335 Stillwater Avenue, Bangor, Maine 04401
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August 28,2023

Celine Donohue, R.N.

Long-Term Care Supervisor

Division of Licensing and Certification

11 State House Station

41 Anthony Ave.

Augusta, Maine 04333-0011

Sent via email only, to: Celine.Donohue@Maine.gov and Cherrie.Manzo@Maine.gov

Dear Ms. Donohue,

Please accept the attached Plan of Correction for the alleged deficiency cited from the self-report investigation conducted at Stillwater Health Care on August 8, 2023.

We appreciate the work that you do.

Sincerely,

Janet Edgecomb, administrator

Janet Edgecomb, RN, BSN, MLNHA

Administrator

Stillwater Healthcare

335 Stillwater Ave.

Bangor, Me 04401

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

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 08/08/2023

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 8/9/2023, an unannounced on-site visit was conducted at Stillwater Health Care for the purpose of investigating complaint #ME00044414. 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	This Plan of Correction constitutes my Written allegation of compliance for the Deficiencies cited. However, submission Of this 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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, review of the facility reportable incident form, and review of the medical record, the facility failed remove a bed pan timely from 1 of residents reviewed. This resulted in harm when a resident was left on a bed pan for approximately 45 minutes and sustained a Stage 2 pressure ulcer (Resident 1). Finding:	F 600	F600 All residents that use the bedpan have the potential to be affected by this alleged Deficient practice. C.N.A #1, who was responsible for not Removing bedpan in timely manner, was Re-educated on bedpan policy and Disciplined per performance Improvement policy. All Clinical staff re-educated on bedpan policy Beginning on 7/25/2023. Education of all clinical staff Completed by 9/8/2023. Monthly Audit of residents that use Bedpan for elimination: 1x / month x 6 months. Monthly education to clinical staff related To who uses the bedpan and the bedpan Policy, all shifts: 1x / month x 6 months. Continue to educate clinical staff on bedpan policy On initial orientation and annually at skills fair.	

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

Janet Edgecomb, administrator 8/30/23

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 600	Continued From page 1 A Nursing Facility Reportable Incident form was faxed to Division of Licensing and Certification office indicating on 7/25/23 at approximately 4:00 a.m., a Certified Nurse Aide (CNA) placed a resident on a bed pan, left resident on bedpan and failed to monitor the resident per policy. At approximately 4:45 a.m., when resident asked to be taken off the bedpan while removing the bed pan, the resident had 2 open areas on left buttock creating a Stage II injury. A review of Resident #1's medical record stated, in a nursing note, on 7/25/23, Certified Nursing Assistant (CNA) #1 at approximately 4:00 a.m., placed a bed pan under [Resident #1] for toileting. At approximately 4:45 a.m. CNA #2 answered Resident #1's call bell. Upon removing the bedpan, skin came off with the bedpan causing a Stage 2 injury. Partial thickness loss of skin layers that presents as an abrasion or blister. Location: left upper buttock, surface area length times width (L X W): 1.5 x 1, Depth: 0.1 centimeters (cm). Location: left lower buttock area, surface area (L X W): 0.5 x 0.5, Depth: 0.1 cm. Skin Monitoring Treatment sheet indicated that the Stage 2 injury was monitored and treated per physician order; Calmospetine to be applied twice a day (BID) until resolved. On 8/3/23 Stage 2 wound had resolved. On 8/9/23 at approximately 10:30 a.m., in an interview with a surveyor, the Nurse Manager and Administrator stated on 7/25/23 Resident #1 was left on the bed pan from approximately 4:00 a.m. until 4:45 a.m., approximately 45 minutes. It was stated that at approximately 4:00 a.m., three CNAs and a RN were assisting a patient for an	F 600	Results to QAPI team monthly x 6months. Date of completion: 9/11/2023	

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F 600	Continued From page 2	F 600		

emergent situation, when the RN noticed a call light at the end of the hall. The RN asked CNA #1 to respond to call light. Approximately, at 4:45 a.m. the assigned CNA #2 answered a call light for Resident #1, removed the bed pan and observed a red imprint on the buttocks from the bed pan with two open areas, Stage 2 injury.

On 8/9/23 at approximately 10:55 a.m., in an interview with a surveyor. Resident #1 stated she was left on the bed pan by a CNA. Resident #1 stated she was not familiar with the CNA and only remembered that she was on the bed pan for a long time until her assigned CNA answered her call light and removed her from the bed pan. Resident #1 stated she was relieved "her CNA" #2 removed the bed pan because she was very uncomfortable.

Review of "Stillwater Bed Pan Policy" (not dated) states, "No resident placed on a bedpan will be left alone in their room until the bed pan is removed from underneath them. No exceptions." "If the resident requires privacy, shut the curtain and stay behind it until the bedpan needs to be removed from the resident." "If the resident tells you that they do not want you in the room, shut the curtain and step outside the door of the room, shut the curtain and step outside the door of the room, keeping the bed in sight until the bedpan needs to be removed from the resident." "Do not leave the doorway until the resident is removed from the bedpan unless there is a true medical emergency. All other needs can wait until the resident is removed from the bedpan."

On 8/9/23 at 11:55 a.m., in an interview, the surveyor confirmed with the Nurse Manager and Administrator that Resident #1 was left on the

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F 600	Continued From page 3 bed pan from approximately 4:00 a.m. until 4:45 a.m. Resident #1 had a reddened area; outline of the bed pan with a Stage 2 injury which was treated with Calmospetine twice a day (BID).	F 600		