STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205064	A. BUILDING _____ B. WING _____	C 03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSS MANOR	**758 BROADWAY 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 3/11/24, an on-site visit was conducted at Ross Manor for the purpose of investigating complaints #ME00044693, #ME00046610, and #ME00046661. It was determined that Ross Manor was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to respond to residents request for assistance in a manner that maintained or enhanced their dignity by not answering the call bells in a timely manner. In addition, the facility failed to respond to a residents request for assistance in speaking to the Administrator to voice grievance with respect to his/her treatment/care for 2 of 5 residents interviewed. (Resident #3, [R3}, and R2) Findings: 1. On 3/11/24 at 11:25 a.m., during an interview with R3, he/she stated that on Sunday he/she rang their call bell at 7:00 a.m., R3 stated he/she remembers the time because they looked at the clock, and no one came in to assist him/her with pain for 50 minutes. The nurse came into R3's room at 7:50 a.m. to address his/her needs. R3 stated this has happened a few times, the last time being when a family member was visiting and the call bell rang for 35 minutes before the family member had to go find staff to assist . R3 couldn't remember what they needed but he/she	F 550		

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F 550	Continued From page 2	F 550		

stated when they don't answer the call bell it increases their anxiety as they fear no one will be there to help if he/she has chest pains. (he/she did not have chest pains but worries that they could have a heart attack and by not having anyone respond to the call bell causes increased anxiety until they do answer the call bell.

On 3/11/24 during review of the facility's call bell log, there were no reports to show how long R3's call bell did ring on those days,

During an interview with the Director of Nursing, it was stated that mornings are very busy and it was possible R3's call bell did ring that long she would have to believe the resident.

2. On 3/11/24 at 2:20 p.m., during an interview with the charge nurse, it was stated that R2 requested to speak to the Administrator prior to discharge to voice concerns about their stay. The charge nurse stated R2 was very upset, and the staff did not assist him/her to meet or speak to the Administrator. The charge nurse stated that R2 was already discharged and because R2 was using foul language the staff did not respond to R2 request and they did not speak to him/her and R2 left the facility before talking to Administration.

On 3/13/24, during an interview with R2, he/she did not receive daily showers as ordered by his/her provider and wanted to speak to the Administrator about this concern. R2 stated that on the day that he/she was leaving they asked to speak to the Administrator, and no one helped him/her with this request. He/she stated this caused him/her much mental anguish and got him/her angry. R2 stated he/she sat in that lobby

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F 550	Continued From page 3 waiting for someone to take them to talk to the Administrator, The charge nurse then told him/her that they were discharged and could leave. R2 Stated that they all stopped talking to him/her and he/she waited for 5 minutes. The charge nurse was sitting at the nurses station that's when she told him/her they were discharged and stopped talking to R2. R2 stated his/her rights were not taken into account he/she was very disappointed and distressed as it was their lack of providing personal hygiene that was needed to treat an open wound and that's why a daily shower was ordered, he/she stated they felt his/her care was not taken seriously and wanted to talk to the Administrator about it. On 3/11/24 at 2:20 p.m., a surveyor confirmed the above finding during an interview with the charge nurse. On 3/11/24 at 4:00 p.m., during the exit meeting the Administrator and the Director of Nursing were not aware that R2 had wanted to speak to them before he/she left the facility.	F 550		
F 600 SS=D	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-	F 600		

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F 600	Continued From page 4 §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 record reviews and interviews the facility failed to ensure that a resident receiving care was free from neglect when the resident was denied a daily shower as ordered by their provider from 2/24/24 to 3/4/24. (Resident #2 [R2]) Finding: On 3/4/24, the department of Health and Human Services received a report of resident neglect. The report alleges that the resident did not receive daily showers as ordered by their provider, and because of the neglect of personal hygiene it was reported that the resident developed a rash in the groin area. During a clinical record review, documentation in R2's clinical records indicated that R2 did have a written order for daily showers with specific instructions to allow staff to complete this task safely. On 2/29/24 a written order is for a shower daily, may get knee wet, put empty saline bottle between elbow and body for support. Left knee daily shower, remove dressing after loose in shower. After showering, flush with saline, apply Medi honey, telfa, ace wrap. Limit knee flexion to 80 degrees max. A review of R2's electronic treatment administration record (eTAR) for February and March 2024 shows that on 2/29/24 the order for daily showers was entered into the electronic clinical record. On the eTAR there were 3	F 600		

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F 600	Continued From page 5	F 600		

entries, one in a red signature (meaning resident refused, one signed in black which would mean he/she received the shower and one in blue which means it was held. The Nursing Note, dated 3/3/24, documents that the treatment was held at 17:20 (5:20 p.m.), that R2 stated that therapy would work with him/her to shower since there were specific orders how to shower.

On 3/11/24 at 2:45 p.m., during an interview with an Occupational therapist (OT),who worked with R2, he stated that he did not assist R2 with an actual shower and that he walked through the steps that R2 would need to take when taking a shower independently. He stated it was just a simulation of a shower.

On 3/11/24 at 3:25 p.m., interview with a Certified nurse's assistant (Cna) who worked with R2 on the night it was documented that R2's shower was held 3/3/24. She stated the night before he/she had asked for a shower, but she told R2 that she didn't know what to do with his/her shoulder brace. She then stated that usually, OT will give the first shower and show us how after. She stated she just didn't know what to do with the brace and the nurse wasn't sure either and we told him/her that we didn't know how to give him/her a shower. I was never shown what to do so I was not comfortable giving him/her a shower. He/she did ask more than once for a shower, and she was unsure if R2 ever got a shower.

The surveyor confirmed at this time that staff were not instructed or shown how to provide a shower to this resident.

On 3/13/24 at 12:12 p.m., during an interview with R2 he/she stated they never received a shower

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F 600	Continued From page 6 nor were they given the opportunity to have a shower. He/she stated that they had a conversation with the charge nurse who told him/her that they failed R2 by not giving him/her daily showers. R2's son was on the phone when the charge nurse stated they couldn't figure out how to give him/her a shower. R2 stated that he/she was told he/she had refused a shower and that it was documented that R2 received a shower. R2 stated that was incorrect that he/she wouldn't be able so upset if they had received a shower as it was ordered to keep him/her clean. During review of R2's Certified Nurses Aide(CNA) documentation for showers the room R2 was in is scheduled for Showers on Monday evenings. The clinical record for bathing lacks evidence that R2 received a shower during their stay at the facility from 2/21/24 to 3/4/24. On 3/11/24 at 2:40 p.m., during an interview with the Director of Nursing the surveyor confirmed that R2 had not received a shower during their stay once cleared by the provider to take a shower on 2/24/24.	F 600		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:	F 676		

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F 676	Continued From page 7 §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure that physician orders were followed for 1 of 5 residents reviewed (Resident #2 [R2] Finding: R2 was admitted on 2/21/24 from an acute hospital following a short stay for right shoulder rotator cuff tear, severe postoperative pain and impaired mobility due to left quadriceps tendon	F 676		

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F 676	Continued From page 8	F 676		

repair. R2 had greatly impaired mobility and safety related to inability to use right upper extremity and need to use cane due to quadriceps tendon repair.

R2 was admitted with discharge orders from the hospital for wound care for dressing changes to right shoulder and left knee. With instructions that if R2 desires to have a shower R2 may have a shower while seated and follow wound care instructions after showering on 2/24/24.

On 3/11/24, during a record review for R2 a written order, dated 2/29/24, was written for R2. The order is for a shower daily, may get knee wet, put empty saline bottle between elbow and body for support. Left knee daily shower, remove dressing after loose in shower. After showering, flush with saline, apply Medi honey, telfa, ace wrap. Limit knee flexion to 80 degrees max.

On 3/11/24, during clinical record review for R2, Certified Nursing Assistant(CNA) documentation shows that from 2/24/24 when cleared to shower by provider to 3/3/24, R2 did not receive any showers.

On 3/13/24, during an interview with a surveyor, R2 stated that he/she had been asking for showers and that he/she had a physician's order for a daily shower. R2 stated that when he/she asked staff for showers R2 was told by staff that they were not able to give him/her a shower due to not being trained in how to give him/her a shower.

On 3/11/24 at 2:40 p.m., during an interview with the Director of Nursing, the surveyor confirmed that R2 had not received a shower during their

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F 676	Continued From page 9 stay once cleared by the provider to take a shower on 2/24/24.	F 676		