STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205116	A. BUILDING _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER HEALTH CARE	**335 STILLWATER AVE BANGOR, ME 04401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/26/24 an unannounced on-site visit was conducted at Stillwater Health Care for the purpose of investigating complaint #ME00046796. It was determined that Stillwater Health Care was not in substantial compliance with 42 CFR 481, Sub-part B-Requirements for Long Term Care Facilities.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure physician ordered medications with parameters to hold were followed for 1 of 1 residents reviewed with medication parameters (Resident [R]1). Findings; 1. On 3/26/24, R1's clinical record was reviewed and included a physician order, dated 2/28/24, for scheduled Acetaminophen, 325 milligrams (mg) tablets x 3 tablets (975 mg) to be administered at 6:00 a.m., 2:00 p.m., and 10:00 p.m. The clinical record also included an as needed (PRN) order for Acetaminophen, dated 2/27/24, 500 mg every 4 hours as needed for pain/fever, with	F 684		

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

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F 684	Continued From page 1	F 684		

parameters not to exceed 3 grams (3000 milligrams) in a 24 hour period.

A review of the Medication Administration Record indicated at on 3/10/24 at 10:00 p.m., R1 received 975 mg of Acetaminophen; on 3/11/24, R1 received 975 mg of Acetaminophen at 6:00 a.m. and 2:00 p.m. and 500 mg at 8:43 a.m. for fever and 4:41 p.m. for pain. The total Acetaminophen documented as being administered in a 24 hour period was 3925 milligrams, exceeding 3000 milligrams in a 24 hour period.

On 3/26/24 at 12:55 p.m., a surveyor confirmed with the Director of Nursing that documentation indicated at R1 received Acetaminophen greater than 3 grams in a 24 hour period.

2. R1's clinical record included a physician order for Nitroglycerin ointment, dated 3/1/24, to be applied to the necrotic area on the left 3rd finger three times a day, at 9:00 a.m., 2:00 p.m., and 7:30 p.m. with parameters to hold if systolic blood pressure is below 100.

On 3/3/24 at 8:29 a.m., R1's blood pressure was documented as 98/52 but the Treatment Administration Record (TAR) indicated that the Nitroglycerin ointment was applied at 9:00 a.m., but should have been held.

On 3/4/24 at 2:28 p.m., R1's blood pressure was documented as 94/59 but the Treatment Administration Record (TAR) indicated that the Nitroglycerin ointment was applied at 2:00 p.m., but should have been held.

On 3/26/24 at 1:10 p.m., during an interview with

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F 684	Continued From page 2 the Director of Nursing, a surveyor confirmed this finding.	F 684		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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F 842	Continued From page 3 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 22 of 31 treatment opportunities for Resident #1's treatment for Nitroglycerin ointment application. Findings:	F 842		

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F 842	Continued From page 4	F 842		

On 3/26/24, R1's clinical record included a physician order for Nitroglycerin ointment, dated 3/1/24, to be applied to the necrotic (dead tissue) area on the left 3rd finger three times a day, at 9:00 a.m., 2:00 p.m., and 7:30 p.m. with parameters to hold if systolic blood pressure is below 100.

The Treatment Administration Record (TAR) was reviewed and contained the following:

3/1/24 at 2:00 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin.
3/2/24 at 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin.
3/3/24 at 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin.
3/4/24 at 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin.
3/5/24 at 2:00 p.m. and 7:30 p.m. the treatment was held but lacked evidence on why it was held.
3/6/24 at 2:00 p.m. and 7:30 p.m. the treatment was held but lacked evidence on why it was held.
3/7/24 at 2:00 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin and at 7:30 p.m. the treatment was held but lacked evidence on why it was held.
3/8/24 at 9:00 a.m., 2:00 p.m. and 7:30 p.m., the

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F 842	Continued From page 5 treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/9/24 at 9:00 a.m., 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/10/24 at 2:00 p.m. and 7:30 p.m., the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin. 3/11/24 at 2:00 p.m. the treatment was administered but the clinical record lacked evidence of a blood pressure prior to the application of the Nitroglycerin and at 7:30 p.m. the treatment was held but lacked evidence on why it was held. On 3/26/24 at 1:10 p.m., during an interview with the Director of Nursing, a surveyor confirmed these findings. The Director of Nursing stated that the way the order was written into the (electronic) system that there was no specific directions to take the blood pressure (even though there were hold parameters.	F 842		