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MAINE VETERANS HOME - BANGOR	44 HOGAN RD BANGOR, ME 04401

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F 000	INITIAL COMMENTS From 9/25/23 through 9/28/23, on-site visits were conducted at Maine Veterans Home - Bangor for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification, and facility reported incident's #ME00044884, and #ME00044739. It was determined that Maine Veterans Home - Bangor was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

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

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F 656	Continued From page 1	F 656		

rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to ensure that care plans were updated to reflect a resident's current needs for 8 of 8 residents reviewed that had a diagnosis of Post Traumatic Stress Disorder. (Resident #2 [R2], Resident #15 (R15), Resident #23 (R23), Resident #25 [R25], Resident #37 (R37), Resident #54 [R54], Resident #80 (R80) and Resident #83 (R83)].

Findings:

1. On 9/26/23, R2's clinical record was reviewed. R2 had a diagnosis of PTSD. R2's current care plan was reviewed. There was no evidence of interventions that identified triggers which may re-traumatize the resident with a history of PTSD, no interventions indicating to staff what behaviors

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F 656	Continued From page 2 may cause a trigger, under the problem care area; Mood-PTSD, depression, nightmares, Cerebral Vascular Accident (CVA) with left hemiparesis. On 9/27/23 at 8:15 a.m., in an interview with the Director of Nursing, she confirmed that the care plan did not have interventions addressing the resident's PTSD care needs. 2. On 9/26/23, R25's clinical record was reviewed. R25 had a diagnosis of PTSD. R25's current care plan was reviewed. There was no evidence of interventions that identified triggers which may re-traumatize the resident with a history of PTSD, no interventions indicating to staff what behaviors may cause a trigger, under the problem care area; Mood-Depression-related to cognitive loss, impaired mobility, right below the knee amputation, PTSD. On 9/27/23 at 8:15 a.m., in an interview with the Director of Nursing, she confirmed that the care plan did not have interventions addressing the resident's PTSD care needs. 3. On 9/26/23, R54's clinical record was reviewed. R54 had a diagnosis of PTSD. R54's current care plan was reviewed. There was no evidence of interventions that identified triggers which may re-traumatize the resident with a history of PTSD, no interventions indicating to staff what behaviors may cause a trigger, under the problem care area; Cognitive Loss-related to congestive heart failure, diabetes, depression, PTSD. On 9/27/23 at 8:15 a.m., in an interview with the Director of Nursing, she confirmed that the care plan did not have interventions addressing the resident's PTSD care needs.	F 656		

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On 9/26/23, R80's clinical record was reviewed and indicated the resident was admitted to the facility on 11/29/22. The admission minimum data set (MDS) 3.0 was completed on 12/7/22. This MDS indicated, under Section I - Active Diagnosis, that the resident had PTSD, review of the resident's current diagnosis list included a diagnosis of PTSD.

Upon review of R80's care plan, the care plan did not include a care area with interventions for the diagnosis of PTSD. On 9/27/23 at 9:50 a.m. the MDS Lead stated she was unable to find a care area in the care plan for R80's PTSD. The surveyor confirmed that there was no evidence addressing what R80's PTSD was caused by or what events might cause re-traumatization.

5. On 9/26/23, R15's clinical record was reviewed which indicated R15 had a diagnosis of PTSD. A review of R15's care plan did not include a care area with interventions for the diagnosis of PTSD.

6. On 9/26/23, R23's clinical record was reviewed which indicated R23 had a diagnosis of PTSD. A review of R23's care plan did not include a care area with interventions for the diagnosis of PTSD.

7. On 9/26/23, R37's clinical record was reviewed which indicated R37 had a diagnosis of PTSD. A review of R37's care plan did not include a care area with interventions for the diagnosis of PTSD.

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F 656	Continued From page 4 8. On 9/26/23, R83's clinical record was reviewed which indicated R83 had a diagnosis of PTSD. A review of R83's care plan did not include a care area with interventions for the diagnosis of PTSD. On 9/28/23 at 8:15 a..m., during an interview with the surveyors, the Director of Nursing stated she was unable to find a care area in the care plan for R15, R23, R37 and R83's PTSD. The surveyor confirmed that there was no evidence addressing what might trigger the PTSD symptoms and there was no evidence of interventions that indicated what staff should or should not do that may cause re-traumatization from the resident's PTSD.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		

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F 657	Continued From page 5 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to revise/update care plans to reflect/address residents current needs and behaviors for 2 of 22 sampled residents (Resident [R] 202 and R252). Findings: 1. On 9/26/23, during a record review for R202, the clinical record reflected that R202 was admitted to the facility on 9/7/23 from a lower level of care facility. An elopement assessment was completed on 9/8/23 with a score of 6 (per the unit manager a score above 5 indicates the resident is at a high risk for elopement). Upon review of R202's care plan with a completion date of 9/14/23, the care plan lacked evidence that a wandering/elopement problem and interventions were implemented to address this risk. On 9/14/23, a physician request form was completed with a note indicating R202 was sitting in his/her room and dining room yelling intermittently, refused to believe he/she lives at facility, he/she was exit seeking, appears to become very distressed, up during the night shift, and appears to be sundowning. This showed resident was actively exit seeking and the facility failed to update and revise their care plan to address R202's current needs/behaviors.	F 657		

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F 657	Continued From page 6 On 9/27/23 at 8:00 a.m., during an interview with the Unit Manager, a surveyor confirmed that R202's care plan was not revised/updated to include his/her elopement risk or his/her anxiety/distress about their recent move to long term care. 2. On 9/27/23, R252's clinical record was reviewed and included a physician order, dated 9/14/23, to restart Eliquis, a medication used to help prevent blood clots, at 5 milligrams, twice a day. An interdisciplinary Team Meeting was held on 9/14/23 that indicated the Resident Representative wanted this medication restarted (after it was discontinued on 9/12/23) and that the Medical Provider explained the risk versus benefits of this medication being used for R252 (the resident was a fall risk). The surveyor could not find any monitoring for this medication being care planned. On 9/27/23 at 2:28 p,m., during an interview with a surveyor, the B Unit Manager stated that she took the Eliquis out the of the care plan (on 9/13/23) when the medication was discontinued on 9/12/23 but forgot to put it back in when the medication was restarted on 9/14/23. She stated that she would add that back into the care plan now.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		

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pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure that a treatment was followed for 1 of 2 sampled residents reviewed for pressure ulcers (Resident [R} 83).

Finding:

On 9/26/23, R83's clinical record was reviewed which indicated the resident had an unstageable pressure ulcer on the back of the left heel. On 8/18/23, a treatment was added to apply Prevelan boots in bed as resident allows every shift.

On 9/26/23 at 1:20 p.m., a surveyor observed Certified Nursing Assistant (CNA) #3 assist R83 into bed. After R83 was in bed and covered up, the surveyor asked CNA #3 about the Prevelan boots. CNA #3 showed the surveyor that they were in the closet and that they were worn by the resident at night. CNA #3 did not attempt to place the Prevelan boots on R83 during this observation. On 9/27/23 at 7:22 a.m., a surveyor discussed the observation on 9/26/23 with the B Unit Manager.

On 9/27/23, after further review of the clinical record, the surveyor noticed that the Charge Nurses are signing off on this treatment in the

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F 686	Continued From page 8 electronic clinical record as the Charge Nurse signed off on this treatment on 9/26/23 at 10:53 a.m. as being completed. On 9/28/23 at 8:34 a.m., during an interview with the Charge Nurse that signed off the completed task on 9/26/23, the Charge Nurse stated that this is a CNA task and that nursing does not put them on for the most part.	F 686		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 8 of 9 sampled residents reviewed with a current diagnosis of PTSD [Resident #2 [R2], Resident #15 [R15], Resident #23 [R23], Resident #25 [R25], Resident #37 [R37], Resident #54 [R54], Resident #80 [R80] and Resident #83 [R83]]. Findings: 1. On 9/27/23, R80's clinical record was reviewed and indicated the resident was admitted to the facility on 11/29/22. The admission minimum data set (MDS) 3.0 was dated 12/7/22.	F 699		

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This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical record that indicated what R80's PTSD was caused by or what events might cause re-traumatization.

On 9/27/23 at 8:48 a.m., during an interview with a surveyor, the Director of Nursing (DON) stated that the MDS Lead would have more information. On 9/27/23 at 9:50 a.m. a surveyor spoke to the MDS Lead and requested information regarding R80's PTSD. At this time the surveyor confirmed the finding that the facility had not obtained information regarding R80's PTSD or what triggers/events might cause re-traumatization.

2. On 9/26/23, R2's clinical record was reviewed and indicated the resident was admitted to the facility on 2/19/2019. The most recent MDS was dated 7/17/23. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical record that indicated what R2's PTSD was caused by or what events might cause re-traumatization. On 9/27/23 at 10:55 a.m., in an interview with the surveyor, the Social Services Director (SSD) confirmed there were no trauma assessments completed that identified the cause of the resident's PTSD and what triggers would cause re-traumatization.

3. On 9/26/23, R25's clinical record was reviewed and indicated the resident was admitted to the facility on 12/16/22. The most recent MDS was dated 8/16/23. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to

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F 699	Continued From page 10	F 699		

find information in the clinical record that indicated what R25's PTSD was caused by or what events might cause re-traumatization. On 9/27/23 at 10:55 a.m., in an interview with the surveyor, the SSD confirmed there were no trauma assessments completed that identified the cause of the resident's PTSD and what triggers would cause re-traumatization.

4. On 9/27/23, R54's clinical record was reviewed and indicated the resident was admitted to the facility on 1/28/22. The most recent MDS was dated 7/26/23. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical record that indicated what R54's PTSD was caused by or what events might cause re-traumatization. On 9/27/23 at 10:55 a.m., in an interview with the surveyor, the SSD confirmed there were no trauma assessments completed that identified the cause of the resident's PTSD and what triggers would cause re-traumatization.

5. On 9/26/23, R15's clinical record was reviewed and indicated the resident was admitted to the facility on 10/29/14. The most recent MDS was dated 8/26/13. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical record that indicated what R15's PTSD was caused by or what events might cause re-traumatization.

6. On 9/26/23, R23's clinical record was reviewed and indicated the resident was admitted to the facility on 12/22/22. R23's diagnosis list indicated that the resident had a diagnosis of PTSD. The surveyor was unable to find information in the clinical record that indicated

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F 699	Continued From page 11 what R23's PTSD was caused by or what events might cause re-traumatization. 7. On 9/26/23, R37's clinical record was reviewed and indicated the resident was admitted to the facility on 10/1/19. The most MDS was dated 9/6/23. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical record that indicated what R15's PTSD was caused by or what events might cause re-traumatization. 8. On 9/26/23, R83's clinical record was reviewed and indicated the resident was admitted to the facility on 4/5/23. The most recent MDS 3.0 was dated 7/4/23. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical record that indicated what R15's PTSD was caused by or what events might cause re-traumatization. On 9/27/23 at 9:40 a.m., during an interview with a surveyor, the SSD stated that they started the process October 2022 when the regulation started so if the resident was here prior to then, we don't have a note in the computer. On 10:55 a.m., in an interview with the surveyor, the SSD confirmed there were no trauma assessments completed that identified the cause of the resident's PTSD and what triggers would cause re-traumatization.	F 699		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		

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F 758	Continued From page 12 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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	205185	A. BUILDING _____ B. WING _____	09/28/2023

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 758	Continued From page 13 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the physician completed a required visit before renewing an as needed (PRN) anti-psychotic medication for 1 of 3 residents reviewed on PRN anti-psychotics (Resident (R) 60). Finding: On 9/26/23, R60's clinical record was reviewed. The physician orders contained a telephone order, dated 9/6/23, to "Renew Risperdal (anti-psychotic) 0.5 milligrams (mg) twice a day (BID) PRN x 14 days but there was no face to face physician visit in the clinical record for 9/6/23. On 9/27/23 at 8:14 a.m., during an interview with the Director of Nursing, a surveyor confirmed that there was no visit completed by the physician on 9/6/23, prior to renewing the PRN anti-psychotic.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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F 880	Continued From page 14 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 15 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment to help prevent the development of urinary tract infections on 3 of 4 survey days (9/25/23, 9/26/23, and 9/27/23), and also failed to use appropriate personal protection equipment, use of gowns, to prevent the risk of infection on 1 of 4 survey days (9/26/23). Findings: 1. On 9/25/23 at 12:35 p.m., a surveyor observed the urinary catheter bag that was attached to the bed frame, was resting on the floor matt. On 9/26/23 at 12:37 p.m., a surveyor observed the urinary catheter bag that was attached to the bed frame, was resting on the floor matt.	F 880		

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F 880	Continued From page 16 On 9/27/23 at 7:07 a.m., a surveyor observed the urinary catheter bag that was attached to the bed frame, was resting on the floor matt. On 9/27/23 at 7:17 a.m., a surveyor and the B Unit Manager observed the urinary catheter bag resting on the floor mat. At 8:26 a.m., during an interview with a surveyor, the Director of Nursing stated that they do not have a policy for urinary catheter bags but that they follow the Centers for Disease Control (CDC)'s guidelines. The surveyor confirmed that the CDC guidelines directed, "Do not rest the bag on the floor". 2. On 9/26/23 at 10:43 a.m., a surveyor observed a sign outside of Resident #52's [R52's] room that stated, "Enhanced Barrier Precautions", and observed Registered #1 [RN]1 and RN2 in R52's room providing care involving his/her PICC line (peripherally inserted central catheter, a thin, soft tube inserted into a vein used to deliver medications and other treatments directly to the large central veins near the heart) and intravenous medication bag to him/her without wearing personal protection equipment, gowns. On 9/26/23 at 10:43 a.m. in an interview with a surveyor, RN1 and RN2 stated they were not wearing a gown while providing care to R52, and RN1 stated that she should have been. On 9/26/23 review of R52's care plan indicated under care area: enhanced barrier precautions, related to: ...PICC line, Nurses: wear gloves and gown for ALL the following high contact resident care activities: ... device care/use-central line ..." On 9/26/23 review of facility policy and procedure	F 880		

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F 880	Continued From page 17 for "Transmission-Based Precautions" states, on page 17, " ... examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: ... Device care or use: central line ..." On 9/27/23 at 8:05 a.m., in an interview with the Director of Nursing, a surveyor confirmed the above finding.	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, and dementia	F 947		

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F 947	Continued From page 18 management by failing to ensure that 1 of 5 Certified Nursing Assistant's (CNA) employed, completed the required annual training (CNA1). Findings: On 9/28/23, during a review of employee personnel records, the following were noted: 1. CNA1's employee personnel record lacks evidence of mandatory abuse training within the last twelve months. 2. CNA1's employee personnel record lacks evidence of mandatory dementia training within the last twelve months. On 9/28/23 at 10:51 a.m., during an interview with a surveyor, the Administrator stated that he was unable to find any dementia trainings or abuse trainings for CNA1 within the past twelve months. The surveyor confirmed this finding during this interview.	F 947		