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 12/04/2024

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 12/4/24, an on-site visit was conducted at Ross Manor for the purpose of investigating facility reported incident #ME00049550. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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.	F 609		

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

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F 609	Continued From page 1	F 609		

This REQUIREMENT is not met as evidenced by:
Based on interviews, policy review, and record review, the facility failed to ensure staff reported an allegation of physical abuse immediately for 1 of 1 residents reviewed during a complaint investigation. (Resident #1[R1])

Finding:

A review of the facility's policy, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating," revised 02/2023, under the heading, on page 1, "Reporting Allegations to the Administrator and Authorities," states, "1. If resident abuse ...is suspected, the suspicion must be reported immediately to the administrator ...2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency ...3. Immediately is defined as: a. within two hours of an allegation involving abuse ..."

On 11/12/24 at 3:24 p.m., the Division of Licensing and Certification received a reportable incident from the facility, alleging that on 11/11/24 at 9:30 p.m., a Certified Nursing Assistant (CNA #2) witnessed CNA #1 grab R1 by the left thumb and twist R1's arm behind his/her neck, causing bruising on his/her left thumb.

Review of the incident form revealed that CNA #2 failed to report the allegation until 11/12/24 at 2:25 p.m., allowing the perpetrator to continue providing care to R1 on 11/11/24 into 11/12/24.

A review of CNA#2's employee file revealed a follow-up conversation between CNA #2 and the

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F 609	Continued From page 2 Director of Nursing (DON), dated 11/15/24, stating that CNA#2 was asked if she reported the situation between CNA#1 and R1 to the charge nurse after it happened, and CNA #2 stated she didn't. The DON asked why, and CNA #2 stated that she didn't feel like anything would get done about it. The DON re-educated CNA #2 that if there is any question of alleged abuse, physical or verbal, that it needs to be reported immediately. On 12/6/24 at 10:00 a.m., during an interview with the DON, 2 surveyors confirmed that CNA #2 failed to report the allegation of resident physical abuse immediately.	F 609		