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	205064	A. BUILDING _____ B. WING _____	04/17/2025

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ROSS MANOR	758 BROADWAY BANGOR, ME 04401

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F 000	INITIAL COMMENTS From 4/14/25 through 4/17/25, unannounced on-site visits were conducted at Ross Manor for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00048261, #ME00049345 and #ME00050495. It is determined that Ross Manor is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		

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

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 655	Continued From page 1 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 2 sampled residents admitted for skilled care services (Resident #2[R2]). Finding: Review of R2's clinical record noted that he/she was initially admitted to the facility on 2/20/25, discharged on 2/23/25 and returned on 2/27/25. The clinical record lacked evidence that the base line care plan was developed with instructions needed to provide minimum healthcare information necessary to properly care for R2 until 3/3/25.	F 655		

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F 655	Continued From page 2 On 4/17/25 at approximately 10:15 a.m., during an interview with the Assistant Director of Nursing, the surveyor confirmed that that baseline care plan was not developed/initiated until 3/3/25 4 days after admission and not within the 48 hours after admission.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to consistently provide Activities of Daily Living (ADL) care in the area of oral hygiene for 1 of 1 residents reviewed for dental care [Resident #58 (R58)]. Finding: On 4/15/25 at 10:15 a.m., during an interview with a surveyor, R58 stated staff do not soak or wash his/her dentures at night. At that time the surveyor observed the denture to be soiled with food debris. On 4/16/25, R58's clinical record was reviewed. The clinical record indicated R58 is cognitively intact. The Care Plan indicates a focus of "[R58] has an ADL self-care performance deficit [related to] ... hemiplegia affecting left non-dominant side ... need for assistance with personal care." The Care Plan intervention for this focus states "PERSONAL HYGIENE/ORAL CARE: the resident requires limited to extensive assist".	F 677		

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F 677	Continued From page 3 Review of Oral Hygiene documentation indicates oral hygiene was not completed after the evening meal for 13 out of 31 days in March (3/1/25, 3/3/25, 3/5/25, 3/7/25, 3/9/25, 3/10/25, 3/14/25, 3/15/25, 3/16/25, 3/21/25, 3/22/25, 3/28/25, and 3/30/25). On 4/16/25 at 10:55 a.m., during an interview with a surveyor and the Director of Nursing (DON) the Oral Hygiene documentation was reviewed. The DON stated evening shift would document "Not Applicable" if they did not provide this service and she would not expect evening shift to complete this task if the previous shift had already documented it as completed. At this time the surveyor confirmed that oral hygiene was not provided consistently after the evening meal.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, the facility failed to follow physician orders for 2 of 19 residents reviewed. (Resident #64 [R64] and R90). Findings:	F 684		

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F 684	Continued From page 4	F 684		

1. On 4/14/25 at 2:52 p.m. during a clinical record review for R64 there is documentation that shows he/she had an order for Levofloxacin 750 milligrams (mg) by mouth every 48 hours until 4/22/25 with a start date of 4/2/25.

Review of the electronic medication administration record (MAR) shows documentation that R64 received a dose of Levofloxacin on 4/2/25 at 6:33 a.m. and he/she received an additional dose on 4/3/25 at 3:18 p.m. which was not 48 hours after the previous dose as ordered.

On 4/16/25 at 1:00 p.m. during an interview with LPN1 and LPN 2, they stated the facilities Pyxis does not have that dose of Levofloxacin and thought the medication would come early in the morning the next day 4/3/25. Review of the MAR with LPN1 and LPN2 the surveyor confirmed that R64 received a dose of Levofloxacin two days in a row (4/2 and 4/3) and not every 48 hours as ordered by the Provider.

2. On 4/15/25 at 12:49 p.m., during a clinical record review for R90, the Treatment Administration Record for April shows that on 4/12/25, R90 had a Blood Sugar (BS) result of 422, per his/her sliding scale insulin coverage the facility would need to give R90 12 units of insulin and call the Medical Doctor (MD). Clinical record shows that they did call the MD and received an order to give an additional 3 units of insulin and to recheck BS in 2 hours.

On 4/16/25 at 12:35 p.m. during an interview with LPN1 and LPN2 the surveyor confirmed there was no evidence in R90's clinical record that his/her BS was not rechecked in 2 hours as

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F 684	Continued From page 5 ordered. .	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, and interviews, the facility failed to provide physician ordered respiratory services for 1 of 1 resident (Resident [R2]) reviewed with a continuous positive airway pressure (CPAP) machine when the facility failed to obtain missing tubing for R2's machine. Finding: On 4/15/25 during a record review for R2, he/she was admitted with an order to apply CPAP every evening with a start date of 2/21/25. Nursing progress note dated 2/21/25 documents that the CPAP was not used, no tubing with machine. His/her clinical record documents that R2 was hospitalized on 2/23/25 with a return date of 2/27/25, he/she was hospitalized on 3/27/25 with a return date of 4/4/25 and was sent to the hospital on 4/6/25 with a return date of 4/10/25. All admission orders had the order to apply CPAP every evening. Documentation in the nursing progress notes and	F 695		

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F 695	Continued From page 6	F 695		

on the electronic treatment administration record (ETAR) shows that R2 was not using the CPAP as ordered due to missing parts. The facility did not assist the resident to obtain the missing parts which resulted in R2 having hospital readmissions. R2's last hospitalization was from 4/6/25 to 4/10/25 and since his/her return, the facility was able to obtain the missing part and R2 has been using it daily since receiving the part.

On 4/15/25 at 10:00 a.m. during an interview with the Assistant Director of Nursing (ADON) she stated that when R2 first came to the facility, his/her CPAP was brought in and did not have the tubing, when the facility contacted the previous place of residence, they said R2 didn't have any parts there. The facility contacted the previous medical equipment provider (Lincare), and they said he/she was not allowed to get parts until September, the facility then contacted a local medical equipment provider (Americoast) and was able to get the parts (tubing) on 4/11/25. It was stated that R2 was refusing to use their CPAP or had stated they would not use it. During this interview the surveyor confirmed that if R2 wanted to use their CPAP they were not able to due to the missing part.

On 4/15/25 at 10:00 a.m. during the interview with the ADON, the surveyor confirmed that for all admissions R2 was not able to use his/her CPAP as ordered due to missing parts and the facility had failed to obtain the missing part since his/her admission on 2/20/25 resulting in R2 having 4 hospital admissions relating to hypoxia (low oxygen levels). The missing part was ordered and received by 4/11/25 (50 days after initial admission)

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F 758	Continued From page 7	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		

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prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure there was a physician ordered renewal for an as needed (PRN) psychotropic medication without a stop date, making it available for administration for 1 of 19 residents reviewed (Resident #6 [R6]).

Finding:

On 4/15/25 at 12:19 p.m., during R6's clinical record review, the record indicated that on 2/12/25 an order for Haldol (atypical antipsychotic medication) dose of 0.25 milliliters (ml) by mouth every 4 hours as needed was started. This medication order did not include a stop date for re-evaluation and the physician progress notes did not include a rationale for continued use of this medication.

On 4/16/25 at 12:45 p.m., during interviews with LPN1 and RN, the surveyor confirmed that the order for the Haldol was still active beyond the 14-day limit without a rationale to continue, the order did not contain a stop date for a re-evaluation.

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F 812	Continued From page 9	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 kitchen equipment that require a 1" air gap on 4 of 4 days of survey. Finding: On 4/14/25, at 12:05 p.m. during the initial kitchen tour, a surveyor observed there was an improper air gap provided on the drain lines of the ice machines, one located in the hallway leading to the kitchen and one located in the kitchen. This direct connection of wastewater and potable	F 812		

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F 812	Continued From page 10 water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). On 4/14/25, at 12:05 p.m., a surveyor confirmed this finding with the Food Service Director (FSD). On 4/15/25 during a second visit to the kitchen, to observe meal preparation a surveyor observed the ice machines continued to have an improper air gap on the drain lines. On 4/16/25, during a third visit to the kitchen to observe a meal service, a surveyor observed the ice machines continued to have an improper air gap on the drain lines. On 4/17/25, during a final kitchen tour a surveyor observed the ice machines continued to have an improper air gap on the drain lines and the vegetable sink had the proper 1" air gap. On 4/17/25 at 10:00 a.m., during an interview with the FSD, a surveyor confirmed the improper air gaps remained on the ice machines.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or

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unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on a clinical record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 19 sampled residents (Resident #2 [R2], and [R1]).

Findings:

1. On 4/15/25 at 10:00 a.m., during a clinical record review for R2 there was an order dated 2/21/25 which instructed nursing to "apply continuous positive airway pressure (CPAP) daily at bedtime".

Review of the Treatment administration record

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(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 842	Continued From page 13	F 842		

(TAR) for March 2025 has documentation of the CPAP being applied on 3/3, 3/4, 3/5, 3/13, 3/18 and 3/19/25. Documentation in R2's clinical record indicates that the CPAP had missing parts and was not able to be used.

On 4/15/25 at 10:00 a.m., during an interview and clinical record review with the Assistant Director of Nursing (ADON), she stated that when R2 first came to the facility, his/her CPAP was brought in and did not have the tubing (had missing part). The surveyor confirmed that documentation on the TAR was inaccurate when it was signed off as the CPAP being applied on the above dates when the missing part was not received until 4/11/25.

2. On 4/16/25, R1's clinical record was reviewed. Review of the Medication Administration Record (MAR) indicated that R1 was prescribed Benztropine Mesylate (used to treat Parkinson's disease and side effects of other drugs) "for Parkinson", and Ziprasidone (used to treat schizophrenia and bipolar disorder) for "psychosis". Review of the active diagnosis list for R1 did not include a diagnosis of Parkinsons disease or Psychosis. Review of the provider notes indicated Benztropine Mesylate was prescribed to treat drug induced tremor, and Ziprasidone was prescribed for a diagnosis of bipolar disorder.

On 4/16/25 at 2:45 p.m., during an interview with a surveyor and the Director of Nursing (DON), R1's clinical record was reviewed. The DON stated R1 does not have a diagnosis of Parkinson's or Psychosis. At this time a surveyor confirmed the MAR contained inaccurate information related to the diagnosed indication for

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	205064	A. BUILDING _____ B. WING _____	04/17/2025

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F 842	Continued From page 14 the medications Benztropine Mesylate and Ziprasidone.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		

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F 880	Continued From page 15 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections for 3 of 4 days of survey (4/14/25, 4/15/25, and 4/16/25).	F 880		

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F 880	Continued From page 16 Findings: On 4/14/25, a surveyor observed the following: -In the shared bathroom for Rooms 302A and 302B, a commode seat in use as an elevated toilet seat was observed over the toilet bowl. Dried blood was observed on the right side of the seat, and stool was observed smeared on the front of the commode seat. Dried blood droplets were observed on the floor in a trail leading toward the bathroom sink. A bed pan was observed unlabeled and exposed to the environment, resting against handrail and the bathroom wall. -In the shared bathroom for Rooms 303A and 303B, a large bed pan was observed to be soiled with stool, unlabeled, and exposed to the environment. -In Room 303B, a soiled linen bed chuck was observed on the floor. -In the bathroom of Room 305, a surveyor observed a hole in the floor of the shower creating an uncleanable surface. -In Room 304A, a soiled linen bed chuck was observed on the floor. -In Room 505 blood was observed on the bed frame of Resident #63 (R63) On 4/14/25 at 11:43 a.m., during an interview with a surveyor and a Registered Nurse (RN2), the following were observed and confirmed: -In the shared bathroom for Rooms 302A and 302B, a commode seat in use as an elevated toilet seat was observed over the toilet bowl. Dried blood was observed on the right side of the seat, and stool was observed smeared on the front of the commode seat. Dried blood droplets were observed on the floor in a trail leading	F 880		

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F 880	Continued From page 17	F 880		

toward the bathroom sink. A bed pan was observed unlabeled and exposed to the environment, resting against handrail and the bathroom wall.
-In the shared bathroom for Rooms 303A and 303B, a large bed pan was observed to be soiled with stool, unlabeled, and exposed to the environment.
RN2 stated bed pans should be in a bag until they are used, they should be labeled to identify who they belong to; after a bed pan is used it should be sanitized, then bagged for future use.

On 4/14/25 at 1:00 p.m., during an interview with a surveyor and a Certified Nursing Assistant (CNA), the blood on R41's bed frame was observed and confirmed, the CNA was unable to identify where the blood came from.

On 4/15/25 at 7:05 a.m., a surveyor observed residual blood dried on R63's bed frame.

On 4/15/25 at 7:22 a.m., a surveyor observed CNA2 assist Resident #60 (R60) with using a bed pan. After CNA2 assisted R60 with peri care, CNA2 returned R60's toiletries to drawers while still wearing soiled gloves. CNA2 then began handling R60's clean clothing while still wearing soiled gloves, at this time the surveyor intervened and confirmed that CNA2 did not remove the soiled gloves or perform hand hygiene before contacting drawers and the resident's clean clothes.

On 4/15/25 11:19 a.m., a surveyor observed opened dressing wrappers on Resident #41 (R41) blankets. At 11:27 a.m., this observation was confirmed with RN2.

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F 880	Continued From page 18 On 4/15/25 at 11:44 a.m., a surveyor observed Resident #47 (R47) in the hall, self-propelling in a wheelchair. R47's foley bag was observed dragging on the floor under the wheel chair. A surveyor observed and confirmed this finding with CNA-M. On 4/16/25 at 11:03 a.m., in an interview with the Director of Nursing (DON), a surveyor reviewed and confirmed the above findings. During the interview the surveyor and the DON observed and confirmed the following: -In the bathroom of Room 305, the floor of the shower has a hole creating an uncleanable surface. -The commode seat used as a raised toilet seat in the shared bathroom, for Rooms 302A and 302B, was observed to have blood on the left side of the seat. This was confirmed at the time of the observation. -The bed frame in Room 505A was observed and confirmed to have residual blood on it (consistent with the original observation on 4/14/25).	F 880		