Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205185	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - Bangor	44 Hogan Rd 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 17282 Based on record review and interviews, the facility failed to protect a resident ' s right to be free from physical abuse by staff, when a Certified Nursing Assistant (C.N.A.) held a residents arms down during care, causing the resident to sustain bruising on arms and causing the resident to be angry for 1 of 1 residents reviewed (Resident #1 [R1]). Finding: On 5/6/24, R1's clinical record was reviewed. The record indicated R1 was diagnosed with dementia, anxiety, severe agitation, and psychosis and resides on the secured [memory care] unit. A nurse note, dated 4/3/24, indicated that the R1 had new bruises on his/her left upper and lower forearm and a bruise on the upper right arm. On 5/6/24 at 8:35 a.m., in an interview with Registered Nurse-Nurse Manager (RN-NM), she stated that on 4/3/24, C.N.A.2 wheeled R1 to her office. C.N.A.2 stated that R1 shouted out angrily that C.N.A.1 threw him/her around. RN-NM and C.N.A.2 observed new bruises on R1's arms. RN-NM assessed the resident and no other injuries were observed. RN-NM stated in her interview that she immediately interviewed C.N.A.1 about the bruising on R1's arms. C. N.A.1 stated he assisted R1 to the toilet and was trying to bath R1. R1 was trying to hit him during morning care so C.N.A.1 stated he grabbed R1's left arm and held it down on the toilet's safety rail while he finished the bath. On 5/6/24 at 9:42 a.m., in an interview with C.N.A.1, he stated in an interview that he did not hold R1's arm down. He stated R1 was trying to hit him so he pushed the resident's arm away. On 5/6/24 at 10:05 a.m., in an interview with C.N.A.2, he stated he took care of R1 on 4/2/24, the day before the incident and he did not notice any bruising on R1's arms. C.N.A.2 stated on 4/3/24, R1 wheeled up to C. N.A.2 and was very angry. R1 pointed at C.N.A.1 and said he threw [R1] around. C.N.A. 2 stated he noticed some red bruising on his arms, so wheeled R1 to RN-NM office. and reported the incident. On 5/6/24 at 10:20 a.m., in an interview with the day Charge Nurse, she stated the RN-NM asked her to take care of R1. Charge Nurse stated she noticed the new bruises on his/her arms. (continued on next page)

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - Bangor	44 Hogan Rd 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 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/6/24 at 11:02 a.m., in an interview with C.N.A.3, she stated she worked on 4/2/24, the day before the incident and she stated she observed R1 in the corridor several times that day and did not notice any bruises on R1's arms. On 4/3/24, C.N.A.3 stated that C.N.A.1 asked her to switch residents with him because R1 was trying to hit him. C.N.A.3 stated she took care of R1 for a while. She stated she washed him up and noticed the bruises on R1's arms. C.N.A.3 also stated that R1 told her C.N.A.1 grabbed [him/her]. On 5/6/24, a review of the facility's Abuse Policy, page 1, paragraph 2, indicated staff will protect each resident from abuse. Defined physical abuse as physical assaults, cruel discipline, excessive use of physical or chemical restraints, or unnecessary or incorrect medication that may cause pain, inability to move limbs, burns, cuts, internal injuries, marks or bruises. As a result of this isolated incident, the following corrective actions were initiated on 4/3/24. -The RN-NM terminated C.N.A.1. -The Staff Development Coordinator and the Assistant Director of Nursing provided all direct care staff and licensed nurses on all the facility's Units (B-Unit, C-Unit and D-Unit) on Resident Abuse, Neglect and Exploitation. In addition, staff were in-serviced on 'Burn Out'.