Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025

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 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. 17282 Based on record review, review of the facility's 'Fall Policy and Procedure' and interview, the facility failed to re-evaluate fall interventions and the relevance of the current fall interventions for 1 of 2 sampled residents (Resident #30 [R30]) reviewed for 7 falls within 8 months timeframe. Finding: On 1/15/25, a review of R30's clinical record was completed. R30 is diagnosed with Alzheimer's Disease/Dementia. Nurse's notes indicated that from 6/3/24 through 1/3/25, R30 has had several unwitnessed falls, mostly in the late afternoon and evening time, in his/her bedroom. On 6/12/24 at 12:23 p.m., R30 was found on their bedroom floor and had sustained a fracture of the right femur. On 8/19/24, R30 found in bedroom and apparently had slid from their wheelchair onto their bedroom floor. On 9/14/24, R30 fell to the bedroom floor. When found, R30 told staff they were reaching for the TV remote. On 10/25/24, R30 found on floor next to the bed. On 11/13/24, R30 found on bedroom floor, slid to the floor from his/her bed while staff in room. On 12/11/24, R30 found on bedroom floor after falling from wheelchair. On 1/3/25, R30 found on bedroom floor after getting up from his/her wheelchair and falling to the bedroom floor. A review of R30's care plan, dated 6/13/24, indicated for the problem of safety and the potential for falls, interventions were to use non-skid footwear, monitor for medication side effects, report behaviors, and keep call bell in reach. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R30's care plan, dated 9/7/24, indicated for the problem of at risk for falls, interventions were to keep call bell in reach, use non-skid footwear, fall mat to each side of bed and use fall risk strategies. The highlighted fall strategies for R30 were to use fall mats, low bed, call light in reach, personal items in reach. On 1/16/25, a review of the facility's Fall policy and Procedure (Clinical Protocol) indicated under Cause Identification: Number 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. Under Treatment/Management: Number 1: Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 2. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continued (for example, if the individual continues to try to get up and walk without waiting for assistance). Under Monitoring and Follow-Up: Number 2. The staff and physician will monitor and document the interventions intended to reduce falling or the consequences of falling. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (bedsides those that have already been identified) and will re-evaluate the continued relevance of current interventions. On 1/16/25 at 10:20 a.m., in an interview with the surveyor, the Director of Nursing confirmed that R30 continues to have unwitnessed falls. He stated has not re-evaluated the effectiveness of the current fall interventions, has not tried other interventions to attempt to reduce the falls, and confirmed that he has not followed the facility's fall policy and procedures.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record review and interviews, the facility failed to provide interventions outlined in the resident's care plan to ensure that two-person assist was provided during activities of daily living (ADL) for 1 of 2 sampled residents (Resident #12 [R12]), reviewed for falls. The failure to have supervision (two-person assist) as directed by the care plan resulted in an avoidable accident; R12 falling out of bed during evening ADL care, requiring transfer to the emergency room [ER] with admission to the hospital, sustaining a laceration to the head, and rib fractures with increased pain. In addition, based on record review, and interview, the facility failed to adequately supervise a fall risk resident for 1 of 2 sampled residents (R30), reviewed for falls. Findings: R12 was admitted on [DATE] with diagnosis to include diabetes mellitus, peripheral vascular disease with history of right above-the knee amputation, most recently a left toe amputation, and history of deep vein thrombosis on Coumadin (a blood thinner). Review of R12's Report a Facility Incident or Complaint form, dated 5/29/24 at 12:22 p.m. from the facility, indicates that on 5/28/24 at 21:00 (9:00 p.m.), while providing incontinent care to R12, Certified Nursing Assistant #4 (CNA4) had to change his gloves, while he stepped away to get clean gloves R12 rolled out of bed. R12 had laceration above left eye. Pain reported in left torso/rib area. R12 was admitted for follow-up and reported rib fracture per imaging report. Review of R12's follow-up report Report of Facility Incident or Complaint form, dated 5/31/24 at 3:28 p.m. from the facility, indicates that, CNA4 tasked with R12's care did not follow his/her plan of care. It is noted that R12 was a 2 person assist in bed and for incontinence care. CNA4 provided care on his own. CNA4 will go back on orientation to ensure that he is providing safe resident care to our residents. This same CNA will also be receiving a disciplinary write up for this infraction. He will also be required to complete safe resident handling education. R12 received a laceration above his/her left eye, and fractured ribs 2 - 6 on the left side. R12 was admitted to the hospital. Review of R12's Baseline Care Plan (CP) dated 5/24/24, indicates under Baseline CP: I NEED: some assistance can't complete my cares on my own; BECAUSE I: have below knee amputation; I REPOSITION IN BED: with 2 helpers providing more than half the effort. Review of R12's Kardex Guidelines for Daily Care indicates under MOBILITY: I reposition in bed: with 2 helpers providing more than half the effort. Review of R12's fall charting indicates on 5/28/24: 21:00 (9:00 p.m.) resident room. Laceration left forehead c/o (complain of) pain left side torso hit head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R12's injury report indicates that on 5/28/24 21:00 (9:00 p.m.) R [12], (CNA4), lac (laceration) left forehead c/o (complain of) pain left side torso hit head, ER . Bed height: higher for hygiene, incontinence care .CNA [4] cleaning resident for incontinence care, he stepped away for a second to grab a clean pair of gloves. R [12] yelled; I'm going. CNA [4] saw R [12] roll out of bed. - ran for additional staff assistance. Resident found on the right side of the bed (on floor, per Administrator interview on 1/15/25). Small amount of blood coming from his/her left eyebrow and forehead area. Vitals taken; ems [emergency medical services] called. c/o (complain of) pain on left side of his/her torso (rib area) and left arm more than c/o pain in his/her head. On 1/16/25 at 8:35 a.m. in an interview with a surveyor via telephone, CNA4 states, R12 rolled out of bed. I was performing care, patient care hygiene. R12 couldn't hold his/her balance, he/she only has one leg, and his/her weight got to him/her. CNA4 states, I think R12 was a two person assist. CNA4 did admit to caring for R12 by himself when the care plan and Kardex states R12 is a 2 person assist. On 1/15/24 at 12:23 p.m. in an interview with a surveyor, CNA7 stated that R12 needs 2-person assistance, and stated that this can be found in the Kardex, and pointed to a binder in the nurses station on A wing where the Kardex, Guidelines for daily care, on each resident is kept. Review of CT Abdomen and Pelvis with Contrast report findings on 5/29/24 at 1:31 a.m., Chest Findings: Displaced acute appearing fractures of the left anterior lateral 2nd through 6th ribs. On 1/15/25 at 10:34 a.m. in an interview with the Director of Nursing (DON), a surveyor confirmed that the baseline care plan for R12 states he/she needs 2-person assistance with repositioning. The failure to have two staff members present during care for R12 resulted in the resident falling out of bed and sustaining injuries. 17282 2. On 1/15/25, a review of R30's clinical record was completed. R30 is diagnosed with Alzheimer's Disease/Dementia. Nurse's notes indicated that R30 had several unwitnessed falls, mostly in the late afternoon and evening time; On 6/12/24 at 12:23 p.m., R30 was found on their bedroom floor and had sustained a fracture of the right femur. On 8/19/24, R30 found in bedroom and apparently had slid from their wheelchair onto their bedroom floor. On 9/14/24, R30 fell to the bedroom floor. When found, R30 told staff they were reaching for the TV remote. On 10/25/24, R30 found on floor next to the bed. On 11/13/24, R30 found on bedroom floor, slid to the floor from his/her bed while staff in room. On 12/11/24, R30 found on bedroom floor after falling from wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/3/25, R30 found on bedroom floor after getting up from his/her wheelchair and falling to the bedroom floor. A review of R30's care plan, dated 6/13/24, indicated for the problem of safety and the potential for falls, interventions were to use non-skid footwear, monitor for medication side effects, report behaviors, and keep call bell in reach. A review of R30's care plan, dated 9/7/24, indicated for the problem of at risk for falls, interventions were to keep call bell in reach, use non-skid footwear, fall mat to each side of bed and use fall risk strategies. The highlighted fall strategies for R30 were to use fall mats, low bed, call light in reach, personal items in reach. On 1/16/25 at 7:15 a.m., in an interview with Certified Nurse Assistant-Medication (C.N.A.-M), she stated she works from 6 a.m. to 6 p.m. She stated she most always works on the A-Wing, where R30 lives. CNA-M stated R30 is a 'sun downer'. [R30] gets more agitated and anxious in the late afternoon and evening. The C. N.A.-M stated they try to keep an eye on R30, but they aren't always able too. C.N.A.-M stated most of the falls occur during late afternoons, dinner time and evening in R30's room and are unwitnessed. On 1/16/25 at 10:20 a.m., in an interview with the surveyor, the Director of Nursing confirmed that he has not evaluated the times and causes for R30's falls and has not put in place a plan for supervision and monitoring of R30 during the times of day that the resident experiences greater anxiety and is at a higher risk for falls.