

PRINTED: 05/10/2024
FORM APPROVED
OMB NO. 0938-0391

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LTYO11 Facility ID: 1916 If continuation sheet Page 1 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 C 05/06/2024
NAME OF PROVIDER OR SUPPLIER MAINE VETERANS HOME - BANGOR			STREET ADDRESS, CITY, STATE, ZIP CODE 44 HOGAN RD 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 600	Continued From page 1 Finding: On 5/6/24, R1's clinical record was reviewed. The record indicated R1 was diagnosed with dementia, anxiety, severe agitation, and psychosis and resides on the secured [memory care] unit. A nurse note, dated 4/3/24, indicated that the R1 had new bruises on his/her left upper and lower forearm and a bruise on the upper right arm. On 5/6/24 at 8:35 a.m., in an interview with Registered Nurse-Nurse Manager (RN-NM), she stated that on 4/3/24, C.N.A.2 wheeled R1 to her office. C.N.A.2 stated that R1 shouted out angrily that C.N.A.1 threw him/her around. RN-NM and C.N.A.2 observed new bruises on R1's arms. RN-NM assessed the resident and no other injuries were observed. RN-NM stated in her interview that she immediately interviewed C.N.A.1 about the bruising on R1's arms. C.N.A.1 stated he assisted R1 to the toilet and was trying to bath R1. R1 was trying to hit him during morning care so C.N.A.1 stated he grabbed R1's left arm and held it down on the toilet's safety rail while he finished the bath. On 5/6/24 at 9:42 a.m., in an interview with C.N.A.1, he stated in an interview that he did not hold R1's arm down. He stated R1 was trying to hit him so he pushed the resident's arm away. On 5/6/24 at 10:05 a.m., in an interview with C.N.A.2, he stated he took care of R1 on 4/2/24, the day before the incident and he did not notice	F 600			

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F 600	Continued From page 2 any bruising on R1's arms. C.N.A.2 stated on 4/3/24, R1 wheeled up to C.N.A.2 and was very angry. R1 pointed at C.N.A.1 and said he threw [R1] around. C.N.A. 2 stated he noticed some red bruising on his arms, so wheeled R1 to RN-NM office. and reported the incident. On 5/6/24 at 10:20 a.m., in an interview with the day Charge Nurse, she stated the RN-NM asked her to take care of R1. Charge Nurse stated she noticed the new bruises on his/her arms. On 5/6/24 at 11:02 a.m., in an interview with C.N.A.3, she stated she worked on 4/2/24, the day before the incident and she stated she observed R1 in the corridor several times that day and did not notice any bruises on R1's arms. On 4/3/24, C.N.A.3 stated that C.N.A.1 asked her to switch residents with him because R1 was trying to hit him. C.N.A.3 stated she took care of R1 for a while. She stated she washed him up and noticed the bruises on R1's arms. C.N.A.3 also stated that R1 told her C.N.A.1 grabbed [him/her]. On 5/6/24, a review of the facility's Abuse Policy, page 1, paragraph 2, indicated staff will protect each resident from abuse. Defined physical abuse as physical assaults, cruel discipline, excessive use of physical or chemical restraints, or unnecessary or incorrect medication that may cause pain, inability to move limbs, burns, cuts, internal injuries, marks or bruises. As a result of this isolated incident, the following corrective actions were initiated on 4/3/24. -The RN-NM terminated C.N.A.1. -The Staff Development Coordinator and the Assistant Director of Nursing provided all direct care staff and licensed nurses on all the facility's	F 600			

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F 600	Continued From page 3 Units (B-Unit, C-Unit and D-Unit) on Resident Abuse, Neglect and Exploitation. In addition, staff were in-serviced on 'Burn Out'.	F 600			