STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205116	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Health Care	335 Stillwater 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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33242 Based on record review and interviews, the facility failed to ensure physician ordered medications with parameters to hold were followed for 1 of 1 residents reviewed with medication parameters (Resident [R]1). Findings; 1. On 3/26/24, R1's clinical record was reviewed and included a physician order, dated 2/28/24, for scheduled Acetaminophen, 325 milligrams (mg) tablets x 3 tablets (975 mg) to be administered at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The clinical record also included an as needed (PRN) order for Acetaminophen, dated 2/27/24, 500 mg every 4 hours as needed for pain/fever, with parameters not to exceed 3 grams (3000 milligrams) in a 24 hour period. A review of the Medication Administration Record indicated at on 3/10/24 at 10:00 p.m., R1 received 975 mg of Acetaminophen; on 3/11/24, R1 received 975 mg of Acetaminophen at 6:00 a.m. and 2:00 p.m. and 500 mg at 8:43 a.m. for fever and 4:41 p.m. for pain. The total Acetaminophen documented as being administered in a 24 hour period was 3925 milligrams, exceeding 3000 milligrams in a 24 hour period. On 3/26/24 at 12:55 p.m., a surveyor confirmed with the Director of Nursing that documentation indicated at R1 received Acetaminophen greater than 3 grams in a 24 hour period. 2. R1's clinical record included a physician order for Nitroglycerin ointment, dated 3/1/24, to be applied to the necrotic area on the left 3rd finger three times a day, at 9:00 a.m., 2:00 p.m., and 7:30 p.m. with parameters to hold if systolic blood pressure is below 100. On 3/3/24 at 8:29 a.m., R1's blood pressure was documented as 98/52 but the Treatment Administration Record (TAR) indicated that the Nitroglycerin ointment was applied at 9:00 a.m., but should have been held. On 3/4/24 at 2:28 p.m., R1's blood pressure was documented as 94/59 but the Treatment Administration Record (TAR) indicated that the Nitroglycerin ointment was applied at 2:00 p.m., but should have been held. On 3/26/24 at 1:10 p.m., during an interview with the Director of Nursing, a surveyor confirmed this finding.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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
	205116	A. Building B. Wing	03/26/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33242 Based on record review and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 22 of 31 treatment opportunities for Resident #1's treatment for Nitroglycerin ointment application. Findings: On 3/26/24, R1's clinical record included a physician order for Nitroglycerin ointment, dated 3/1/24, to be applied to the necrotic (dead tissue) area on the left 3rd finger three times a day, at 9:00 a.m., 2:00 p.m., and 7:30 p.m. with parameters to hold if systolic blood pressure is below 100. The Treatment Administration Record (TAR) was reviewed and contained the following: 3/1/24 at 2:00 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/2/24 at 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/3/24 at 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/4/24 at 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/5/24 at 2:00 p.m. and 7:30 p.m. the treatment was held but lacked evidence on why it was held. 3/6/24 at 2:00 p.m. and 7:30 p.m. the treatment was held but lacked evidence on why it was held. 3/7/24 at 2:00 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin and at 7:30 p.m. the treatment was held but lacked evidence on why it was held. 3/8/24 at 9:00 a.m., 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/9/24 at 9:00 a.m., 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/10/24 at 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/11/24 at 2:00 p.m. the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin and at 7:30 p.m. the treatment was held but lacked evidence on why it was held. On 3/26/24 at 1:10 p.m., during an interview with the Director of Nursing, a surveyor confirmed these findings. The Director of Nursing stated that the way the order was written into the (electronic) system that there was no specific directions to take the blood pressure (even though there were hold parameters.