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 05/07/2024

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 5/7/24, an unannounced on-site visit was conducted at Stillwater Health Care to investigate facility reported incident's #ME00047097 and #ME00047103. It was determined that Stillwater Health Care was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by State and Federal Law.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and facility policy review, the facility failed to ensure an alleged violation involving fall with major injury was thoroughly investigated for 1 of 2 facility reported incidents reviewed (Resident #1 (R1). Finding:	F 610	F610 This incident happened in the past and cannot be undone. Administrator and/or DON will ensure that investigations pertaining to all reportable events are reported timely, thoroughly investigated, that all staff involved in the reportable event are interviewed and statements were received in writing. All investigation materials pertaining to each individual reportable event will be kept in a folder so that it can be easily accessed if needed during or after an investigation is completed.	5/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 5/22/24

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.

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F 610	Continued From page 1 On 4/10/24, the Division of Licensing and Certification received from the facility a Reportable Incident Form which indicated an allegation of fall with major injury of R1. A review of the closed clinical record for R1 revealed an admission date of 4/4/24 from private residence. Diagnoses included a history of heart disease and Alzheimer's disease and was admitted with hospice services. R1 sustained a fracture and was discharged to acute care hospital on 4/10/24. The facility's "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation - Reporting and Investigating", revised 2/23, indicated that, "Investigating Allegations. 1. All allegations are throughly investigated." There is no evidence that staff were interviewed. On 5/7/24 at 12:02 p.m., in an interview with a surveyor, a hospice registered nurse stated that R1 stated he/she fell, and when asked how he/she got into bed, R1 stated, I put me, and then stated they threw me. On 5/7/24 at 3:49 p.m., in an interview with a surveyor, a Certified Nursing Assistant stated that R1 stated he/she fell, then stated he/she said a group of people picked him/her up and threw him/her up in the bed. On 5/7/24 at 12:52 p.m., in an interview with a the Director of Nursing (DON), a surveyor confirmed that the allegation of fall with major injury was not thoroughly investigated.	F 610	The administrator will audit all reportable events to ensure that they are reported timely, are completely investigated, documented and that all staff interviews have been completed timely. The administrator will also insure that the investigation folders are completed including all written reports. Will review at monthly QAPI x6 months.	
F 655 SS=D	Baseline Care Plan	F 655	F655	5/31/24

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F 655	Continued From page 2 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655	This incident happened in the past and cannot be undone. All nursing staff who participate in care plan documentation have been re-educated to our policy & procedure pertaining to comprehensive and baseline care plans, their use, goals & objectives, as well as resident participation. DON will audit all new admissions to ensure that care plans have been developed within 48 hours of resident admission. Will review at monthly QAPI x6 months.	

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F 655	Continued From page 3 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 2 residents reviewed for fall with major injury (Resident #1 (R1)). Finding: A review of the closed clinical record for R1 revealed an admission date of 4/4/24 from private residence. Diagnoses included a history of heart disease and Alzheimer's disease was admitted with hospice services. R1 sustained a fracture and was discharged to acute care hospital on 4/10/24. A review of the clinical record failed to locate evidence that a baseline care plan was developed and implemented within 48 hours of R1's admission. On 5/7/24 at 12:52 p.m., in an interview with a surveyor, the Director of Nursing confirmed that no care plan had been developed.	F 655		