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No. 0938-0391

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 03/17/2025
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.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35904 Based on a review of the reports from Adult Protective Services (APS), the facility's internal investigations, facility policies, clinical record reviews and interviews, the facility failed to assess a resident (Resident#5 [R5]) for the ability to consent to sexual behavior with another resident (R6). The failure to assess R5 for the ability to consent resulted in R5 not being free from potential sexual abuse. Additionally, the facility failed to ensure that residents were free from verbal and physical abuse by a Certified Nursing Assistant (CNA) for 3 of 3 residents reviewed for abuse. This failure created an immediate jeopardy situation. (R5, R3 and R2). Findings: 1.On 1/31/25, the State Survey Agency, (also known as Division of Licensing and Certification (DLC) received an Adult Protective Services (APS) report which stated on 1/30/25 the facility called R5's court appointed guardian informing her that, R5 was in a male patient's room and his pants were down. The staff wheeled R5 back to his/her room and are doing 15-minute checks on R5. The court appointed guardian stated to APS intake staff, facility didn't share the male patient's name and R5 is unable to communicate if anything happened. On 2/18/25, the DLC received another APS report which stated that R5's court appointed guardian called APS and stated that a Hospice nurse reported to her that on 2/13/25 the same male patient [in the 1/30/25 incident] had exposed himself to R5 and attempted to enter R5s room on 2/14/25. R5s guardian called the facility, and the facility stated that the incidents were consensual. However, the report states that R5 has dementia and is under guardianship. A review of the facility's investigation titled Internal Fact-Finding Summary dated 2/27/25 stated, Synopsis of Issues: On 1/30/25 R5 was found in R6's room. R6 had pants down and R5's mouth was on R6's penis. And stated On 2/14/25 RN4 reported to RN5 that R5 was being pushed in a wheelchair by R6. RN4 reported that R5 cowered into the nurse's station and appeared to be afraid of R6. At this time R6 was moved to another unit. A review of R5s clinical record states [he/she] has a diagnosis that includes but is not limited to, vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R5s current care plan includes an approach dated 1/31/25 Resident may exhibit sexual behaviors with male residents. If resident displays sexual behaviors, assess resident for signs of behavior changes related to sexual behaviors. If resident appears agitated, anxious, or is crying, redirect resident away from male residents. Notify the supervisor or nurse manager if sexual behavior is occurring and is creating an unwanted interaction. If resident is engaging in consensual sexual behavior, provide privacy. A review of R5s clinical record lacks evidence that R5 was assessed for the ability to consent to sexual behaviors with male residents. Additionally, review of A State of Maine Physician's/Psychologist's report (Guardianship and/or conservatorship Proceedings) document signed on 4/6/23 by a registered physician assistant states under the evaluation of Respondent's mental and physical condition [R5] lacks executive function and cannot make [his/her] own decisions During the clinical record review for Resident 6 [R6] the surveyor noted a Provider Request form dated 10/28/2024, which stated On Sunday R6 was found in [his/her] room with a female resident. The door was shut, and when staff entered both had their pants down and were touching one another. I am not sure if this is a one-time thing or increased sexual behavior and another notification to the medical provider in January of 2025 resulted in new medications added to the medication regime for R6 related to inappropriate sexual behaviors. On 3/12/25 at 11:23 a.m. in a telephone interview with a surveyor, R5's court appointed guardian confirmed that R5 does not have the capability to consent and has no history of sexual behavior. It was reported to her from the facility that on 1/30/25 an incident occurred with R5 that was consensual, and when she asked what that meant, she was told by the facility that consensual meant they are both participating. The court guardian confirmed that R5 is not able to make his/her own decisions and would not have the capacity to consent to sexual behavior with male residents. On 3/13/25 at 1:14 p.m. in a telephone interview with a surveyor, CNA5 stated that: -R6 has had several observed incidents of trying to get female residents to enter [his/her] room, with many of the female residents stating, get away from me. -R6 was observed in rooms of female residents with pants down, standing over the female resident as they were lying in their beds. -CNA5 recalled looking for R5 and went to R6s room but the door had been barricaded shut with two wheelchairs, once she did gain entry, she found R5 in there sitting in [his/her] wheelchair crying. After this incident, CNA 5 stated R6 was on 15-minute checks. On 3/13/25 at 1:36 p.m. in an interview with the Director of Nursing Services (DNS), a surveyor confirmed that the facility failed to protect R5 from potential sexual abuse by R6, who has a known history of hypersexual behaviors (as evidenced by R6's provider notes and orders), by barricading R5 in R6's room and performing a sexual act. The DNS stated that we determined that no harm had happened, and R5 was okay with the act. R5 wasn't crying, yelling, didn't seem upset. We don't feel all sexual acts are abuse. The facility did not report the incident of 1/30/25 to DLC or any other authority of potential sexual abuse of R5 by R6. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R5's right to be free from sexual abuse was violated. The facility failed to take action to ensure that R5 was assessed for the capacity to consent to sexual behavior with R6. A reasonable person would potentially suffer psychological distress, emotional harm, embarrassment, and deep sadness due to lack of control over the situation and would experience fear of R6. 2. On 2/26/25 the Division of Licensing and Certification (DLC) received a facility report with an allegation that a Certified Nursing Assistant 1 (CNA1) witnessed CNA2 swearing towards residents. [R3] And that CNA2 was placed on administrative leave effective 2/20/25 and voluntarily resigned his position on 2/21/25. A review of the facility's investigation titled Internal Fact-Finding Summary dated 2/28/25 stated that on 2/20/25 CNA1 reported that in the past month she heard and witnessed on five occasions CNA2 make inappropriate remarks to residents; forcefully grab residents by the arms and take them to their rooms. Additionally, CNA1 stated that CNA2 stated the following to R3: -[R3] needs to get the fuck back to bed and stay there and grabbed R3s arm and forcefully took R3 back to their room. R3 stated Please don't hurt me three times, CNA1 noted that R3 was visibly uncomfortable. -CNA2 stated he [R3] needs to shut the fuck up CNA1 heard R3 get into bed while CNA2 was in the room, R3 stated don't do that please CNA2 told CNA1 That should calm [R3] down for a while then stated to R3 I'm not going to hurt you, but you'll know when I do. CNA1 also reported the following between CNA2 and R2: -CNA2 called R2 a stupid bastard CNA1 did not observe any physical interaction between CNA2 and R2, but she did hear R2 yell out AHHH! -CNA2 stated R2s really going to regret coming back out again referring to R2 coming out of his/her room. CNA1 also reported that she noticed more often than not residents have very notable injuries that occur the nights [CNA2] is present. Additionally, under Facts Summary CNA1 stated that these incidents/events had occurred over the last month, maybe three weeks. CNA1 stated CNA2 told her You just take your knee and hit them [residents] in thigh, and they won't get out of bed. CNA2 was interviewed by the facility and denied the allegations. CNA1 completed the facility's abuse training on 11/21/24 and CNA2 completed the training on 11/18/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The clinical record review for R3 revealed a nursing note dated 12/22/24 at 11:38 a.m., a bruise was observed on the back of his/her right thigh measuring 15 centimeters (cm) by 7.5 cm in width. Additionally, during review of the CNA documentation for R3, it showed that CNA2 was the staff who provided care to R3 for the two-night shifts before the bruising was observed (bruising can be observed 24 to 48 hours after injury). Comparing the markings on R3 and the statement that CNA2 made claiming that all you have to do is knee the resident in the thigh and this will keep them in bed for the night. The bruise measuring 15 cm x 7.5 cm and matches the possibility of being struck by a knee. R3's clinical record does not show that R3 had any falls prior to this bruise being found making a fall the reason for this bruised area. A review of staffing schedules was completed within the timeframe CNA1 reports that she observed the incidents between CNA2 and residents. Because of the delay in CNA1 reporting, CNA2 continued to be able to work with residents for a total of 36 shifts. (See F609 for details). On 3/12/25 at 1:09 p.m. during an interview with facility administration, the surveyor confirmed that the facility failed to ensure residents were free from psychological, verbal and physical abuse. Please see F-0000 Initial comments for details related to the IJ template, removal plan, and removal of the IJ. 32540

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

32540

Based on a review of the Nursing Facility Reportable Incident submitted to the Division of Licensing and Certification (DLC) on 2/26/25, the incident report from Adult Protective services on 2/26/25, the facility's internal investigations, written statements by staff, facility policies, clinical record reviews and interviews, the facility failed to ensure staff reported allegations of psychological, physical, verbal, and sexual abuse immediately for 4 of 4 residents reviewed during complaint investigations, (Resident #1[R1], R2, R3, and R5) and failed to report an injury of unknown origin for 1 of 3 residents sampled R3.

Findings:

A review of the facility's policy, Abuse, Neglect, Exploitation and Misappropriation of Property revised 4/24/23, under the heading, on page 1, Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, punishment that causes or is likely to cause physical harm, pain or mental anguish. Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal abuse is the use of oral, written or gestured language that includes disparaging and/or derogatory terms to residents or their families within their hearing distance, regardless of their age, ability to comprehend or disability. Physical abuse is physical assaults, cruel discipline, excessive use of physical or chemical restraints, or unnecessary or incorrect medication that may cause pain, inability to move a limb, burns, cuts, internal injuries, marks or bruises. Mental abuse is verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. On page 3 under section 5.4 Identification/detection: 5.4.1 Resident abuse may be overt or covert. It may be perpetrated by anyone, including but not limited to a staff member, another resident, a family member or another visitor. 5.4.2 reasons to suspect that abuse has taken place may include but are not limited to: 5.4.2.1 Resident complaints of abuse 5.4.2.2 actual observation of physical, verbal or sexual attack 5.4.2.4 unexplained bruises or other injuries 5.4.2.5 resident complaints of pain that are new or sudden and cannot be correlated to any of the resident's diagnosis. 5.4.2.6 resident's apparent fear of another person, whether staff, resident or visitor. 5.4.3 any of the reasons listed above, or any unexplained changes in a resident physical condition or behavior may indicate the possibility that the resident has been subjected to abuse and should be brought to the attention of the Supervisor immediately, but not later than 2 hours if serious bodily injury is involved. Section 5.6 protection 5.6.1 staff will intervene immediately to protect the resident(s) in any situation of actual or potential abuse, neglect, exploitation, or mistreatment. 5.7 Reporting and Response: 5.7.1 staff members will be expected to report actual or suspected abuse, neglect, exploitation or misappropriation of property to their supervisor immediately with subsequent reports to the Administrator and DNS (Director of Nursing Services) 5.7.2 licensed or certified staff and unlicensed assistive personnel are required by Maine law to report actual or suspected abuse, neglect, or exploitation to DHHS and APS. 5.7.5 as required by Maine law and regulation, a report must be made to DHHS with 24 hours and followed up by a written report if requested by DHHS.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 the DLC received a facility report with an allegation that a Certified Nursing Assistant (CNA) was witnessed swearing towards residents. The date of the alleged abuse was 2/20/25 and was not reported to the DLC until 2/26/25. On 2/26/25 at 3:24 p.m., the DLC received a reportable incident from the facility, alleging that on 2/20/25 CNA1 reported that she witnessed CNA2 being physically and verbally abusive to residents (R1, R2, and R3) she stated this has been going on for approximately 3 weeks to a month and did not report it. This allowed CNA2 to work 36 shifts continuing to subject the residents to his verbal and physical abuse. On 3/11/25 at 12:14 p.m. during an interview with the DON she stated she asked CNA1 why this wasn't reported sooner, CNA1 stated she had told her charge nurse, the charge nurse RN1 denied being told until the morning of 2/20/25. DNS stated that CNA1 was re-educated on the spot about reporting things immediately and not waiting. CNA1 reported to DNS that she was afraid of CNA2. At this time the surveyor confirmed that an observed allegation of verbal and physical abuse was not reported to the State timely. On 3/12/25 during a clinical record review for R3 there was a note dated 12/23 for an order to x-ray right hip and upper thigh due to bruise to back of right hip and upper thigh measuring 15cm x 7.5 cm. It is documented that this bruise was found on 12/22/24 and there is no evidence that this injury of unknown origin was reported or investigated. On 3/12/25 at 1:09 p.m. during an interview with a Unit Manager RN3, a surveyor confirmed that this injury of unknown origin was not reported to the DLC. 35904 A review of a facility Internal Fact-Finding Summary dated 2/27/25 stated, Synopsis of Issues: On 1/30/25 R5 was found in R6's room. R6 had pants down and R5's mouth was on R6's penis. On 2/14/25 RN4 reported to RN5 that R5 was being pushed in a wheelchair by R6. RN4 reported that R5 cowered into the nurse's station and appeared to be afraid of R6. At this time R6 was moved to another unit. On 3/13/25 at 1:36 p.m. in an interview with the DNS, a surveyor confirmed that the facility failed to notify DLC of potential sexual abuse on 1/30/25 involving R6 to R5.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 32540 Based on clinical record reviews and interviews, the facility failed to investigate an injury of unknown origin after a resident was found with a bruise for 1 of 6 residents reviewed for abuse (Resident #3 [R3]). Findings: On 3/12/25 at 11:30 a.m. during a clinical record review for R3, there is a nursing note dated 12/22/24 at 11:38 a.m. documenting a bruise on the back of the right thigh measuring 15 centimeters (cm) by 7.5 cm. additional note at 11:43 a.m. documents the bruise is to the back right hip/upper thigh area. The clinical record lacks evidence that this area of bruising injury of unknown origin was investigated by the facility. On 3/12/25 at 1:09 p.m. during an interview with a Unit Manager RN3, the surveyor confirmed that the injury of unknown origin was not investigated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 35904 Based on record reviews and interviews, the facility failed to ensure a care plan was resident centered and updated accurately for 1 of 6 residents reviewed during complaint investigations (Resident #5 [R5]). Findings: 1. Clinical record review indicated R5 has a diagnosis of vascular dementia. The care plan updated 2/26/25 identified the following: -A care area identified on 9/21/23, indicated Dementia. No goal listed. An approach dated 1/31/25 indicated Resident may exhibit sexual behaviors with male residents and If resident displays sexual behaviors, assess resident for signs of behavior changes related to sexual behaviors. If resident appears agitated, anxious, or is crying, redirect resident away from male residents. Notify supervisor or nurse manager if sexual behavior is occurring and is creating an unwanted interaction. If resident is engaging in consensual sexual behavior, provide privacy. On 3/12/25 at 2:28 p.m., during an interview with a surveyor and RN6, R5's care plan was reviewed. The care plan did not address R5's cognitive ability to engage in consensual sexual activity. At this time the surveyor confirmed R5's care plan was not resident centered or updated for an accurate approach due to R5 diagnosis of dementia and inability to consent to sexual activity. At this time the surveyor confirmed R6's care plan was not updated and implemented to meet R5's needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on clinical record review and interviews, the facility failed to ensure physician orders were followed for 1 of 2 sampled residents (Resident #6, [R6]). Findings: Review of R6's physician order sheet, handwritten, dated 10/28/24, stated, in one month present case to Doctor #1 (DR1). Review of R6's physician order sheet, handwritten, dated 10/29/24, stated, medroxyprogesterone 2.5 m.g PO (by mouth) daily for hypersexual behaviors. POA (power of attorney) consented for use. Review of R6's physician order sheet, handwritten, dated 11/11/24, stated, increase medroxyprogesterone to 5 m.g QD (every day). Review of R6's physician orders signed 11/14/24, page 3, stated under medications, 11/11/24 medroxyprogesterone acetate 5 m.g tablet by mouth daily given for antisocial sexual behavior (sexual-associated behavior disruptive to others). Review of R6's physician order sheet, handwritten, dated 12/13/24, increase medroxyprogesterone to 10 m.g PO daily. Re-present to DR1 next opportunity. Review of R6's physician orders signed on 1/16/25, page 2, stated diagnoses to include, Z72.51 high risk for heterosexual behavior. Review of R6's clinical record dated 2/14/25, acute visit, provider PA-C, stated, R6, [AGE] years old, was seen today for escalation of sexually inappropriate behaviors. Staff reports that the patient has been going after several female residents, trying to get them alone closing doors in order to attempt to have inappropriate sexual relations. He/she has been seen making sexual gestures to several female residents. Medroxyprogesterone was resumed subsequently increased. On 1/31/25, medroxyprogesterone 5 m.g daily was initiated due to inappropriate sexual behaviors, with a plan to increase to 10 m.g daily on 2/15/25.Given the fact that the patient has been targeting certain female residents and attempted again today, nursing reached out to management and the patient will be moved to a different room off of the unit to avoid any further incidents. On 3/13/25 at approximately 12:50 p.m., during record review and interview with RN3, a surveyor could not find evidence that R6's case has been presented to DR1 as ordered on 10/28/24 and 12/13/24. RN3 stated DR1 is no longer available, and RN3 and surveyor could not find evidence of follow-up pertaining to DR1 referrals with ordering PA-C as of 3/13/25, 121 days beyond the first order from the PA-C for case to be presented to DR1.