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	01/08/2026

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 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** Based on observations and interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair for 1 of 1 environmental tour and failed to adequately provide housekeeping and maintenance services necessary to maintain an environment free from offensive odors. On 1/5/26 between 10:45 a.m. and 11:10 a.m., the following were observed on the Skilled Unit: In room [ROOM NUMBER], the divider curtain is unhooked in different places. In room [ROOM NUMBER]-2, behind head of the bed, the wall plaster has several gouge marks. In room [ROOM NUMBER], the trapeze over the resident's bed is soiled. In room [ROOM NUMBER], three red droplets are observed on the floor near the room sink. At 11:15 a.m., in an interview with the unit Charge Nurse, she confirmed the droplets looked like blood and had the area cleaned immediately. On 1/6/26 at 8:00 a.m., on the Skilled Unit, in the corridor near rooms [ROOM NUMBERS], a strong odor of urine was observed and again 1:15 p.m., a strong urine odor was observed. On 1/8/26 at 1:15 p.m., in an interview with the Administrator, the surveyor discussed the above findings. On 1/5/26 upon entrance of the facility for their annual survey it was noted by this surveyor a strong odor of urine in the long-term hallway (the end closer to the dining area) this odor remained for the survey hours of 10:30 a.m. – 3:00 p.m On 1/6/26 during survey the strong odor of urine was noted again in the long-term hallway, areas were near the horseshoe area and near the Director of Nursing (DON) office. This odor was noted during the survey hours 7:00 a.m. – 3:30 p.m. On 1/7/26 at 7:20 a.m. the long-term hallway had a strong odor of urine, at 8:25 a.m. the surveyor and the DON went into the long-term hallway and both the surveyor and the DON acknowledged the strong odor of urine. The DON stated she has been in all rooms this morning and did not smell urine in the resident rooms. She notices the smell but is unable to determine where the smell is coming from. On 1/8/25 at 2:00 p.m. two surveyors noted the strong urine odor in long-term hallway, from mid-hall to dining area doorway. (continued on next page)

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

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	01/08/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/26 at 10:23 a.m. in a confidential interview with a resident's family, they stated that the smell of urine in the facility is really bad a lot of the time and was told by the facility that this is a non-fume place, meaning it's a facility that doesn't use aerosols to get rid of odors, so the resident's family member has had to use Vicks their self to stop smelling the odor of urine in the facility when visiting.

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	01/08/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on employee record reviews, facility policy review, and interviews, the facility failed to implement its own Abuse, Neglect and Exploitation policy to ensure Maine background checks and references were completed for new employees before they were permitted to work for 4 of 7 sampled employees (Certified Nursing Assistant #1 [CNA1], [CNA2], [CNA3], and Therapist #1 [T1). In addition, the facility failed to implement its own Abuse, Neglect and Exploitation policy by not reporting to the state agency (Licensing and Certification) an allegation of resident-to-resident inappropriate sexual contact in a timely manner for 1 of 1 resident-to-resident incident reviewed Resident #28 [R28]). Findings: 1. The facility policy, Abuse, Neglect and Exploitation, revised 11/1/25, indicated under the section of Screening that potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property by the following: - Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. - Screens may be conducted by the facility itself, third-party agency or academic institution. - The facility will maintain documentation of proof that the screening occurred. On 1/6/26, between 12:30 p.m. - 1:00 p.m., a surveyor reviewed employee files and confirmed the following with the Assistant Director of Nursing: - CNA1 was hired on 3/4/24. The employee file lacked evidence of the facility completing a Maine background check prior to hire. The background check in the employee file was dated 8/19/22 (over 1 year prior to hire) and was ordered by a staffing agency, not the facility. - CNA2 was hired on 10/9/24. The Maine background check in the employee file was completed on 10/30/24, 21 days after being hired. - CNA3 was hired on 10/9/24. The Maine background check in the employee file was completed on 10/30/24, 21 days after being hired. - T1 was hired on 10/28/25. The employee file lacked evidence of references being checked. 2. On 1/6/26, a review of R28's clinical record was completed. In a nurse's note, dated 1/3/26, it indicated that R28 had been touched in a sexually inappropriate manner by a male resident. A review of both resident's clinical records indicated that both residents are wheelchair bound and have dementia. A nurse note dated 1/5/26, indicated that R28's guardian was notified of the incident. On 1/8/26 at 8:31 a.m., in an interview with the surveyor, the Director of Nursing (DON), confirmed that the incident occurred on Saturday, 1/3/26, and she was not notified until Monday, 1/5/26, and at that time she notified the state agencies (Licensing and Certification and Adult Protective Services) of the incident. The DON confirmed that the state agencies were not notified in a timely manner.

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	01/08/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record reviews and interviews, the facility failed to ensure care plans were resident centered and updated accurately for 3 of 20 sampled resident care plans reviewed. (Resident #5 [R5], R17, R11). Findings:1. On 1/7/26, a review of R5's clinical record was completed. R5 had an indwelling Foley catheter and a pressure wound on the left heel and buttocks. On 1/7/26 at 9:00 a.m., an Enhanced Barrier Precautions (EBP) sign was observed hanging on R5's clothes closet and Personal Protective Equipment (PPE) was stored in the closet. A review of R5's current care plan addressed the pressure wounds and catheter, but there was no evidence that the care plan addressed that R5 is on Enhanced Barrier Precautions (EBP). On 1/7/26 at 11:51 a.m., in an interview with the surveyor, the Director of Nurses, confirmed that the care plan did not address EBP. 2. On 1/7/26, a review of R17's clinical record was completed. R17 had a non-weight bearing status, and pressure wounds on the left and right heels. There is no evidence of the pressure wounds, weight bearing status and EBP being addressed in R17's care plan. On 1/7/26 at 10:10 a.m., in an interview with the surveyor, the Director of Nurses, confirmed that the care plan did not address EBP, weight bearing status or the current pressure wounds on R17's heels. 3. On 1/7/26 a review of R11's clinical record was completed. R11 had a pressure wound to left buttock, and a wound to the right inner thigh. On 1/7/26, a review of R11's current care plan addressed the wounds, but there was no evidence that the care plan addressed that R11 is on EBP. On 1/7/26 at 11:48 a.m., in an interview with the surveyor, the Director of Nurses, confirmed that the care plan did not address EBP.

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	01/08/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations and interviews, the facility failed to provide a resident with oral care on 3 of 4 days of survey. (Resident #29 [R29], on 1/5/26, 1/6/26 and 1/7/26)Findings:On 1/5/26 at 1:45 p.m., during the first observation and attempted interview with R29 the surveyor observed that his/her dentures were not clean and were falling down in his/her mouth and was not able to speak to surveyor. They appeared to be caked with food substance. On 1/5/26 during a record review for R29, his/her care plan was reviewed, and the care plan addresses that he/she does need substantial assistance of 1 staff to assist with personal hygiene and oral care. On 1/6/26 at 9:42 a.m. R29 during the second attempt to interview R29 was not able to talk without his/her dentures falling in his mouth. On 1/6/26 at 9:50 a.m. during an interview with a Certified Nursing Assistant (Cna) she was asked if R29's dentures not fitting properly was a daily issue. She stated she had tried Fixodent before but R29 did not tolerate it very well so she tried a smaller amount and that didn't work so she has not been putting anything on the dentures and has not said anything to the Social Worker or nursing. On 1/7/26 at 12:35 p.m. during an observation of R29, he/she was in their bed with his/her lunch tray in front of them. He/she stated he/she could not eat this. As he/she was talking their dentures were falling out of his/her mouth. R29 stated he/she needed some adhesive for his/her teeth. This surveyor made the nurse aware and he went to get R29 some denture adhesive. When nurse came back to room he asked resident for their dentures and they were rinsed but not brushed, and mouth care was not done. Adhesive was applied to dentures and with a second dollop of adhesive R29 was able to keep dentures in place and stated oh that is so much better he/she was able to talk and eat with his/her dentures not falling. On 1/7/26 at 1:45 p.m. during an interview with Cna7, who is assigned to assist R29, she stated she had not gotten to R29 yet as she had a lot of people ringing and voiding a lot that took a lot of her time. She was not aware that he/she used denture adhesive. She will wash R29 up soon. On 1/7/26 at 2:00 p.m., during an interview with the Director of Nursing the surveyor was able to confirm that R29 had not been assisted with oral care and his/her dentures were not fitting and was not assisted with using denture adhesive on 1/5/26, 1/6/26 and 1/7/26.

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	01/08/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and interviews, the facility failed to follow physician orders for 1 of 12 residents reviewed for admissions (Resident #42 [R42]), and failed to notify the provider of a significant weight gain as ordered by a provider for 1 of 2 residents reviewed for pressure ulcers (R11).Findings: 1.On 1/8/26 at 2:29 p.m. during a clinical record review for R42 a review of his/her Medication Administration Report (MAR) for [DATE] and [DATE] was completed. It was documented that R42 was admitted with an order for Keppra Oral Tablet 500 (milligrams) mg Give 1 tablet by mouth two times a day for epilepsy. During this clinical record review, it was identified that this order was entered into their electronic Health Care System (point click care [PCC] inaccurately. It was entered as an unsupervised self-administration medication and during this clinical record review, it was determined that R42 was not self-administering any medications. By the nurse entering this order as an unsupervised self-administration medication it caused R42 to miss 40 doses of Keppra Oral Tablet 500 mg a medication that is used for epilepsy. On 1/8/26 at 12:56 p.m. during an interview with the Director of Nursing the surveyor confirmed that due to the inaccurate medication entry R42 missed 40 doses of her Keppra medication an Epilepsy medication, in December 2025 and January 2026. 2.Resident 11 has an active diagnosis of heart failure. Review of R11's physician order on the Treatment Administration Record (TAR), 1/1/2026-1/31/26 states, Monthly weight every day shift starting on the 1st and ending on the 7th every month. Call MD (Doctor of Medicine [physician]) if 2-3 lbs (pounds) weight gain -Start Date- 10/01/2025 0700. Review of R11's weights in the clinical record, under Weights are as followed: On 1/4/26 at 15:17 (3:17 p.m.) R11's weight was 251.0 lbs. (pounds). On 1/5/26 at 10:26 a.m. R11's weight was 250.6 lbs. On 1/5/26 at 10:27 a.m. R11's weight was 260.6 lbs. On 1/6/26 at 6:47 a.m. R11's weight was 260.6 lbs. On 1/6/26 at 10:51 a.m. R11's weight was 260.6 lbs. On 1/6/26 at 10:51 a.m. R11's weight was 260.6 lbs. On 1/6/26 at 14:46 (2:46 p.m.) R11's weight was 259.9 lbs. The physician order on the TAR dated 10/1/25 directed the physician to be notified of, 2-3 lbs weight gain. The clinical record lacks evidence that the provider was contacted of the weight gain as directed. On 1/7/26 at 11:48 a.m. in an interview with the Director of Nursing, a survey confirmed that there is (continued on next page)

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	01/08/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no evidence in the clinical record that the physician was notified of a weight gain of more than 2-5 lbs. on 1/5/26 when R11 had a weight gain of 9.4 lbs.

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	01/08/2026

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on employee record reviews, and interviews, the facility failed to complete annual performance evaluations at least every 12 months for 3 of 3 sampled staff (Certified Nursing Assistant #1 [CNA1], CNA2, and CNA3). Findings: 1. CNA1 was hired on 3/4/24. The facility was unable to provide evidence that an annual performance evaluation had been completed. 2. CNA2 was hired on 10/9/24. The facility was unable to provide evidence that an annual performance evaluation had been completed. 3. CNA3 was hired on 10/9/24. The facility was unable to provide evidence that an annual performance evaluation had been completed. On 1/06/26 at 11:50 a.m., during an interview with a surveyor, the Assistant Director of Nursing stated they were unable to find any annual evaluations for the 3 CNAs.

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	01/08/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to label beverage thickeners with an open date on 2 of 3 food carts (Food Cart #1, and Food Cart #2). Findings:On 1/5/26 at 12:24 p.m. on top of Food Cart #2, a surveyor observed one open carton of Thick & Easy (beverage that is thickened) that was not labeled with an opened date. Storage and handling instructions on the carton were to discard if not used within 4 days of open. On 1/5/26 at 12:38 p.m. on top of Food Cart #1, a surveyor observed 1 open carton of Thick & Easy (beverage that is thickened) that was not labeled with an opened date. Storage and handling instructions on the carton were to discard if not used within 4 days of open. On 1/5/26 at 12:38 p.m. in an interview with the Kitchen Supervisor, a surveyor confirmed that the open Thick & Easy carton's on Food Cart #2, and Food Cart #1 were available for Resident use and not labeled with an opened date. The Kitchen Supervisor removed the carton's at this time.

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	01/08/2026

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 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** Based on observations, facility policy reviews, and interviews, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to ensure staff wash hands during a medication pass observation, failed to ensure equipment was cleaned after used in a contact room, and failed to utilize proper personal protective equipment (PPE) in contact rooms for 3 of 3 observations of EBP designated rooms Rooms #12 (Resident #5 [R5]) and #29 [R17]. Findings: Findings: 1. On 1/05/26 at 11:27 a.m., a surveyor observed Registered Nurse #1 (RN1) complete a medication pass for a resident; at the end of the observation, RN1 took the resident's cup used for water and placed it in the garbage at the medication cart. RN1 immediately started to prepare the next resident's medications but failed to wash her hands or use hand sanitizer after completing the previous medication pass or prior to starting this medication pass. At 12:03 p.m., during an interview with RN1, a surveyor confirmed this finding. 2. On 1/5/26 at 11:48 a.m., a surveyor observed RN1 use the mobile vital signs monitor in an Enhanced Respiratory precautions room; the monitor was moved outside of room (not sanitized after use in a contact room) and a surveyor stayed in the area to continue observations. On 1/5/26 at 12:20 p.m., a staff member moved the monitor from outside of room [ROOM NUMBER] to the wall between room [ROOM NUMBER] and 31, still uncleaned and available for use. On 1/5/26 at 12:30 p.m., during an interview with the Infection Preventionist (IP), a surveyor confirmed that this monitor was used in room [ROOM NUMBER] but has been out of sight of the staff member that initially used the machine multiple times, it has been moved to a different location, and has been available for use but not cleaned for at least 40 minutes. The IP stated that she would clean it now. 3. The facility's policy, Bangor Nursing and Rehabilitation Center (BNRC) Respiratory Viral Pathogen Outbreak Plan, undated, indicated that the following Personal Protective Equipment (PPE) for a resident with or suspected coronavirus (COVID): N95 respirator, gown, gloves, and eye protection. On 1/5/26 at 11:15 a.m., a surveyor observed a sign that notified staff that room [ROOM NUMBER] was on Enhanced Respiratory Precautions and that the following PPE was required: gown, N95 respirator or higher level respirator, eye protection (goggles or face shield), and one pair of gloves. There was a plastic drawer storage located outside of the room with the PPE. On 1/5/26 at 12:23 p.m., two surveyors observed Certified Nursing Assistant #4 (CNA4) in room [ROOM NUMBER] standing next to a resident who was in bed. CNA4 was wearing a blue surgical mask, disposable gown, and gloves but not wearing an N95 respirator or eye protection. The surveyor confirmed with CNA4, after review of the posted sign, that she was not wearing the proper PPE for this room. 4. On 1/7/26, a review of Resident #5 (R5) clinical record was completed. In the physician order section, it indicated R5 had treatments to open wounds on the left heel (pressure ulcer) and buttocks. On 1/7/26 at 9:00 a.m., the surveyor observed the unit Charge Nurse perform the wound treatments to the heel and buttocks. While observing the wound treatments, it was observed that on R5's clothes closet was anEnhanced Barrier Precaution sign indicating the Personal Protective Equipment (PPE) face mask, gloves and gown were required whenperforming any direct care to the resident. The unit Charge Nurse did not wear all the required PPE's during the wound treatments (no gown). On 1/7/26 (continued on next page)

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	01/08/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 10:15 a.m., in an interview with the surveyor, the unit Charge Nurse, confirmed that she did not don all the required PPE's prior to doing the pressure ulcer/wound dressing changes. The Centers for Disease Control and prevention Definition and Scope of Enhanced Barrier Precautions: dated 6/23/24 states, Enhanced Barrier Precautions (EBP) involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). EBP expand the use of gown and gloves beyond anticipated blood and body fluid exposures . Standard Precautions still apply while using EBP. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. On 1/7/26, a review of the Facilities Enhanced Barrier Precautions dated 1/1/25 - 12/31/25 indicated: Overview: Enhanced Barrier Precautions (EBP) focus on residents with infection or colonization with MDRO's and residents at risk for developing or becoming colonized. Enhanced barrier precautions are precautions that in addition to Standard Precautions, will be implemented during high contact resident care activities . Procedure: precautions should be applied to all residents .Enhanced barrier precautions are to be implemented in addition to standard precautions when other transmission-based precautions do not apply, when the facility identifies any resident with: . any indwelling medical device, for example urinary catheters. 5. On 1/7/26, a review of R17's clinical record was completed. In the physician order section, it indicated R7 had treatments to open wounds on the right and left heel (pressure ulcer). A review of the Facilities Enhanced Barrier Precautions dated 1/1/25 - 12/31/25 indicated: Overview: Enhanced Barrier Precautions (EBP) focus on residents with infection or colonization with MDRO's and residents at risk for developing or becoming colonized. Enhanced barrier precautions are precautions that in addition to Standard Precautions, will be implemented during high contact resident care activities . Procedure: precautions should be applied to all residents .Enhanced barrier precautions are to be implemented in addition to standard precautions when other transmission-based precautions do not apply, when the facility identifies any resident with: . any indwelling medical device, for example urinary catheters. On 1/7/26 at 7:45 a.m. during a wound care dressing change with LPN2 the surveyor observed the Charge Nurse LPN2 perform the wound treatments to the right and left heels. While observing the wound dressing change, it was observed that R17's room did not have an Enhanced Barrier Precaution sign and LPN2 was performing direct care/wound care to R17. LPN2 did not wear all the required PPE's during the wound dressing change (no gown). On 1/7/26 at 10:10 a.m., in an interview with the surveyor, the Director of Nursing stated they misread the second page of their policy she thought EBP was used for chronic wounds only and that R17 was not on EBP because the wounds developed after R17's admission.

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	01/08/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on facility policy review, Infection and Antibiotic monitoring tool reviews, and interview, the facility failed to implement its Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and a system to monitor antibiotic use for 3 of 3 months reviewed (September, October and November 2025). This has the potential to affect all residents receiving an antibiotic.Finding: The facility's policy, Antimicrobial Stewardship Program Long Term Care, Jan.1 2025-Dec. 31, 2025, indicated the following: the purpose (of the program is to reduce the risk of multidrug-resistant developmentCovenant Health is dedicated to helping reduce the risk of multi-drug resistant development by following the Centers for Disease Control and Prevention's seven core measures for antimicrobial stewardship.The seven core elements of Antibiotic Stewardship are leadership commitment, accountability, drug expertise, actions, for improvement, tracking, reporting, and education.Tracking: The facility will monitor all antibiotic prescribing (dose, duration, indication), clinical assessments (diagnostic testing and symptoms), and adherence to facility-specific treatments using the U.S. Department of Health and Human Services monitoring tool. The facility will monitor all patterns of multidrug-resistant organism. On 1/6/26 at 9:16 a.m., during an interview with a surveyor, the Infection Preventionist (IP) shared September 2025's infection and Antibiotic tracking tool which included the following documentation: Location/unit, resident name, skilled/long term care, Room/Bed, date of admission, infection resolved or resident discharged , date of infection, date of resolution, age of infection in days, days to resolve, facility acquired, infection, Fever onset, symptom, met facility adopted criteria, culture or test obtained, source of culture/test, [NAME] blood cell count, Colony count for urine, culture results, were culture results reviewed within 48-72 hours of results, antibiotic names, start and end dates, days of treatment for month, total days of treatment without end date, hospital start, prescriber, prophylaxis or treatment, and re-assessment within 48-72 hours of facility start. During September's review, it was observed that sections of this monitoring tool contained no information including Location/unit and resident room number (which could be used to identify location trends) and information regarding if the infections were resolved or if the resident was discharged , the date of resolution, and number of days to resolve noting that some antibiotic use end dates documented were in September. During this review, the IP stated that she has not had a chance to complete the monitoring tool; September 2025 was the last month with information entered as October and November were not done. The surveyor confirmed that tracking had not been completed during this interview.

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	01/08/2026

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview. the facility failed to designate a qualified staff member to function as the Infection Preventionist who was responsible for the facility's Infection Control Program and worked at least part time in the role for 4 of 4 months reviewed (September, October, November, and December 2025). This has the potential to affect all residents in the facility. Finding: On 1/6/26, at 9:16 a.m., during an interview with a surveyor, the Infection Preventionist (IP) stated that she had not completed the training yet. She has hired in July 2025, and the old IP left the end of August 2025. She stated she had started the Center for Disease Control (CDC) modules but during the process, the CDC changed the version, and she had to start all over again.

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	01/08/2026

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. Based on record reviews, Centers for Disease Control and Prevention (CDC) recommendations, and interviews, the facility failed to offer/administer a Pneumococcal vaccination to 2 of 5 residents (Resident # [R28] and R33).Findings:1. On 1/5/26, a surveyor reviewed R28's clinical record and noted that the resident was admitted in September 2024; a review of the immunizations tab in the electronic clinical record contained no documentation regarding a pneumococcal vaccination status and uploaded in the files of the clinical record was a blank pneumococcal consent form, dated September 2024. On 1/5/26 at 2:50 p.m., during an interview with a surveyor, the Infection Preventionist (IP) stated they were waiting on consents from the guardian. On 1/6/26 at 9:13 a.m., during an interview with a surveyor, the IP stated she called the guardian, got consent to administer the pneumococcal vaccine, and ordered the vaccine after the surveyor inquired yesterday. 2. On 1/5/26, a surveyor reviewed R33's clinical record and noted that the resident received the Pneumococcal polysaccharide vaccine 23(PPV23) in November 2023. The CDC PneumoRecs VaxAdvisor App for Vaccine Providers recommended to give one dose of Pneumococcal conjugate vaccines (PCV) of either PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23. On 1/5/26 at 2:50 p.m., during an interview with the IP, a surveyor asked if R33 had been offered the PCV20 based on the recommendations. On 1/6/26 at 9:16 a.m., during an interview with a surveyor, the IP stated she had consent to administer the pneumococcal vaccine and ordered the vaccine after the surveyor inquired yesterday.

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	01/08/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to promote care for residents (Resident #48 [R48 and R7) in a manner that maintains the resident's dignity and respect during resident observations on 1 of 1 days of survey (1/8/26) Findings: 1.On 1/8/26 at 10:15 a.m., during a resident observation R48 was being assisted by a staff person down the hallway, R48's feet were dragging on the floor, and R48 stated stop my feet, the staff person then said to R48 well if you would lift your feet it wouldn't hurt, It was observed that R48 was wheeled to an office to sit with this staff person. On 1/8/26 at 10:30 a.m. during an interview with the Director of Nursing (DON) she was made aware of the observation. The surveyor asked the DON what the facilities policy was for transporting residents in a wheelchair. She stated that residents who can self-propel the footrests are removed to prevent any trip hazards. If staff transport the residents they need to have the footrests in place. She then stated they are all aware of this as they have been working with therapy to find the footrests for all chairs. The staff person who was assisting R48 and made the statement was the staff sitting with R48 in the office, this person was identified as the schedular, she is also Cna (Cna6). At this time the surveyor confirmed this observation with the DON. 2. On1/8/26 at 1:46 p.m. the surveyor observed Cna1 pulling R7 backwards in a shower chair while in the hallway. R7 was observed being pulled down the hallway backwards with his/her buttocks and thighs exposed. At the time of the observation the surveyor confirmed with Cna1 that R7 should have been covered better not to expose his/her body parts and should not have been pulled backwards in the chair.

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	01/08/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, the facility policy and procedure for reporting and interview, the facility failed to notify the State Agency (Division of Licensing and Certification) of a resident -to-resident sexual altercation in a timely manner for 1 of 1 resident reviewed for a resident -to-resident sexual. altercation (Resident #28 [R28]). Finding:On 1/6/26, a review of R28's clinical record was completed. R28 is cognitively impaired and is wheelchair dependent. In the nurse note section, a note indicated on Saturday/1/3/25, in the afternoon, R28 was inappropriately sexually touched by a cognitively impaired male resident who is wheelchair dependent).A nurse note dated 1/5/26 (Monday), indicated the Director of Nursing and the Social Worker were notified of the resident-to-resident sexual altercation.On 1/8/26, a review of the facility Abuse-Risk Management Folder, under Take Action - (When an allegation of abuse is made), #3 Based on allegation: notify State agency, Adult Protective agency .A review of the facility Compliance with Reporting Allegations of Abuse/Neglect/Exploitation-Procedure for Response-#2a. Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident.On 1/8/26 at 8:31 a.m., in an interview with the surveyor, the Director of Nursing confirmed that the incident occurred on Saturday 1/3/26 and should have been reported to Licensing and Certification at that time. She stated she was not notified of the incident until Monday 1/5/26, at which time she notified the state agency (Licensing and Certification).

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	01/08/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide a written bed hold notice to a resident who was transferred to the hospital for medical evaluation for 1 of 3 closed record residents reviewed (R61).On 1/7/26, R61's clinical record was reviewed. On 2/24/25 R61 was transferred to the hospital for medical evaluation and treatment following a fall with major injury. The clinical record lacked evidence that R61 and/or R61's representative received a bed hold notice upon transfer.On 1/8/26 at 9:45 a.m., during an interview with a surveyor, the Licensed Social Worker stated she looked through the entire record and found several bed holds but not for the day in question. At this time the surveyor confirmed R61 did not receive a bed hold notice for the transfer to the hospital on 2/24/25.

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	01/08/2026

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 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 Based on record review 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 7 residents reviewed (Resident #42 [42])Finding: Review of Resident #42's clinical record noted that he/she was admitted to the facility on 1218/25. The clinical record lacked evidence that the base line care plan was developed to include the instructions needed to provide minimum healthcare information necessary to properly care for R42. On 1/8/26 at 12:54 p.m., during a clinical record for R42 and during an interview with the Director of Nursing the surveyor confirmed that R42's baseline care plan was not developed within the 48 hours after admission.

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	01/08/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure opened Fluticasone Propionate (Advair Discus) inhalation medication was labeled with an open date and that liquid Lorazepam was kept in a refrigerator in 2 of 2 medication carts (Skilled and Long-Term Care). Findings: 1. On 1/6/26 at 8:15 a.m., during a review of the Skilled Medication cart with Licensed Practical Nurse #1 (LPN1), a surveyor confirmed the following were not labeled or stored properly: - There were 2 bottles of liquid Lorazepam kept in the locked narcotic box with a sticker on the bottle that read refrigerate. LPN1 called the pharmacy in the presence of a surveyor; the pharmacy personnel informed LPN1 that the unrefrigerated Lorazepam were no good. - There were 2 opened packages of Fluticasone Propionate that were not labeled with an open date. The directions on the box indicated the medication was good for 30 days from opening. 2. On 1/6/26 at 8:40 a.m., during a review of the Long-Term Care Medication cart with Certified Nursing Assistant - Medication #1 (CNA-M), a surveyor confirmed the following were not stored properly: -There were 3 bottles of liquid Lorazepam kept in the locked narcotic box with a sticker on the bottle that read refrigerate.

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	01/08/2026

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on record review, observations and interview, the facility failed to provide assistive devices (Kennedy cups; which is a spill proof drinking cup with a secure lid and handle) for 1 of 2 residents reviewed for nutrition (Resident #16 [R16]) and in addition the facility failed to have enough eating equipment/utensils for between meals and snack times for 3 of 4 days of survey. (1/6, 1/7 and 1/8/26)Findings:On 1/6/26 at 12:13 p.m. during a meal observation with R16, an observation of his/her lunch tray in front of R16. R16 had finished his/her meal the surveyor observed R16 had a Kennedy cup with milk in it and a regular cup of coffee (mug). Surveyor requested to review his/her meal slip and on this slip it documented for this resident to use an assistive device which was a Kennedy cup. Surveyor asked if R16 always received their coffee this way? R16 stated yes the coffee is always in a regular mug and not the cup with cover (Kennedy cup) The Son who was present stated this was a daily thing not having his coffee in a Kennedy cup.On 1/6/26 at 1:45 p.m., a Certified Nursing assistant (Cna) came into R16's room when R16 asked for more coffee. She returned to the room with a regular cup of coffee (not in a Kennedy cup as directed on the meal slip). The surveyor asked this Cna why she did not provide a Kennedy cup for the coffee. She stated that they did not have any on the floor and if she went to the kitchen they would not have any additional cups. They have enough for mealtimes but there are never any extras to use.On 1/6/25 at 2:35 p.m. during an observation of the kitchenette area with a Certified Nursing Assistant medication aide (Cna-M1) an observation of the cupboards was done, there were no assistive devices (Kennedy cups, covered cups,) and no regular drinking glasses, no coffee cups, and no bowls, Cna-M1 showed that they have cans of soup but no microwave to heat them and no bowls to put it into stating this is daily. On the top shelf a small package of Styrofoam cups was available for resident use.On 1/6/26 at 2:40 p.m., during an interview with the Food Service Director (FSD), the surveyor confirmed that the facility failed to have enough assistive devices like the Kennedy cup for use between meals and snack times.On 1/7/26 during a second observation of the kitchenette area on the Long Term Care side (LTC) of the facility, the kitchenette remained empty of extra cups, bowls, coffee mugs, regular drinking cups and no assistive devices (cups with covers, cups with handles)On 1/8/26 during a third observation of the kitchenette on the LTC side of the facility the kitchenette lacked any coffee mugs, bowls, cups, regular drinking cups and no assistive devices (cups with covers, cups with handles)On 1/7/26 at approximately 9:10 a.m. during a follow up interview with the FSD, he stated they did have more bowls, cups, glasses and built-up utensils but they seem to go missing. He will order more and make sure the kitchenettes have some available for staff to use for the residents.

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	01/08/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain a garbage storage area and in a sanitary condition to prevent the harborage and feeding of pests for one trash dumpster and for an area outside the back kitchen door for 1 of 4 days of survey (1/7/25).Finding:On 1/07/26 at 8:51 a.m. a surveyor and the Administrator along with the Food Service Director observed a bag of garbage on the ground and not contained in the dumpster, additionally on the back dock there were several soiled gloves on the floor/ground and not contained in a garbage bag. The Surveyor confirmed the findings at the time of the observation.

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	01/08/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 sampled residents (Resident #42 [R42], R4). Findings:1.R4's clinical electronic medical record was reviewed. Prescriber written Order Summary Report, dated [DATE], indicated under Other Order Summary, Advance Directive: CPR (cardiopulmonary resuscitation) Order Status, Active. R4's clinical electronic medical record was reviewed, an attachment under misc. [miscellaneous], topic CODE STATUS was signed by a provider on [DATE] and is checked DO NOT RESUSITATE. An attachment under misc., topic DO-NOT-RESUSCITATE (DNR) DIRECTIVE, handwritten, -DO NOT INTUBATE- was signed by R4's representative and a provider on [DATE]. On [DATE] at 2:58 p.m., the Director of Nursing (DON) and a surveyor reviewed R4's electronic clinical record. The surveyor confirmed in an interview with the DON that R4's clinical medical record contained two different directions for code status. 2.On [DATE] at 2:29 p.m. during a clinical record review for R42 a review of his/her Medication Administration Report (MAR) for [DATE] and [DATE], resident was admitted with an order for Keppra Oral Tablet 500 (milligrams) mg Give 1 tablet by mouth two times a day for epilepsy. On [DATE] the day of admission a nurse entered this order in the electronic health care system (Point Click Care, [PCC]). The order was entered incorrectly/inaccurately; it was entered as an unsupervised self-administration medication. By the nurse entering this order as an unsupervised self-administration medication it caused R42 to miss 40 doses of Keppra Oral Tablet 500 mg a medication that is used for epilepsy. During this clinical record review, it was determined that R42 was not self-administering any medications. On [DATE] at 12:56 p.m. during an interview with the Director of Nursing, the surveyor confirmed that due to the inaccurate medication entry R42 missed 40 doses of her Keppra, an epilepsy medication.

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	01/08/2026

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded for Hospice services for 1 of 1 resident reviewed for Hospice services Resident #44 [R44]). Finding: On 1/8/26, a review of R44's clinical record was completed. A Social Service note, dated 11/17/25, indicated the resident was started on Hospice services. A review of the 11/25/25 significant change MDS indicated Hospice was not coded under J1400 or under OK1.On 1/8/26 at 1 p.m., in an interview with the surveyor, the MDS Coordinator, confirmed that the 11/25/25 significant change MDS was not coded for Hospice under J1400 or under OK1.