

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Eastport Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Boynton Street Eastport, ME 04631	

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)
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17282</p> <p>Based on record review and interviews, the facility failed to ensure that a resident was provided a hearing aid device daily for 1 of 1 resident that required a hearing aid (Resident #1 [R1]).</p> <p>Finding:</p> <p>On 10/7/24, a review of R1's clinical record was completed. R1 was admitted on [DATE] with a diagnosis of bilateral sensorineural hearing loss. On R1's current physician orders dated 9/19/24, there is an order to install 1 device (hearing aid) in each ear in the morning and remove devices at bedtime.</p> <p>Documentation on a nurse's note dated 8/13/24, written by the Director of Nursing, indicated staff were educated about hearing aids and reminded that it is in his/her plan of care.</p> <p>R1's current care plan indicates R1 has the potential to have problems communicating. The intervention indicates to make sure R1 has his/her hearing aids, and that they are functioning appropriately. In addition, under the care plan problem of anxiety and agitation, the intervention is to evaluate R1 for situational stressors such as are his/her hearing aids in.</p> <p>On 10/7/24 at 12:30 a.m., in an interview with a family member, they stated R1 often has no hearing aid in because staff are unaware how to use them, and on 10/6/24 at around 2:00 p.m., R1 did not have a hearing aid in when the family member came to visit.</p> <p>On 10/7/24 at 1:30 p.m., in an interview with the Director of Nursing (DON), she stated that on 10/6/24, she was responsible for putting R1's hearing aide in and she did not. She stated they try to get the hearing aid in for Zoom (a communications platform that allows users to connect with video, audio, phone, and chat) visits that occur at 2 p.m. but she was unable to determine if the aid is in while resident is awake at other times of the day. The DON confirmed they do not have a system in place to monitor the use and care of the hearing aid and if R1 is being provided the hearing aid daily.</p>

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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