

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER Maine Veterans Home - Bangor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>37648</p> <p>Based on observations and interviews, the facility failed to ensure that a resident requiring feeding assistance was done in a dignified manner for 1 of 1 resident observed requiring feeding assistance (Resident #2).</p> <p>Finding:</p> <p>On 7/8/24 during observation of breakfast tray pass. Resident #2 was sitting in a Broda chair at one of the entrances to the dining area. Next to resident #2 was a dining room chair. A Certified Nurse's Assistant (CNA) placed Resident #2's breakfast tray on the tray table in front of him/her at 8:24 a.m. and walked away. The same CNA continued to deliver trays to the other residents in the dining room and two additional residents outside the dining area. At 8:50 a.m., the CNA approached Resident #2 standing in front of him/her and feed the resident two bites of food, put the spoon down and walked away. At 9:02 a.m., the same CNA returned and collected the uneaten tray without speaking to the resident or asking if he/she wanted more food.</p> <p>On 7/8/24 at 9:32 a.m., the above was discussed with the Director of Nursing and Assistant Director of Nursing.</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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648</p> <p>Based on record review, observations, and interview, the facility failed to provide interventions outlined in the resident's care plan in the area of Self-care deficit and Nutrition for 1 of 3 sampled residents. (Resident #2)</p> <p>Finding:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnosis of Dementia and Dysphagia. The History and Physical dated 2/21/24 states he/she is a nonverbal resident. Review of Resident #2's care plan, initiated 2/20/24, last revised 5/28/24 for self -care deficit in the area of eating has a nursing intervention of, I am dependent. One assist. Please alternate 1 to 2 bites of food followed by a sip of liquid. If client refuses a meal, please reapproach . The care plan initiated on 2/29/24, last updated on 5/28/24 for nutrition has a nursing intervention of, Assist to eat, Set up foods as needed. Feed all meals. Maintain eye contact during feeding.</p> <p>On 7/8/24 observation of Resident #2 in a Broda chair at the entrance of the dining room with an empty chair next to him/her. At 8:24 a.m., the Certified Nurse's Assistant (CNA) placed residents #2 tray in front of him/her then walked away. At 8:50 a.m., the CNA approached resident #2, stood in front of the tray table and asked the resident, are you going to eat some breakfast, your sleeping the CNA then attempted to feed the resident a spoon full of puree banana muffin, which resident refused (moving his/her head). CNA then stated, you need to wake up, is it too cold, want some water? The CNA did not heat up the food or give the resident fluids. She then offered the resident another bite. The resident was given 2 spoonful's of food. The CNA then put down the spoon and walked away. At 9:02 a.m., the same CNA returned and collected the uneaten tray, not speaking to the resident or asking if he/she wanted more food.</p> <p>On 7/8/24 at 9:32 a.m., the above was discussed with the Director of Nursing and Assistant Director of Nursing.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37648</p> <p>Based on facility policy, record reviews and interviews, the facility failed to follow physician orders for 1 of 3 sampled residents review for medications (Resident #3).</p> <p>Findings:</p> <p>Facilities Medication Administration Procedure dated 1/2020 states, Assign AM and PM for medication administration times unless specified otherwise by physician services . physician services will specify if they want medications administered every twelve hours or other hourly times . Schedule hypothyroid medication to be administered on an empty stomach, but must be scheduled for consistency, however not before 7:00 AM unless resident prefers.</p> <p>On 7/8/24 at 11:45 a.m., during an interview, Resident #3's family representative stated his/her Parkinson's medication is not being given timely with regards to doses being to close together, given with meals or as instructed by the neurologists.</p> <p>Review of the scheduled mealtimes for resident #3 are as follows: Breakfast served at 8:30 a.m., Lunch at 12:30 p.m. and Dinner at 5:30 p.m.</p> <p>A review of Resident #3's clinical record containing Provider orders and the Medication Administration Record (MAR) indicated the following medications Sinemet and Levothyroxine were given at incorrect times/or with meals:</p> <p>1. A provider order dated 12/22/23 for Levothyroxine Sodium (Hypothyroid medication) 75 microgram (mcg) tablet by mouth daily at 7:00 a.m. for hypothyroidism.</p> <p>On 6/8/24 the Levothyroxine dose was given at 8:54 a.m.</p> <p>On 6/9/24 the Levothyroxine dose was given at 8:48 a.m.</p> <p>On 6/21/24 the Levothyroxine dose was given at 8:26 a.m.</p> <p>On 7/1/24 the Levothyroxine dose was given at 8:31 a.m.</p> <p>On 7/3/24 the Levothyroxine dose was given at 8:29 a.m.</p> <p>On 7/4/24 the Levothyroxine dose was given at 8:06 a.m.</p> <p>On 7/6/24 the Levothyroxine dose was given at 8:17 a.m.</p> <p>On 7/7/24 the Levothyroxine dose was given at 8:22 a.m.</p> <p>On 7/8/24 the Levothyroxine dose was given at 8:10 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. A Provider order dated 6/5/24 for (Sinemet) Carbidopa - Levodopa 25 milligram (mg)-250mg table, give 1 tablet by mouth five times a day 5:30 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 7:00 p.m. for Parkinsonism.</p> <p>On 6/6/24 the 3:00 p.m. Sinemet dose was given at 5:15 p.m.</p> <p>3. A provider order dated 6/6/24 for Sinemet 25mg -250mg table, give 0.5 tablet by mouth at 10:00 p.m. Administration Instructions: Leave current timing of medications per neurologists.</p> <p>On 6/8/24 the Sinemet was given at 7:47 p.m.</p> <p>4. New Provider orders dated 6/18/24 for (Sinemet) Carbidopa - Levodopa 25 milligram (mg)-250mg table, give 1 tablet by mouth five times a day 7:00 a.m., 10:00 a.m., 2:00 p.m., 4:30 p.m., 7:00 p.m. for Parkinsonism. Administration Instructions: Leave current timing of medications per neurologists. Do not give with meals and the order for Sinemet 25mg -250mg table, give 0.5 tablet by mouth at 10:00 p.m. Administration Instructions: Leave current timing of medications per neurologists. Do not give with meals.</p> <p>On 6/19/24 the 2:00 p.m. Sinemet dose was given at 11:47 a.m., and the 10:00 p.m. dose was given at 8:56 p.m.</p> <p>On 6/21/24 the 7:00 a.m. Sinemet dose was given at 8:26 a.m.</p> <p>On 6/22/24 the 10:00 p.m. Sinemet dose was given at 8:36 p.m.</p> <p>On 6/25/24 the 10:00 a.m. Sinemet dose was given at 12:17 p.m.</p> <p>On 7/1/24 the 7:00 a.m. Sinemet dose was given at 8:32 a.m.</p> <p>On 7/3/24 the 7:00 a.m. Sinemet dose given at 8:30 a.m., the 10:00 a.m., dose was given at 8:37 a.m.</p> <p>On 7/6/24 the 10:00 p.m. Sinemet dose was given at 7:00 p.m.</p> <p>On 7/7/24 the 10:00 p.m. Sinemet dose was given at 7:09 p.m.</p> <p>5. A new Provider order dated 7/3/24 for Sinemet 25mg -250mg table, give 1 tablet by mouth five times a day 7:00 a.m., 10:00 a.m., 2:00 p.m., 4:30 p.m., 7:00 p.m. for Parkinsonism. Administration Instructions: ***Alert *** DO NOT GIVE WITH MEALS/FOOD -Leave current timing of medications per neurologists.</p> <p>On 7/4/24 the 7:00 a.m. Sinemet dose was given at 8:06 a.m.</p> <p>On 7/5/24 the 10:00 a.m. Sinemet dose was given at 11:08 a.m.</p> <p>On 7/6/24 the 7:00 a.m. Sinemet dose was given at 8:17 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/7/24 the 7:00 a.m. Sinemet dose was given at 8:22 a.m., the 2:00 p.m., dose was given at 3:32 p.m.</p> <p>On 7/8/24 the 7:00 a.m. Sinemet dose was given at 8:11 a.m.</p> <p>On 7/8/24 at 2:15 p.m., during an interview, the Director of Nursing confirmed the above medication times were given outside of the provider orders.</p>		