STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20210804	A. BUILDING: _____ B. WING _____	C 11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB CANTON	26 PLEASANT ST CANTON, ME 04221

(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) COMPLETE DATE
P 000	Initial Comments On 11/18/24, an unannounced on-site visit was conducted at Pinnacle Health and Rehabilitation - Canton for the purpose of investigating complaint #ME00049629. It was determined that Pinnacle Health and Rehabilitation - Canton was not in compliance with Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level IV Private Non-Medical Institutions.	P 000		
P 203	5.10 Resident Rights Right to freedom from abuse, neglect or exploitation. Residents shall be free from mental, verbal, physical and/or sexual abuse, neglect and exploitation. [Class I, II, III, IV] This STANDARD is not met as evidenced by: Based on record review and interviews, the facility neglected to supervise 1 of 1 sampled resident with wandering behaviors and confusion to prevent an elopement. This failure to provide supervision and maintain a safe environment, resulted in the resident leaving the facility and being found by passers-by approximately 3 miles from the facility. Finding: On 11/15/24 at 2:04 p.m., the Division of Licensing & Certification received a faxed report that indicated Resident #1 had eloped from the facility on 11/12/24 at approximately 4:00 a.m. and police found the resident at 6:30 a.m. Oxford County Sheriff's office report dated 11/12/24 indicates that the officer arrived on-scene and observed an older male (Resident #1) standing up and being supported by two	P 203		

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P 203	Continued From page 1	P 203		

bystanders. When the Deputy asked Resident #1 where he/she came from. Resident #1 stated he could not find his/her car. The report indicates the deputy observed Resident #1 wearing an ankle bracelet (secure bracelet) and was informed by dispatch that Resident #1 was a resident at Pinnacle Health & Rehabilitation in Canton and the facility did not know the resident was missing. Resident #1 was found at an address approximately 3 miles from the facility. Medcare Ambulance services transported the resident back to the facility.

Resident #1's Minimum Data Set (MDS) assessment, dated 10/21/24, was coded, (in section B), to indicate the resident has short term & long-term memory problems, and the resident's cognitive skills were moderately impaired - decisions poor; cues/supervision required. This MDS under Behavioral Symptoms indicates Wandering behavior occurred daily, seemingly oblivious to needs or safety.

The resident's service plan, dated 11/18/22, indicated the resident had cognitive impairments that interfere with the resident's well-being. The service plan identified that the resident wears a wander guard and frequently exit seeks. therefore, causing a safety risk and need for frequent redirection.

Behavior monitoring sheets dated 11/3/24 - 11/13/24 indicate that Resident #1 wandered without purpose daily.

On 11/18/24 at 10:45 a.m., during an interview with a surveyor, the Residential Care Director confirmed that on the morning of 11/12/24 Resident #1 had eloped from the facility and the incident was not reported to the state agency.

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P 203	Continued From page 2 The Residential Care Director indicated that Resident #1 does have a diagnosis of dementia, wears a wander guard and frequently exit seeks. On 11/18/24 at 12:15 p.m. the above findings were discussed with the Administrator who was not aware that the elopement incident occurred. On 11/19/24 at 1:26 pm during a telephone interview with Staff member #1, she stated that Resident #1 frequently exit seeks. Staff member #1 stated that Resident had been on 15-minute checks the past 5 days and was told he/she was no longer on 15-minute checks. Staff member #1 recalls having to redirect Resident #1 several times that evening. The last time she saw the Resident #1 was at 9 p.m. when she brought him/her back to his room.	P 203		
P 222	5.25 Resident Rights Mandatory report of rights violations. Any person or professional who provides health care, social services or mental health services or who administers a long term care facility or program who has reasonable cause to suspect that the regulations pertaining to residents ' rights or the conduct of resident care have been violated, shall immediately report the alleged violation to the Department of Health and Human Services ((800) 383-2441) and to one or more of the following: Disability Rights Center (DRC), pursuant to Title 5 M.R.S.A. § 19501 through § 19508 for incidents involving persons with mental illness; the Long Term Care Ombudsman Program, pursuant to Title 22 M.R.S.A. § 5107-A for incidents involving elderly persons; the Office of Advocacy, pursuant	P 222		

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P 222	Continued From page 3 to Title 34-B M.R.S.A. § 1205 for incidents involving persons with mental retardation; or Adult Protective Services, pursuant to Title 22 M.R.S.A. § 3470 through § 3487. Reporting suspected abuse, neglect and exploitation is mandatory in all cases. Documentation shall be maintained in the facility that a report has been made. Mandated reporters shall contact the Department of Health and Human Services ((800) 383-2441) immediately after receiving and/or obtaining information about any rights violations. [Class IV] This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to report an allegation of neglect to the State Agency. Finding: On 11/15/24 at 2:04 p.m., the Division of Licensing & Certification received a faxed report that indicated Resident #1 had eloped from the facility on 11/12/24 at approximately 4:00 a.m. and police found the resident at 6:30 a.m. approximately 3 miles from the facility Oxford County Sheriff's office report dated 11/12/24 indicates that the officer arrived on-scene and observed an older male (Resident #1) standing up and being supported by two bystanders. When the Deputy asked Resident #1 where he/she came from. Resident #1 stated he could not find his/her car. The report indicates the	P 222		

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P 222	Continued From page 4 deputy observed Resident #1 wearing an ankle bracelet (secure bracelet) and was informed by dispatch that Resident #1 was a resident at Pinnacle Health & Rehabilitation in Canton and the facility did not know the resident was missing. Medcare Ambulance services transported the resident back to the facility. On 11/18/24 at 10:45 a.m., during an interview with a surveyor, the Residential Care Director confirmed that on the morning of 11/12/24 Resident #1 had eloped from the facility and the incident was not reported to the state agency. On 11/18/24 at 12:15 p.m. the above findings were discussed with the Administrator who was not aware that the elopement incident occurred.	P 222		