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	08/22/2024

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33242 Based on observation and interview the facility failed to promote care to residents in a manner that maintains each resident's dignity for 3 of 4 meal observations in 2 dining rooms on the B Unit. Findings: 1. On 8/19/24 between 12:30 p.m. - 12:55 p.m., during lunch observation in the East Wing dining room on B Unit, a surveyor observed the following: A surveyor observed Certified Nursing Assistant #1 (CNA1) assisting Resident (R46) with eating at 12:43 p.m. The surveyor observed R46 in his/her chair with CNA1 standing up as she was feeding R46. During an interview with a surveyor, CNA1 stated that she was standing because there were no extra chairs to sit in, in the dining room. R46's tablemate did not receive his/her meal tray until 12:53 p.m. Resident #79 (R79) was observed eating at 12:35 p.m., but his/her tablemate(s) did not receive their food until 12:49 p.m. There was a table with 6 residents, R65 received his/her lunch at 12:43 p.m. The surveyor left the dining room at 12:55 p.m., and 3 of 6 tablemates had not received their lunch by this time. On 8/19/24 at 12:51 p.m., a surveyor asked CNA2 how the meal service is supposed to be delivered. CNA2 stated that they are supposed to serve by table. CNA3 stated that typically we give the kitchen our tickets so they know where the residents are but they wanted to do it themselves today. The kitchen staff was observed bringing the trays into the dining room but with no direction of whose trays were coming in and when. 49635 2. On 8/19/24 at 12:49 p.m., during lunch observation in the [NAME] Wing dining room, a surveyor observed R6 request a sliced turkey sandwich. R6 stopped eating when he/she did not receive one. The Licensed Practical Nurse publicly provided education to R6 regarding their medication, diagnosis, and dietary restrictions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 8/20/24 at 8:40 a.m., during breakfast observation in the [NAME] Wing dining room, a surveyor observed R94 and R41 sitting at a table with 4 other residents. All residents at the table were served except R94 and R41. Staff observed serving other tables. At 8:46 a.m., R94 was served, staff then served other tables. At 8:52 a.m., R41 was the last resident served in the dining room On 8/22/24 at approximately 10:30 a.m., the above observations were reviewed and confirmed with the Administrator.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 17282 Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was admitted with a diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 5 sampled residents reviewed for PASRR (Resident #30 [R30]). Finding: On 8/21/24, R30's clinical record was reviewed which included a PASRR evaluation completed by the hospital, dated 4/4/24, that indicated no PASRR level II was required and there was a mental health diagnosis of anxiety. A review of R30's diagnosis list included in the clinical record: Post-traumatic stress disorder (PTSD), and anxiety disorder, all added to the clinical record on 4/9/24, the date of admission. On 8/21/24 at 12:43 p.m., in an interview with the surveyor, the Licensed Social Worker confirmed that the PASRR should have been updated to include the diagnosis of PTSD and the State mental health authority should have been notified.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review and interviews, the facility failed to update/implement a care plan in the area of communication for 1 of 1 resident reviewed for communication (Resident #76). Finding: Resident #76 was admitted on [DATE] and has diagnoses to include a hearing deficit requiring use of hearing aids. Review of Resident #76's care plan updated 6/21/24 states communication: Impaired communication. Goal: 3 months Approach: assess for unmet needs such as pain, toileting, hunger, thirst. allow extra time to respond. validate understanding. Allow time to respond face resident, speak clearly Further review of Resident #76's care plan lacked evidence that goals and interventions were put into place for his/her hearing needs. Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #76 is hard of hearing and requires hearing aids. Review of Resident #76 clinical record revealed Physician Order Sheet dated 7/12/24 for ENT referral for [right] ear pain/clear drainage/ruptured tm [tympanic membrane] . During an interview on 8/22/24 at 11:38 a.m., the Director of Nursing reviewed Resident #76 care plan and confirmed he/she does depend on hearing aids and care plan does not include goals and interventions for hearing loss / hearing aids.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review, facility policy review, and interviews, the facility failed to complete neurological assessments after unwitnessed falls for 1 of 4 residents reviewed for falls (Resident #7 [R7]). Finding: Clinical Record Review indicated R7 was admitted on [DATE] with a diagnosis of Vascular Dementia. According to the Minimum Data Set (a standardized assessment tool) on 6/19/24, R7 had a Brief Interview for Mental Status (BIMS) score of 1, and a BIMS of 3 on 8/16/24 (a score of 0-7 suggests severe cognitive impairment). Nurse documentation indicated R7 had two unwitnessed falls on 8/14/24. The clinical record lacked evidence that follow-up assessments were completed after the unwitnessed falls. The Fall Prevention policy (dated 4/24/23) indicates a fall may be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or ground, and An Occurrence Report will be completed in ECS following a resident fall, and Neurological Checks will be implemented following any fall with suspected head injury. The Neurological Assessments policy (dated 5/8/24) indicated, In the case of an unwitnessed fall, the resident will be considered to have hit their head unless he/she can reliably state that he/she did not, and Assessments will be completed every 15 minutes for the first hour after the fall; every 30 minutes for the subsequent 4 hours; every shift for the next 72 hours. Between 8/19/24 through 8/22/24, during an interview with a surveyor, regarding R7's falls on 8/14/24, Anonymous (A) staff members (A1, A2, A3, and A4) stated: A1 stated, I couldn't see, but I heard it. [R7] has a habit of coming out in the morning, I heard the crash. We ran right to [R7]. A2 stated, he/she observed the staff and heard the fall, the nurse ran, all the staff ran. A4 I hear a loud bang in the dining room. Staff got up and went over there, and I heard a yelp. [R7] was laying on [their] left side, on the floor. There was no one there to witness it. A3 stated, R7 was found on the floor after an unwitnessed fall, fall assessments were started but then discarded without being recorded in the electronic medical record (ECS). On 8/22/24 at 11:22 a.m., in an interview with a surveyor, the Director of Nursing stated, within 20 minutes a post fall investigation has to be filled out. It includes multiple staff members input (medication technician, charge nurse, certified nursing assistants, and supervisors) The information is used to for a mini root cause analysis. The provider and family are supposed to be called, and it should be documented. Care plans are reviewed to see if new interventions need to be put in place. If a resident puts themselves on the floor, the need to complete a post fall evaluation varies. If a noise is heard from outside the room, and they are found on the floor. It's considered a fall, no matter what, and the post fall investigation needs to be completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 12:06 p.m., in an interview with the Director of Nursing and the B Unit Manager, a surveyor confirmed R7's clinical record lacked evidence that the neurological assessments were completed after the two unwitnessed falls.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review and interview, the facility failed to recognize a potential significant weight loss for 1 of 1 sampled residents reviewed for nutrition (Resident #101 [R101]). Finding: On 8/20/24 at 9:59 a.m., clinical record review indicated R101 was admitted on [DATE] with a diagnosis of dementia and abnormal weight loss. R101's weight on admission was 111.4 pounds (lbs). On 4/18/24, the Baseline Care Plan for R101's dementia included the dietary intervention Provide ordered diet, Identify likes/dislikes, Offer substitute foods, Dietary consult PRN. On 7/25/24, the Potential for Unintended weight loss was added to the Care Plan, including request for dietary evaluation. Monthly weight documentation indicated: On 4/19/24 the resident weighed 112 pounds (lbs). On 5/7/24 the resident weighed 111.1 lbs. On 6/4/24 the resident weighed 106.7 lbs On 7/2/24 the resident weighed 108.7 lbs On 8/6/24 the resident weighed 100.0 lbs (8% weight loss in 1 month and 10.23% in 4 months) On 8/21/24 at 8:10 a.m., in an interview with the B Unit Manager, a surveyor confirmed the clinical record lacked evidence that nursing staff had notified the medical provider or the registered dietitian, and had not initiated nutritional interventions, such as requesting supplements, to address the weight loss.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 49635 Based on record review and interview, the facility failed to ensure a resident's physician supervised and evaluated weight loss for 1 of 1 residents reviewed with significant weight loss (Resident #101 [R101]). Finding: On 8/20/24 at 9:59 a.m., R101's clinical record was reviewed. On 4/17/24 the resident's admission weight was 111.4 pounds (lbs). On 7/2/24 the resident weighed 108.7 lbs. On 8/6/24 the resident weighed 100.0 lbs (an 8% weight loss in one month, and a 10.23% weight loss in 4 months). On 8/21/24 at 8:10 a.m., in an interview with the B Unit Manager, a surveyor confirmed that the clinical record lacks evidence the provider was notified of significant weight loss, nor were there any Provider Progress notes that addressed the significant weight loss.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 33242 Based on record review and interview, the facility failed to follow up on pharmacist recommendations timely, for 1 of 5 residents reviewed for unnecessary medications (Resident #19 [R19]). Finding: On 8/20/24 at approximately 2:03 p.m., a surveyor and the B Unit Manager reviewed R19's clinical record which included an order, dated 4/18/24, for Trazodone 50 milligrams as needed (PRN) at bedtime with no duration of the order. The surveyor reviewed the pharmacist recommendations, dated 4/19/24 and 5/16/24, for the medication Trazodone, with both of the recommendations indicating use of PRN (as needed) antidepressants must be limited to 14 days with the exception that the prescriber documents their rationale in the patient's medical record and indicates the duration for that PRN order. This order was not discontinued until 6/11/24. The surveyor confirmed with the B Unit Manager this finding.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on facility policy review, interviews, and record reviews, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS), used to monitor for potentially irreversible side effects of antipsychotic medications, was completed when an antipsychotic medication was started, when a dose changed, or every 6 months, for 2 of 4 sampled residents reviewed (Resident [R] 19. R74). In addition, the facility failed to ensure the physician wrote a rationale and/or order with a duration to extend an as needed (PRN) psychotropic medication beyond the 14-day limit, for 1 of 1 resident reviewed (R19) . Findings: The facility's policy, Antipsychotic Medications, last reviewed [DATE], defines that an AIMS test will be done at the initiation of the antipsychotic (medication) or with a change in dosage and at least every 6 months there after. On [DATE] 2:35 p.m. During an interview with a surveyor the Director of Nursing (DON) and Assistant DON (ADON) stated that an AIMS test should be completed as a baseline, with a dosage change and at least every 6 months. 1. On [DATE], R19's clinical record was reviewed and included a physician order for Risperidone (antipsychotic medication). At 2:45 p.m., the ADON and surveyor reviewed R19's physician orders and noted that R19 had a dose increase of Risperidone 0.5 milligrams (mg) on [DATE], from twice a day to three times a day. The most recent AIMS test in the clinical record was completed on [DATE]. The surveyor confirmed that an AIMS test was not completed when the Risperidone increased with the ADON during this review. On [DATE] at approximately 2:03 p.m., a surveyor and the B Unit Manager reviewed R19's clinical record which included an order, dated [DATE], for Trazodone 50 mg as needed (PRN) at bedtime with no duration of the order. The surveyor reviewed the pharmacist recommendations, dated [DATE] and [DATE], for the medication Trazodone, with both of the recommendations indicating use of PRN (as needed) antidepressants must be limited to 14 days with the exception that the prescriber documents their rationale in the patient's medical record and indicates the duration for that PRN order. The surveyor reviewed with the B Unit Manager noting that R19 received the PRN dose on [DATE] but the order was not active because it expired on [DATE]. 2. On [DATE], R74's clinical record was reviewed and included a physician order for Seroquel (antipsychotic medication). At 2:45 p.m., the ADON and surveyor reviewed R74's clinical record. R74 was admitted to the facility on [DATE] with orders for Seroquel (anti-psychotic medication) for 25 mg daily; on [DATE], this dose was increased to 50 mg daily. There was no baseline AIMS in the clinical record and the most recent AIMS test was completed on [DATE]. The surveyor confirmed this finding with the ADON during this review.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17282 Based on observations, and interviews, the facility failed to ensure that bowls were dried properly and failed to ensure the kitchen was free from insects for 1 of 2 kitchen tour ([DATE]). In addition, the facility failed to ensure that milk was not expired during 1 of 2 meal observations on the B Unit ([DATE]). Findings: 1. On [DATE] at 10:20 a.m. an initial tour of the kitchen was done with the Nutrition Manager. Observed on a shelf, available for use, were 30 cereal bowl and 30 small white bowls that were wet stacked/nestled. Near the baking station area, fruit flies were observed coming from and around the floor drain. These findings were confirmed at the time of the observation. 33242 2. On [DATE] at 12:39 p.m., during a lunch observation in the East Wing dining room on B Unit, a surveyor observed in the beverage trays with ice, 2 unopened 1% milk with an expiration date of [DATE]. The surveyor confirmed this with the Registered Nurse.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on facility policy review, record reviews and interviews, the facility failed to ensure that resident records contained accurate, complete, and/or readily accessible information for 3 of 5 resident records reviewed for falls (Resident #84 [R84], R74 and R7). Findings: The facility's policy, Neurological Assessments, (neuro checks) last reviewed 5/8/24, indicates that a neurological assessment will be completed and documented in ECS (electronic medical record) after any incident or fall in which a head injury is suspected. In the case of an unwitnessed fall, the resident will be considered to have hit their head unless he/she can reliably state he/she did not. Assessments will be completed every 15 minutes for the first hour after the fall, every 30 minutes for the subsequent 4 hours, every shift for the next 72 hours. 1. On 8/21/24, R84's clinical record was reviewed and indicated that on 8/15/24 at 12:00 p.m., R84 was observed on the floor in the dining room and neuro checks were started. A review of R84's Treatment Administration Record (TAR) and documented neurological assessments indicated the following: On 8/9/24, the TAR indicated when the 15 and 30 minute neuro checks were to be completed but upon review of the clinical record, the neurological assessments were not documented at the time the assessment occurred. The assessment that was completed for a 15 minute check at 12:00 p.m., was not documented in the clinical record until 5:53 p.m.; The assessment that was completed for a 15 minute check at 12:15 p.m., was not documented in the clinical record until 5:54 p.m.; The assessment that was completed for a 15 minute check at 12:30 p.m., was not documented in the clinical record until 5:55 p.m.; The assessment that was completed for a 15 minute check at 12:45 p.m., was not documented in the clinical record until 5:56 p.m.; The assessment that was completed for a 15 minute check at 1:00 p.m., was not documented in the clinical record until 5:58 p.m.; The assessment that was completed for a 30 minute check at 1:30 p.m., was not documented in the clinical record until 5:59 p.m.; The assessment that was completed for a 30 minute check at 2:00 p.m., was not documented in the clinical record until 5:59 p.m.; The assessment that was completed for a 30 minute check at 2:30 p.m., was not documented in the clinical record until 6:00 p.m.; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment that was completed for a 30 minute check at 3:00 p.m., was not documented in the clinical record until 6:01 p.m.; The assessment that was completed for a 30 minute check at 3:15 p.m., was not documented in the clinical record until 6:02 p.m.; The assessment that was completed for a 30 minute check at 4:00 p.m., was not documented in the clinical record until 6:03 p.m.: and The assessment that was completed for a 30 minute check at 4:30 p.m., was not documented in the clinical record until 6:04 p.m. The above documentation does not indicate a late entry or mention of what time the documented assessment actually was completed. 2. On 8/21/24, R74's clinical record was reviewed and indicated that on 8/9/24 at 5:45 p.m., R74 was observed on the floor in his/her room and neuro checks were started. A review of R74's Treatment Administration Record (TAR) and documented neurological assessments indicated the following: On 8/9/24, the TAR indicated when the 15 and 30 minute neuro checks were to be completed but upon review of the clinical record, the neurological assessments were not documented at the time the assessment occurred. The assessment that was completed for a 15 minute check at 6:00 p.m., was not documented in the clinical record until 9:51 p.m., and did not include vitals; The assessment that was completed for a 15 minute check at 6:15 p.m., was not documented in the clinical record until 9:51 p.m. and did not include vitals; The assessment that was completed for a 15 minute check at 6:30 p.m., was not documented in the clinical record until 9:51 p.m., and indicated refusing vitals; The assessment that was completed for a 15 minute check at 6:45 p.m., was not documented in the clinical record until 9:52 p.m., and indicated refusing vitals; There was an extra 15 minute check documented at 10:00 p.m. per assessment (not listed on the TAR), and indicated refusing vitals; The assessment that was completed for a 30 minute check at 7:15 p.m., was not documented in the clinical record until 10:01 p.m., and indicated refusing vitals; The assessment that was completed for a 30 minute check at 7:45 p.m., was not documented in the clinical record until 10:02 p.m., The assessment that was completed for a 30 minute check at 8:15 p.m., was not documented in the clinical record until 10:02 p.m., and indicated refusing vitals; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment that was completed for a 30 minute check at 8:45 p.m., was not documented in the clinical record until 10:02 p.m., and indicated refusing vitals; The assessment that was completed for a 30 minute check at 9:15 p.m., was not documented in the clinical record until 10:47 p.m., and indicated refusing vitals; The assessment that was completed for a 30 minute check at 9:45 p.m., was not documented in the clinical record until 10:47 p.m., and indicated refusing vitals; and The assessment that was completed for a 30 minute check at 10:15 p.m., was not documented in the clinical record until 10:47 p.m., and indicated refusing vitals. The above documentation does not indicate a late entry or mention of what time the documented assessment actually was completed. On 8/22/24 at 10:23 a.m., a surveyor reviewed documentation of the neuro checks with the Director of Nursing. The Treatment Administration Record (TAR) was reviewed and the time on the TAR included the time that an assessment was done but the documentation of the assessment in the clinical record does not correlate with the time on the TAR. The surveyor confirmed that the documentation of the assessments are not reflective of the time that they were completed. On 8/22/24 at 11:14 a.m., in an interview with a surveyor, a Certified Nursing Assistant (CNA) #5 stated vitals are completed as part of the post fall packet. The CNAs take the vitals and keep them with the packet and the nurses are responsible for entering them into the ECS (electronic medical record) when the packet is completed. 49635 3. Clinical Record Review indicated R7 was admitted on [DATE] with a diagnosis of Vascular Dementia. According to the Minimum Data Set (a standardized assessment tool) on 6/19/24, R7 had a Brief Interview for Mental Status (BIMS) score of 1, and a BIMS of 3 on 8/16/24 (a score of 0-7 suggests severe cognitive impairment). Nurse documentation indicated R7 had two unwitnessed falls on 8/14/24. The clinical record lacked evidence that neurological assessments were completed after the unwitnessed falls. Between 8/19/24 through 8/22/24, during an interview with a surveyor, Anonymous (A) Staff Members (A3 and A4) stated: A4 stated, after an unwitnessed fall, R7's initial neurological assessment and vitals were documented in a fall packet on the morning of 8/14/24, but then staff were directed by management to discard them (prior to completion) without being recorded in the electronic medical record (ECS). A3 stated, R7 was found on the floor after an unwitnessed fall, neurological assessments and vitals were documented in the fall packet but then discarded (prior to completion), without being recorded in ECS. (continued on next page)

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 08/22/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24 at 11:14 a.m., in an interview with a surveyor, a Certified Nursing Assistant (CNA) #5 stated vitals are completed as part of the post fall packet. The CNAs take the vitals and keep them with the packet and the nurses are responsible for entering them into the ECS when the packet is completed. On 8/22/24 at 11:22 a.m., in an interview with a surveyor, the Director of Nursing stated, within 20 minutes a post fall investigation has to be filled out. It includes multiple staff members input (medication technician, charge nurse, certified nursing assistants, and supervisors) The information is used to for a mini root cause analysis. The provider and family are supposed to be called, and it should be documented. Care plans are reviewed to see if new interventions need to be put in place. If a resident puts themself on the floor, the need to complete a post fall evaluation varies. If a noise is heard from outside the room, and they are found on the floor. It's considered a fall, no matter what, and the post fall investigation needs to be completed. On 8/22/24 at 12:06 p.m., in an interview with the B Unit Manager and the Director of Nursing, the B Unit Manager stated post fall assessments may be discarded after step 4 if staff feel it was not a fall based on assessments. At this time the surveyor confirmed that resident medical records are not retained when assessments and vitals are discarded before being entered into the electronic record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42531 Based on facility policy review, record review, and interview, the facility failed to maintain an effective infection control program, and failed to analyze and follow-up on known infections in the facility. This has the potential to affect all residents receiving an antibiotic in the facility. In addition, the facility failed to ensure a shared glucometer was cleaned after each use for 1 of 2 observations (8/20/24), Findings: Review of facility policy Infection Prevention and Control Program dated 9/25/23 states will establish, implement and maintain an infection prevention and control program that will provide safe, sanitary and comfortable environment to help prevent, recognize, and control, the onset, development and transmission of communicable disease and infection to residents . Surveillance and investigation to prevent and control the onset and spread of infection within the facility.Program Record Keeping maintains records of incidents and corrective actions related to infections . 1. Review of facility provided Infection Report revealed the following: -During the month of 6/2024, there were 25 documented facility acquired infections that were prescribed antibiotics. -During the month of 7/2024, there were 20 documented facility acquired infections that were prescribed antibiotics. -From 8/1/24 through 8/29/2024 there were 15 documented facility acquired infections that were prescribed antibiotics. Further review of infection report lacked evidence the facility analyzed and followed up on known infections in facility. During an interview on 8/21/24 at 12:01 p.m., Director of Nursing (DON) confirmed they review antibiotics during the monthly Antibiotic Stewardship meetings but have not looked at trends or root cause of the infections. During an interview on 8/22/24 at 9:20 a.m., Infection Preventionist indicated the facility does have a lot of antibiotic use and realized that there are a lot of antibiotic prescriptions that do not meet McGuires criteria and haven't done any tracing/surveillance to form a root cause of the infections. 33242 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Maine Veterans Home - Bangor		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Hogan Rd Bangor, ME 04401	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 8/20/24 at 8:23 a.m., a surveyor observed Certified Nursing Assistant #4 (CNA4) complete a blood sugar on a resident, using a shared glucometer. At 8:25 a.m., the surveyor then observed CNA4 walk over to another resident and complete another blood sugar, without cleaning the glucometer inbetween use. On 8/20/24 at 8:26 a.m., during an interview with CNA4, the surveyor asked if she cleaned the glucometer after using on one resident, before completing the blood sugar check on the other resident. CNA4 stated that she does have the Sani Cloths to clean the glucometer and that sometimes she cleans it when she remembers. The surveyor confirmed during this interview that the glucometer was not cleaned inbetween resident use.

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NAME OF PROVIDER OR SUPPLIER Maine Veterans Home - Bangor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 42531 Based on facility policy review, record reviews, and interviews, the facility failed to implement its Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and a system to monitor antibiotic use. This has the potential to affect all residents receiving an antibiotic. Findings: Review of the facility policy Antibiotic Stewardship Program dated 2/2/23 states .To improve patient safety and assist in the prevention of multi-drug resistant organisms (MDRO) and Clostridium difficile infections (CDI) by optimizing use of antibiotic drugs and to provide continuous improvement by utilizing prescribing and outcomes data to identify opportunities of targeted initiatives and optimal antibiotic prescribing .Tracking and trending for appropriate antibiotic selection and identification . Review of facility policy Medication Regimen Review dated 1/2019 states .The consultant pharmacist compiles and analyzes data collected from MMR's and presents findings to the Quality Assurance and Process Improvement (QAPI) Committee as part of the facility continuous improvement (CQI) program. Review of facility provided Infection Report revealed the following: -During the month of 6/2024, there were 25 documented facility acquired infections that were prescribed antibiotics. -During the month of 7/2024, there were 20 documented facility acquired infections that were prescribed antibiotics. -From 8/1/24 through 8/29/2024 there were 15 documented facility acquired infections that were prescribed antibiotics. Further review of infection report lacked evidence these antibiotics were reviewed or discussed. Review of facility provided Quality Pharmacy Report for Quarter #3 dated 10/9/23, Quarter #4 dated 1/8/24, Quarter #1 dated 4/1/24, and Quarter #2 dated 6/26/24, lacked evidence that the pharmacist/facility reviewed antibiotic use during these meetings. During an interview on 8/21/24 at 12:01 p.m., Director of Nursing (DON) indicated that for the most part the providers put their own orders in the electronic medical record (EMR) and the infection report is generated through the EMR, and that is what they review during the monthly Antibiotic Stewardship meetings, but they have not looked at trends or root cause. During a follow-up interview on 8/21/24 at 3:01 p.m., with 2 surveyors, the DON indicated she spoke with pharmacist confirming the provided pharmacy reports contain everything that is discussed in QAPI, and antibiotic stewardship has not been discussed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Maine Veterans Home - Bangor		STREET ADDRESS, CITY, STATE, ZIP CODE 44 Hogan Rd Bangor, ME 04401	

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/24 at 9:20 a.m., Infection Preventionist (IP) indicated the facility does have a lot of antibiotic use and realized through the survey process that there are a lot of antibiotic prescriptions that do not meet McGuires criteria. IP further indicated that at this point no one had discussed antibiotic use with the providers before and they have not implemented any tracking systems.

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	205185	A. Building B. Wing	08/22/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42531 Based on record review and interview, the facility failed to ensure that 1 of 5 residents reviewed for immunizations included documentation in the medical record to indicate the resident received a pneumococcal immunization (Resident #7). Finding: Review of Resident #7's clinical record revealed .Pneumococcal Vaccine Consent signed 11/6/23. Further review of resident's clinical record lacked evidence that this vaccination was administered. During an interview on 8/20/24 at 10:54 a.m., the Education Coordinator reviewed the clinical record and confirmed Resident #7 signed pneumococcal immunization consent on 11/6/23, and did not receive the vaccination.