findings were confirmed by the surveyor at the time of this interview. 33242 5. On [DATE], R18's clinical record was reviewed and indicated that R18 was admitted on [DATE]. The clinical record lacked evidence of the Advance Directive being offered or reviewed as the Admission Face Sheet, signed by R18 on [DATE] for the question: have advance directives been discussed with responsible party was not answered and there was not a Medical Power of Attorney document on file. On [DATE] at 3:06 p.m., an email was sent to the Administrator requesting Advance Directive information for residents that included R18. On [DATE] at 7:25 a.m., during an interview with a surveyor, Social Services Interim stated she started in mid-November and during the admission process, she does not provide an Advance Directive packet to the responsible party and only reviewed the code status with the resident/family. On [DATE] at 10:15 a.m., documents were provided by the facility regarding what they could find for Advance Directive information in the clinical records. At 10:37 am., during an interview with a surveyor, the Admissions Coordinator stated she was unable to find any additional information in R18's clinical record as of this time but the Business Office Manager stated R18's family was called and would bring in paperwork today. 49635 6. R37 was admitted to the facility on [DATE]. A review of R37's clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 7. R102 was admitted to the facility on [DATE]. A review of R37's clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. On [DATE] at 7:48 a.m., during an interview with Registered Nurse #1 (RN1), R102's advanced directive regarding code status (cardiopulmonary resuscitation [CPR]) was reviewed. R102's electronic medical record indicated a code status of DO NOT RESUSCITATE (Do not provide CPR). RN1 stated demographics are printed for reference in case of power and / or internet failure. R102's printed demographic, located at the nurse's station indicated a codes status of FULL CODE (provide CPR). At this time the surveyor confirmed the facility had conflicting choices for code status for R102. On [DATE] at 2:00 p.m., during an interview with 3 surveyors, the Administrator stated there is no evidence in the Social Services office or in the resident's records to show Advanced directives were offered and/or reviewed with the resident and/or their representative. At this time a surveyor confirmed the above findings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32540 Based on record reviews and interview, the facility failed to notify the Provider of a change in status for 1 of 1 sampled resident (Resident #11[R11]). Finding: On 12/16/24 at 3:01 PM during a clinical record review for R11, a nursing note dated 10/11/24 labeled Health Status note documents that R11 vomited once, a large amount (copious) of dark brown/black liquid with undigested food and medication. Bowel sounds were noted to be less active than normal (hypoactive) but active (positive) in all four sections (quadrants). Low pitched (Course crackles) were heard (auscultated) throughout all lung lobes. Afebrile at 98.0. pulse 87, BP 97/66 though patient frequently is hypotensive. O2 95% on RA, respirations 20. Resident does present with cough, although this is not a new finding. Resident states he/she feels better since vomiting. He/She denies any further nausea. Will continue to observe. Upon Further review of his/her clinical record R11 has a Physicians order dated 8/10/24 to notify provider if recurrence in condition (vomiting) occurs. There is no evidence in the clinical record that the provider was made aware of the occurrence on 10/11/24. On 12/18/24 at 3:45 PM, during an interview with the Director of Nurses the surveyor confirmed that there is no documentation or evidence to support that R11's Provider was made aware of the above incident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 1 of 1 environmental tour (12/18/24). Findings: On 12/18/24, between 10:47 a.m. through 11:13 a.m., an environmental tour was completed with the Director Plant Operations, Healthcare Services Group District Manager, and three surveyors, the following findings were confirmed at the time of observations: 1. - In room [ROOM NUMBER], there was paint chipped near both televisions and by the headboard for Bed 2. The metal bed enabler on Bed 1 had chipped paint. - In room [ROOM NUMBER], both nightstand coverings were damaged, the wall above the sink was damaged, there was a water-stained ceiling tile, there were handles missing on the dresser drawers, the trim on the headboard and footboard for Bed 1 were broken, the metal bed enablers for Bed 1 had chipped paint and the bedside table edges were damaged. - In room [ROOM NUMBER], there were 2 wooden chairs with yellow vinyl seats that were torn/cracked, creating an uncleanable surface. The outside of the windows had visible dust and dirt on the windows. The window was dirty inside and out. - Resident # (R) 13's wheelchair back was cracked, creating an uncleanable surface. - In room [ROOM NUMBER], on the wall to the left of the sink there was missing/gouged area under a plastic shelf. 49635 2. -In room [ROOM NUMBER], the walkers stored behind the door were heavily soiled with crusted debris. -The left arms rest on Resident #17's wheel chair was ripped, creating an uncleanable surface. 35904 3. - In room [ROOM NUMBER], Bed 1, there was chipped paint on the trapeze (a metal triangular mobility appliance). - In room [ROOM NUMBER], the outside of the windows had visible dust and dirt on the windows. - In the horseshoe shaped hallway there were multiple areas on the walls that were patched but not painted.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 32540 Based on record reviews and interviews, the facility failed to incorporate recommendations from the Preadmission Screening Resident Review (PASARR) level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 3 of 4 sampled resident (Resident #19 [R19, R16, and R37]). Findings: 1. On 12/17/24 at 9:58 a.m., during a record review of R16's clinical record, the PASARR II dated 10/7/24 has the PASRR determination explanation that R16 met the State of Maine's definition for serious mental illness due to a diagnosis of depression over the past three to six months, your diagnosis has led to intermittent functional limitations in interpersonal functioning, concentration or adaptation to change. Onset of symptoms and persistence causes significant distress and impairment in your ability to function independently. R16's PASRR Level II required: Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. Peer Support Services, delivered by a Certified Mental Health Peer Support Specialist Ongoing psychiatric service by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services: you may benefit from ongoing medication management to be sure your mental health medications continue to work for you. Rehabilitative services: You will need to be provided the following services and/or supports: Service or Support for socialization/leisure/recreation activities, Supportive Counseling from NF Staff. The reason for these supports is below. Socialization/Leisure/Recreation Activities: Being around others is important to reduce loneliness and isolation and provide support. Supportive Counseling from NF staff: Support and validation from caregivers is important for emotional wellbeing and could assist with symptoms as they occur. On 12/18/24 11:07 a.m, during an interview and review of R16's care plan with the Director of Nurses (DON) and a 2nd surveyor there is no evidence that the Level II services were included in care plans or provided to R16. The DON stated she just got off the phone (12/18/24) with Acadia and they are looking at a 15 month wait list for Psychiatric services. The DON was observed entering an intervention for continued mental health care, the surveyor asked if she knew what services R16 qualified for and the DON stated she was not aware and has not read the Level II. 2. 12/17/24 07:52 a.m., during a record review of R19's clinical record, the PASARR II dated 11/7/24 has the PASRR determination explanation that R19 met the State of Maine's definition for serious mental illness due to a diagnosis of bipolar disorder and anxiety. Over the past three to six months, your diagnoses have led to intermittent functional limitations in interpersonal functioning, concentration or adaptation to change. Onset of symptoms and persistence causes significant distress and impairment in your ability to function independently. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19's PASRR Level II required: Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. You may benefit from ongoing medication management to be sure your mental health medications continue to work for you. Rehabilitative services: You will need to be provided the following services and/or supports: Service or Support for socialization/leisure/recreation activities, Family involvement in the individual's care Supportive Counseling from NF Staff. The reason for these supports is below. Socialization/Leisure/Recreation Activities: Being around others is important to reduce loneliness and isolation and provide support. You also enjoy bingo, coloring and music. Supportive Counseling from NF staff: Support and validation from caregivers is important for emotional wellbeing and could assist with symptoms as they occur. Family involvement in the individual's care: your family is very important to you. Your caregivers should promote a continued connection with your nephew. On 12/18/24 11:07 a.m, during an interview and review of R19's care plan with the Director of Nurses (DON) and a 2nd surveyor there is no evidence that the Level II services were included in care plans or provided to R19. The DON stated she just got off the phone (12/18/24) with Acadia and they are looking at a 15 month wait list for Psychiatric services. 49635 3. On 12/17/24, during a record review of R37's clinical record, the PASARR II dated 10/2/24 has the PASRR determination explanation that R37 met the State of Maine's definition for serious mental illness due to a diagnosis of depression and anxiety. Over the past three to six months, your diagnoses have led to intermittent functional limitations in interpersonal functioning, concentration or adaptation to change. Onset of symptoms and persistence causes significant distress and impairment in your ability to function independently. R37's PASRR Level II requires: Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. You may benefit from ongoing medication management to be sure your mental health medications continue to work for you. Individual Therapy by a licensed behavioral health professional (may include mobile therapy): You may benefit from individual counseling which could help you learn coping skills and provide a consistent person to talk with. This additional emotional support and social interaction may be beneficial to you. Rehabilitative services: You will need to be provided the following services and/or supports: Education regarding medication compliance and/ or side effects, Socialization/Leisure/Recreation Activities, Family Involvement in the Individual's Care, Supportive Counseling from NF Staff, [and] A Behaviorally-Based Treatment Plan. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 11:07 a.m., during an interview with the Director of Nurses (DON) and a 2nd surveyor, R37's care plan was reviewed. The DON stated she just got off the phone (12/18/24) with Acadia, who had offered R37 a telehealth option. The DON felt R37 would not be a good candidate for the telehealth option, so R37 was placed on an in person wait list with an estimated 15 month wait for Psychiatric services. At this time 2 surveyors confirmed there is no evidence that the Level II services were provided to R37 or included in the care plan.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record reviews and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 2 residents reviewed that were admitted in the last 30 days (Resident #54 [R54]), Finding: On 12/16/24, R54's clinical record was reviewed which indicated that R54 was admitted to the facility on [DATE] after R54 had a fall which resulted in fractures prior to admission, requiring therapy and pain monitoring with diagnoses that included diabetes, use of an anti-coagulant, and a pressure ulcer to sacrum. These care areas were not added to the baseline care plan until after 48 hours of admission. On 12/18/24 at 9:47 a.m., during an interview with a surveyor, the Director of nursing stated that the nurses are responsible for the baseline care plan. R54's baseline care plan was reviewed and the surveyor confirmed that fall with fractures, pain, diabetes, anti-coagulant use, and pressure ulcer were not added until between 12/8/24 - 12/13/24, greater than 48 hours.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32540 Based on record reviews and interviews, the facility failed to ensure that physician orders for treatments were followed for 2 of 20 sampled residents. (Resident #11 [R11]), R19). The facility failed to monitor a residents treatment until 4 days after treatment was administered for 1 of 1 sampled resident (12/13/24 to 12/16/24). Findings: 1. On 12/17/24 at 11:03 a.m,, during a clinical record review a diet order dated 11/16/24 instructs that R11 needs constant supervision with meals. On 12/18/24 at 8:35 a.m., an observation was made that R11 was in his/her room and in bed. The privacy curtain was pulled halfway causing R11's upper body to not be visible. At this time CNA #2 was coming out of his/her room with the breakfast tray. A surveyor asked if she had assisted R11 with his/her meal and she stated that he/she eats by himself/herself after they set him/her up. She then stated that she had just come to pick up the tray because they were done eating. The surveyor confirmed, at this time that R11 was not in constant supervision during their breakfast meal. On 12/18/24 at 8:38 a.m. during an interview with RN#3 stated this was her first shift at this facility and she was not aware that R11 needed constant supervision for meals. At this time the surveyor confirmed R11 was not in constant supervision with his/her breakfast meal. 2. On 12/18/24 during a clinical record review for R19, the surveyor noted that on his/her Treatment Administration Record (TAR) for December 2024 it is documented that on the morning of 12/10/24 R19 had a blood sugar level of 86. He/she has a Physician order to receive 44 units of Lantus for Diabetes Mellitus and to hold for blood sugar less than 100. Documentation on the TAR indicates that on 12/10/24 R19 received 44 units of Lantus with a blood sugar of 86 when it should have been held. On 12/18/24 at 9:58 a.m. during an interview with the Director of Nursing the surveyor confirmed that the facility failed to hold the insulin for R19 on the morning of 12/10/24. 35904 3. On 12/16/24 during a clinical record review for R28, the surveyor noted that on 12/12/24 R28 was treated with a prescribed medicated shampoo for the treatment of lice. The directions were to monitor effectiveness of treatment by checking for lice post treatment. There was no evidence in the clinical record that R28 was monitored after treatment. On 12/17/24 at 11:07 a.m. in an interview with the Infection Preventionist, a surveyor confirmed that no one was monitoring the effectiveness of the treatment of lice from 12/12/ 24 until 12/16/24, 4 days after treatment.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33242 Based on record reviews and interviews, the facility failed to ensure that a resident received monitoring and wound care for 1 of 3 residents reviewed with a pressure ulcer wound (Resident #42 [R42]). This lack of monitoring and wound care resulted in the pressure wound deteriorating and requiring a transfer and admission to the hospital for further treatment. Finding: On 12/6/24, the facility sent a reportable incident form to the State Agency alleging that Licensed Practical Nurse #1 (LPN1) documented that she had changed R42's pressure wound dressing on 12/2/24 and 12/4/24 but on 12/6/24, the pressure wound dressing was observed by Registered Nurse #1 (RN1), dated 11/30/24. On 12/16/24, R42's clinical record was reviewed. R42's December Treatment Administration Record (TAR) included a physician ordered treatment (started 11/19/24) for the right heel pressure wound that directed staff to cleanse with normal saline or wound wash, pat dry, apply Medihoney alginate, then Mepilex or foam equivalent, and may secure with gauze roll or kerlix and to change every other day on the night shift and as needed (PRN). R42 was to wear off-loading boots to bilateral feet when in bed. Review of R42's December TAR was signed by LPN1 to indicate that a weekly skin check was completed on 12/1/24 and documented at 8:00 p.m. in the clinical record, under Skin Check-LPN, that a foot evaluation completed and described wound #3 as a blister; however on 11/25/24, Family Nurse Practitioner (FNP) documented that it was a new unstageable open area on right heel-malodorous and draining purulent drainage. some discomfort and ordered an antibiotic. On 12/3/24, documentation indicated that Family Nurse Practitioner (FNP) visited R42 but did not observe the right heel dressing and documented that that off-loading boot was on. On 12/5/24, R42's Brief Interview for Mental Status (BIMS]) was 15 (cognitively intact), refused a weekly pressure wound assessment two times and the dressing was not observed as R42 was wearing the off-loading boots. On 12/17/24 at 1:50 p.m., during an interview with a surveyor, FNP stated that she observed the unstageable pressure wound on 11/25/24; it looked like a blister that had popped. FNP stated she ordered an antibiotic (Keflex times (x) 7 days) due to the drainage and odor of the wound (the last dose administered was 12/2/24). FNP stated that on 12/7/24, she ordered R42 be transferred to the hospital because he/she needed a wound debridement to the right heel pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/17/24 at 2:10 p.m., during a joint interview with Registered Nurse #1 (RN1), RN2 and a surveyor, RN1 stated that on 12/6/24, he saw [Resident] 42 and asked how he/she was doing. [Resident] 42 mentioned that his/her (right) foot was hurting and RN1 stated that he asked how the dressing changes were going; [Resident] 42 stated they haven't been changed for a while. RN1 stated he took the green boot off which was covering the (right heel) dressing and saw 11/30/24 written on the dressing (a photo of the dated dressing was taken and provided to the surveyor). RN1 stated he last saw the wound on 11/28/24 and it looked good (On 12/6/24 at 6:00 p.m., RN1 documented that the wound now had a new odor and with new blackened tissue present with dried drainage observed on the old dressing). RN2, who observed the wound on 11/28, stated that it was healing well, to the point of wanting to contact the provider about maybe discontinuing the Medihoney, as it did its job. RN2 stated that weekly pressure wound assessments are supposed to be done weekly but they are not always done by her. RN1 stated that he called FNP and a televisit was completed to review the status of the right heel wound. FNP ordered a mobile x-ray that was completed 12/7/24 and they thought it was possible osteomyelitis (bone infection) and [Resident] 42 was sent to the hospital for further tests. RN1 stated he called the hospital to obtain status on [Resident] 42 and found it was not osteomyelitis, but [Resident]42 was admitted for broad spectrum IV antibiotics (intravenous medication used when a bacterial infection is suspected but the group of bacteria is unknown). [Resident] 42 did not return to the facility. R42's care plan, last updated 11/14/24, for the care area of, The resident has pressure ulcer right heel pressure ulcer development related to (r/t) immobility, with interventions added on 11/14/24 that included: Administer treatments and monitor for effectiveness; assess/record/monitor wound healing measure length, width, and depth where possible; assess and document status of wound perimeter, wound bed and healing progress; monitor/document/report as needed (PRN) any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length times (x) width x depth), stage; and weekly treatment documentation to include the measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage). On 12/17/24 at 8:34 a.m., the Director of Nursing (DON) provided the surveyor with the weekly pressure wound assessments that were completed for R42's right heel pressure injury which included the dates of 11/13/24 and 12/6/24. The surveyor confirmed that weekly pressure wound assessments were not completed every week. On 12/17/24 at 3:15 p.m., during an interview with a surveyor, the DON stated that weekly skin checks are to be done on shower days. The surveyor confirmed LPN1's inaccurate description of a weekly skin check completed on 12/1/24, documenting the description of an unstageable pressure wound (as described by FNP on 11/25/24) as a blister and LPN1 would have needed to remove the dressing, dated 11/30/24, in order to see the area to complete the weekly skin check. The surveyor also confirmed that R42 had a dressing change scheduled every other day and PRN, R42 was on an antibiotic until 12/2/24 due to drainage of the wound, and wore off-loading boots while in bed. There was no evidence that staff had been monitoring the area (as directed by the care plan), because if they would have removed the right foot off-loading boot to observe the treatment for effectiveness, staff would have seen that the last time the dressing had been changed was 11/30/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/31/24 at 2:03 p.m., the surveyor spoke with LPN1 via telephone. LPN1 stated that she did not remember completing or documenting that she had completed a foot/skin check on 12/1/24 or a dressing change to R42's right heel pressure wound on 12/4/24. LPN1 did state that on 12/2/24, at the beginning of her shift, she documented that she had completed R42's right heel pressure wound dressing change but then was pulled to pass medications She stated that she informed R42 that the dressing change wouldn't be done until after 10 p.m. to which R42 stated that was too late. LPN1 stated that she forgot to change the documentation to indicate that the dressing had not been changed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review and interview, the facility failed to provide recommended nutritional services for 1 of 1 residents reviewed for dialysis [Resident #102 (R102)]. Finding: Review of the Dialysis Patient Care Policy created and approved on 05/21/2018 indicated, Dietary management involves restriction of protein, sodium, potassium, and/or fluid intake per physician's orders. On 12/17/24, clinical record review revealed: R102 was admitted on [DATE] with a diagnosis of dependence on renal dialysis. The resident was discharged to the hospital on 11/29/24 and returned to the facility on [DATE] with the same care plan in place. The care plan revised on 9/29/24 indicated the resident was on a renal diet. The dietary notes on 10/24/24 indicated the resident was on a renal, carb consistent, low sodium diet. The discharge orders from the hospital dated 12/12/24 indicated R102 continue the carb consistent, low sodium diet on return to the facility. On 12/12/24, the dietary communication slip indicated R102 was placed on a House/Regular diet upon return from the hospital. On 12/17/24 at 11:30 a.m., during an interview with a surveyor, the Kitchen Manager stated the House/Regular diet is not considered a low sodium diet. On 12/18/24 at 11:07 a.m., during an interview with the Director of Nursing (DON), 2 surveyors confirmed the record contained conflicting diet recommendations. The DON stated the dialysis center should direct the diet order; the dietician may discuss with them and make adjustments, but there would be a note for that. At this time 2 surveyors confirmed the facility did not provide the recommended nutritional services to R102 on his/her return from the hospital.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35904 Based on observations and interviews, the facility failed to provide oxygen therapy in a sanitary manner for 1 of 2 sampled residents using oxygen (Resident #25 [R25]). Finding: On 12/18/24 at 10:55 a.m., during an environmental tour with the Director of Plant Operations, Healthcare Services Group District Manager, and surveyor observed R25 wearing oxygen via nasal cannula attached to an oxygen concentrator. The concentrator filter located on the back of the machine was dusty. On 12/18/24 at 10:55 a.m. in an interview with the Director Plant Operations, and Healthcare Services Group District Manager, a surveyor confirmed R25's oxygen concentrator was dusty.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 49635 Based on record review and interview, the facility failed address the needs of a resident in order to minimize triggers that may cause re-traumatization for 1 of 2 resident reviewed for Mood/Behavior (Resident #15 [R15]). Finding: R15 was admitted to the facility with hospice services on 11/28/23. R15's diagnoses are significant for anxiety disorder, hallucinations, delusional disorder, dementia with behavioral disturbance, and need for assistance with personal care. On 12/15/24 at 8:08 p.m., a nurse note stated, [patient] stated to [2 staff] that the last two people who were in [his/her] room molested [him/her]. On 12/17/24 at 4:01 p.m., a nurse note stated, This afternoon the Hospice nurse and social worker reported to me [R15] was very upset when they saw [him/her] today. [He/She] reported being afraid and made claims of a sexual assault. Upon probing, the resident could not identify when it happened and stated it was not here. ? if [he/she] may have had a previous trauma triggered by a male caregiver. On 12/18/24, the provider signed a note stating, report to [Director of Nursing (DON)] of [patient] stating [he/she] was sexually abused. Investigation thought to be a trigger from a male caregiver with [history] of old trauma. On 12/19/24 at 9:54 a.m., during an interview with the DON, 2 surveyors confirmed that the clinical record lacked evidence that interventions were put in place for R15, in order to prevent re-traumatization.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540 Based on record reviews and interviews, the facility failed to ensure that physician ordered medications were available for use to meet the needs of the residents for 1 of 3 residents reviewed as a closed record. (Resident #51 [R51]). Finding: On 12/19/24 at 1:07 p.m., during a review of Resident #51's clinical record, R51 was admitted to the facility on [DATE] after a stay at the hospital for the treatment of a surgical wound infection. He/she was admitted with an order for Vancomycin HCl in dextrose intravenous (IV) solution 1.25-5 gram (GM)/250 milliliters (ML) -% use 250ml intravenously two times a day for infection with a start date of 12/15/24 at 8:00 p.m. The Treatment Administration Record (TAR) shows documentation that on 12/15/24 at 8:00 PM a code of 9 was entered. The code 9 using the chart codes on the TAR indicated other/see progress notes. The progress note dated 11/15/24 documents the vancomycin HCl in dextrose intravenous solution 1.25-5gm/250ml% (antibiotic) was not in yet from the pharmacy, resulting in R51 missing his/her evening dose of his/her antibiotic treatment. On 11/16/24 at 8:00 a.m. a second dose of IV vancomycin HCl in dextrose intravenous solution 1. 25-5gm/250ml% was due to be administered. In a nursing note dated 11/16/24 documents the correct formulation of the medication was not available, which resulted in R51 missing a second dose of IV antibiotics to treat his/her surgical infection. On 11/16/24 at 10:43 a.m., R51 and the spouse told the nurse that he/she was leaving against medical advice stating they were unhappy with the care and the IV medication, and they would be going to the ER to get the IV antibiotics. On 12/19/24 at 12:55 p.m., during an interview with the Infection Preventionist, she stated that they have been having an issue with the pharmacy with getting medications timely. They have pharmacy runs in the evening and again on the overnight shift during the week, on the weekends they get one pharmacy run. They do have a backup pharmacy but does not believe they can get IV medications from the local Walgreens. A surveyor confirmed at this time that R51 missed two doses of his/her IV antibiotics due to unavailability of the correct formulation of his/her medication order.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 32540 Based on record review and interview, the facility failed to follow up on pharmacist recommendations timely, for 4 of 6 residents reviewed for medications (Resident #11 [R11], R16, R34 and R37). Findings: 1. On 12/18/24 during R11's clinical record review it was noted that on 10/30/24 the Pharmacist completed a medication record review and had made the following recommendations: - To confirm a diagnosis for Buspar therapy as the current diagnosis is not an approved indication for use, this medication is generally used to treat anxiety. - That this resident has been taking Risperidone 4 milligrams (mg) twice daily since 7/5/24. Please evaluate the current dose and consider a dose reduction. During clinical record review there is no evidence that the Pharmacist recommendations have been reviewed or responded by the Medical Provider. 2. On 12/18/24 during R16's clinical record review it was noted that on 9/22/24 the Pharmacist completed a medication record review and had made the following recommendations: - To review dosing schedule for Oxybutynin and Gabapentin schedule. Both orders have an AM window of 7 am to 10 am, however the afternoon dose is scheduled for 11 am. If the AM dose is administered at 10 am, this is too close to the 11 am dosing. Please either ensure AM dose is administered earlier or the afternoon dose later. Pharmacist medication review dated 10/29/24 has the following recommendations: - That this resident has been taking Sertraline 150mg daily since 3/6/24. Please evaluate this current dose and consider a dose reduction. During clinical record review there is no evidence that the Pharmacist recommendations have been reviewed or responded by the Medical Provider. On 12/19/24 at 11:30 a.m. during an interview with 2 surveyors the Director of Nursing (DON) stated we don't have any of the responses to the pharmacy recommendations. The DON was Unable to verify that the pharmacy recommendations were addressed or acknowledged by the Medical Provider. 49635 3. On 12/19/24, review of R34's clinical record revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24, the Medication Regimen Review for R34 was completed and the pharmacist recommendation stated, Resident has an order to receive Tum's every 2 hours as needed (PRN). Please consider updating the Medication Administration Record (MAR) to include a daily limit ([that is] do not exceed 8,000 [milligrams (mg)] per day). Review of the MAR for active orders in August revealed an order dated 6/26/24 for Tums (calcium carbonate) 500mg tablets, 2 tablets to be given every 2 hours as needed for indigestion. Additionally, the MAR had an order for a Calcium Carbonate 600 mg supplement dated 4/23/24, scheduled for 1 tablet to be given by mouth twice a day. There was no indication that the orders were updated or changed to include a daily limit. On 12/19/24 at 11:30 a.m., during an interview with the Director of Nursing, 2 surveyors confirmed there is no evidence that this recommendation was reviewed and / or acknowledged by the provider. 4. On 12/19/24, review of R37's clinical record revealed the following: On 7/29/24, the Medication Regimen Review for R37 was completed and the pharmacist recommendation stated, Resident has a scheduled and a PRN order for Acetaminophen. Please consider updating the PRN order to include a daily limit such as 3 grams per day. On 9/22/24, the Medication Regimen Review for R37 was completed and the pharmacist recommendation stated, Resident has a scheduled and a PRN order for Acetaminophen. Please consider updating the PRN order to include a daily limit such as 3 grams per day. Review of R37's MAR and physician's orders revealed two orders for Acetaminophen 325 mg tablets, one scheduled and one to be given as needed. The as needed Acetaminophen has a start date of 6/15/24 and directs 2 tablets (650mg) to be give every 4 hours as needed for pain. The scheduled Acetaminophen has a start date of 7/31/24 and directs 2 tablets (650mgs) to be given every morning and bedtime for pain. As of 12/19/24 both orders remain active without indication of a daily limit. On 12/19/24 at 11:30 a.m., during an interview with the Director of Nursing, 2 surveyors confirmed there is no evidence that this recommendation was reviewed and / or acknowledged by the provider.

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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. 49635 Based on observations, and interviews, the facility failed to monitoring food temperatures to prevent food borne illness prior to serving residents for 1 of 4 days of survey (12/17/24), and the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code on 2 of 4 days of survey (12/17/24, and 12/18/24). This has the potential to effect all residents in the facility. Findings: 1. On 12/17/24 at 11:38 a.m., a surveyor observed the Kitchen Manager serve mashed potato, pureed green bean, and ground chicken onto an early plate from the steam table. The plate was covered and put to the side in preparation of being served ahead of the lunch service. At 11:39 a.m., a surveyor observed the Kitchen Manager begin to check holding temperatures of the food on the steam table, prior to serving the lunch service. The ground chicken was observed to be 133 degrees Fahrenheit, and the pureed chicken was observed to be 126 degrees Fahrenheit (Minimum safe holding temperature for hot foods is 135 degrees Fahrenheit). On 12/17/24 at 11:45 a.m., a surveyor confirmed with the Kitchen manager that the pureed chicken and ground chicken were not maintained at a safe holding temperature and the early plate had been prepared and was ready to serve with the ground chicken that was not maintained at a safe holding temperature. 2. The 10-114 State of Maine Rules Chapter 226, definition Section A, defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils. On 12/17/24 at 2:34 p.m., a surveyor observed an improper air gap on the drain line of the ice machine, this finding was confirmed with the Kitchen Manager. On 12/18/24 at 12:00 p.m., a surveyor observed an improper air gap on the drain line of the ice machine, this finding was confirmed with the Kitchen Manager.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33242 Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #42 [R42]) and 1 of 1 reviewed for Respiratory care. Findings: 1. On 12/16/24, a surveyor reviewed information provided for a facility reported incident, dated 12/6/24, involving Licensed Practical Nurse #1 (LPN1) documenting that dressing changes were completed on R42's right heel on 12/2/24 and 12/4/24, but on 12/6/24, the dressing was observed and labeled last changed on 11/30/24 by Registered Nurse #3. Upon further review, the surveyor noted that LPN1 also documented a skin check was completed on 12/1/24 that included documentation of Foot evaluation completed and that R42's right heel pressure wound was a blister but on 11/25/24, the Family Nurse Practitioner #1 documented that the wound (that was a blister) was now unstageable and open, with drainage, to the right heel. On 12/17/24 at 3:15 p.m., during an interview with the Director of Nursing, a surveyor confirmed this finding. 32540 2. On 12/16/24 during a resident observation and interview it was noted that R19 was using an oxygen concentrator at 2 Liters per minute using a nasal cannula. Observation of the nasal cannula (oxygen tubing) showed that it had a date of 12/8/24. During review of R19's Treatment Administration Record (TAR) for December it was noted that the nurse signed the TAR that the oxygen tubing was changed on 12/15/24. 12/18/24 at 7:22 a.m., observation and record review was done with the interim Social Service nurse, the surveyor confirmed the date on the oxygen tubing was 12/8/24 and that it was signed on the TAR as being changed on 12/15/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on observations, record reviews, and interviews, the facility failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection for residents on precautions and during a medication pass observation for 3 of 4 days of survey (12/16/24, 12/17/24, and 12/18/24). Findings: 1. On 12/17/24 at 7:00 a.m., in the hallway by the nurses station, a surveyor observed Certified Nursing Assistant - Medication #1 (CNA-M1) with medications in her bare hands, giving them to Resident #16. The surveyor confirmed this observation with CNA-M1 at this time. 2. On 12/17/24, Resident #21 (R21)'s clinical record was reviewed which indicated that R21 had a Foley catheter and a history of a bacteria, Extended-spectrum beta-lactamase (ESBL), requiring contact precautions when providing care. At 8:43 a.m., the surveyor observed a sign on the the door to R21's room indicated that which required staff to put on gloves and a gown before entering the room; the surveyor did not observe a personal protective equipment (PPE) cart outside of the room. On 12/17/24 at 9:20 a.m., a surveyor observed two Certified Nursing Assistants providing morning care to R21 and neither CNA was wearing a gown. At 9:27 a.m., during an interview with a surveyor, the Infection Preventionist (IP) stated that R21 is on precautions and staff should be wearing a gown and gloves when providing care to R21. The surveyor confirmed that the two CNAs were not wearing gowns while providing morning care for R21. The facility's policy, Enhanced Barrier Precautions, [DATE] - [DATE], states: - Enhanced Barrier Precautions (EBP) signage should be placed where staff can easily identify - Personal protective equipment is required for all staff providing high contact resident care activities to include: Gowns and gloves with dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy) and wound care to chronic wounds and unhealed surgical sites. - EBP will be in place for the duration of the resident's stay or until a wound is resolved or the indwelling medical device is discontinued. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 12/16/24 at 12:10 p.m., during an interview with a surveyor, R54 stated that he/she had a wound with a dressing on his/her bottom. The surveyor did not observe a sign outside of R54's room, notifying staff that R54 was on Enhanced Barrier Precautions to notify staff that PPE must be worn when providing care nor observed a PPE cart nearby. On 12/17/24 at 9:14 a.m., a surveyor observed two Certified Nursing Assistant (CNA) students enter R54's room and there was already a CNA in the room assisting R54 who was standing with the use of a walker; neither the CNA nor the students were observed wearing a gown. At 9:23 a.m., during an interview with a surveyor, R54 stated that the CNA assisted him/her to use the restroom. On 9:27 a.m., during an interview with a surveyor, the Infection Preventionist stated that she forgot to put a sign on the outside of R54's room that would have notified staff that R54 was on enhanced barrier precautions. The surveyor explained the observation of the CNA nor the students wearing a gown as personal protective equipment. At 10:30 a.m., during an interview with a surveyor, CNA1 stated that she was unaware that R54 was on enhanced barrier precautions until after she provided care for R54 because there was no sign on the door at that time. She noticed that one was put up now, after she provided care. 32540 4. On 12/17/24 at 10:31 a.m., during resident observation and interview it was noted that he/she had a foley catheter. At this time the surveyor observed there was no sign for his/her EBP and no PPE readily available for staff use. On 12/18/24 at 2:51 p.m, during a combined staff interview, they stated that R17 has had a foley catheter since their return from the hospital and they were not made aware of the EBP. The staff stated it wasn't until that afternoon (12/18/24) that they were made aware of the need to wear PPE when providing care to R17. On 12/18/24 at 3:00 p.m, during an observation of R17's room with the Infection Preventionist (IP), it was noted there are no gowns available for staff to put on prior to entering the room. The IP stated the PPE are placed in a drawer in the rooms, there were no PPE found in any of the residents drawers. At this time the surveyor confirmed there was no PPE available for use for this resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bangor Nursing & Rehabilitation Center	103 Texas Ave Bangor, ME 04401

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record review, and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease Control and Prevention (CDC) recommendations for 5 of 5 residents reviewed for immunizations (Resident [R]3, R43, R25, R28, and R12). Findings: On 12/18/24 at 12:01 p.m., during an interview with the Infection Preventionist (IP), she stated that per the facility pharmacist, and CDC guidance, if a resident received the PCV13 and PPSV23, they should receive the PCV20 five years after the last pneumococcal vaccine given. 1. R3's admitted to the facility was on 12/6/23. During review of immunization records, R3 received a PPSV23 on 1/16/18, and a Pneumovax Dose 2 on 8/25/06. A surveyor could not locate evidence that R3 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 2. R43's admitted to the facility was on 3/29/24. During review of immunization records, R43 received a PPSV23 on 2/29/11. A surveyor could not locate evidence that R43 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 3. R25's admitted to the facility was on 11/30/23. During review of immunization records, a surveyor could not locate evidence that R25 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 4. R28's admitted to the facility was on 8/26/24. During review of immunization records, a surveyor could not locate evidence that R28 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 5. R12's admitted to the facility was on 12/15/21. During review of immunization records, a surveyor could not locate evidence that R12 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. On 12/18/24 at 12:01 p.m., during an interview with the IP, a surveyor confirmed that R3, R43, R25, R28, and R12 were not offered, or received a pneumococcal vaccine according to CDC recommendations and should have been.