STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205166	A. BUILDING _____ B. WING _____	C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GORHAM HOUSE	**50 NEW PORTLAND RD GORHAM, ME 04038**

(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 7/1/25, an unannounced on-site visit was conducted at Gorham House for the purpose of an investigation of complaints #ME00050189, #ME00052023, and facility reported incident #ME00052028. It was determined that Gorham House in past non-compliance with 42 CFR 483, Sub-part B-Requirements for Long Term Care Facilities.	F 000		
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- §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 review of the Facility Reported Incident ("FRI"), 5-day incident follow-up, facility's abuse prohibition policy, and investigative report, the facility failed to ensure that 1 of 6 sampled residents was free from verbal abuse. (#1) Finding: On 6/13/2025 the Division of Licensing and	F 600	Past noncompliance: no plan of correction required.	

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

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F 600	Continued From page 1 Certification ("DLC") received a facility reported incident ("FRI") reporting that on 6/12/25 two CNAs were alleged to have verbally abuse a resident ["Resident #1], the incident was reported to the facility by [non-facility member] who overhead what was said while using a video and audio communication app. On 6/17/25 the DLC received the facility 5-day follow-up to the 6/13/25 incident the follow-up stated that the two CNAs involved were interview and admitted to saying to Resident #1 "I hope you are not saying inappropriate things to my peers, you will be in big trouble." And "if you touch me, I will bite you." The two CNAs also admitted to saying things such as when Resident #1 asked the year they stated "2022" and told Resident #1 "your [spouse] is dead." When Resident #1 asked to go the bathroom Resident #1 was told to "go in your pants." Additionally, the follow-up states that Resident#1 did not recall any of the interactions with the CNAs, and the two CNAs involved were terminated from employment. A review of the facility investigation states that Resident #1 has a history of being sexually inappropriate and has dementia-severe with psychotic disturbance diagnosis and does exhibit behaviors at times. The facility investigation confirms that the two CNAs admitted to making the statements to Resident #1. The investigation concluded that the CNAs violated: "professional behavior, dignity of a resident, resident right to feel safe in environment, and compassionate care." A review of the facility's Abuse Prohibition Policy with a last review date of 3/6/25 states "The	F 600		

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F 600	Continued From page 2 resident has the right to be free from abuse...." and the policy/procedure includes information regarding verbal abuse. Resident #1 was not able to be interviewed, however; a clinical record review does not reveal any negative outcome because of the above interactions with the two CNAs. On 7/1/25 at approximately 9:00 a.m., in an interview with the Director of Nursing, the surveyor discussed that Resident #1 was verbally abused by two CNAs employed at the facility. At the time of the survey, the facility presented the surveyor with corrective action taken to address this incident. The facility was determined to be in past non-compliance after the review and verification of the implemented corrective actions. The facility conducted a facility wide education on "Compassionate Dementia Care and Abuse Training." Completed a review of staff hired during the month of June to ensure that all staff have received abuse training during their orientation process. The CNAs involved were terminated from duty. Observations of Resident #1 find that [he/she] is well-groomed and interactions with staff are courteous and professional.	F 600		