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P 000	Initial Comments On 6/4/25, an unannounced onsite visit was made at Gorham House Assisted Living and Memory Care, for the purpose of complaint investigation #ME00051829. It was determined that Gorham House Assisted Living and Memory Care is not in substantial compliance with 10/144, Chapter 113- Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 012	3.4.3.3 Licensing Comply with all other applicable laws and regulations pertaining to licensing; This Regulation is not met as evidenced by: Based on record review and interview, the facility did not utilize the Maine Background Check Center to obtain a comprehensive background check report as required by 10-144 C.M.R., Ch.60, Maine Background Check Center Rule (effective date October 17, 2018), established under 22 M.R.S. Ch. 1691, Maine Background Check Center Act for 5 of 5 personnel files reviewed (Employees #1, #2, #3, #4, #5). Findings: On 6/4/25, the surveyor reviewed five (5) personnel files for staff working on the Oxford unit. On 6/9/25, the surveyor requested the Administrator forward copies of the Maine Background Checks for the 5 employees. The Administrator provided the following: 1. Employee #1, contracted through the NURSA agency, failed to have documented evidence of the agency utilizing the Maine Background Check	P 012		

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P 012	Continued From page 1 Center for employee background checks. The file contained a background check completed by First Advantage, dated 4/5/25. 2. Employee #2, contracted through the NURSA agency, failed to have documented evidence of the agency utilizing the Maine Background Check Center for employee background checks. The file contained a background check completed by First Advantage, dated 4/8/25. 3. Employee #3, failed to have documented evidence of the agency utilizing the Maine Background Check Center for employee background checks. The file contained a background check completed by JDP - Palantine, dated 9/10/24. 4. Employee #4, failed to have documented evidence of the agency utilizing the Maine Background Check Center for employee background checks. The file contained a background check completed by JDP - Palantine, dated 4/29/25. 5. Employee #5, failed to have documented evidence of the agency utilizing the Maine Background Check Center for employee background checks. The file contained a background check completed by JDP - Palantine, dated 4/8/25.	P 012		
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]	P 203		

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This STANDARD is not met as evidenced by:
Based on interviews, observations and record reviews, the facility neglected to supervise 1 of 1 sampled resident (R1) with wandering behaviors and confusion to prevent an elopement. This failure to provide supervision and maintain a safe environment, resulted in the resident exiting the facility from a second story window and being found injured on the ground outside.

Findings:

On 6/2/25, the Division of Licensing and Certification received a fax report from the facility, dated 6/1/25, which stated R1 had been exit seeking throughout the evening shift of 5/31/25. At 9:00 p.m., staff were unable to locate R1 and began searching for him/her. After approximately 5 minutes, staff observed an open window and R1's hat outside on the ground. Staff ran outside and found R1 sitting on his/her buttocks on the ground approximately 25 feet away from the building and holding onto a wooden footbridge. Staff observed R1 was in distress and bleeding from his/her foot. Staff called 911 and R1 was immediately transported to the hospital via ambulance.

On 6/9/25 at 9:20 a.m., two surveyors completed a tour with the Administrator of the facility's Oxford unit, a secure memory unit located on the second floor. The surveyors were escorted to resident room 230, which was not R1's room. The Administrator stated a window located on the right side of the room was where R1 had fallen. The window had a broken block of wood approximately 2 x 3 inches screwed into the left side of the frame and a small block of wood approximately 3 x 3 inches screwed into the right

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side of the frame which allowed the window to only open about 4 to 6 inches. The Administrator reported R1 had pulled the left side of the wind out of the track, breaking the small wooden block. Surveyors observed the drop to the grass covered ground to be approximately 20-to-25 feet. After falling from the window, R1 had crawled to the wooden footbridge where he was found at approximately 9:15 p.m.

The surveyors examined the other window in room 230 and found the window to be a newer model that had two release slides at the top of the lower window unit that would allow the window to tilt inwards. This left window only had one block on the left side of the window. When asked by a surveyor about window blocks, the Administrator stated that the windows were supposed to have two blocks on them and was not sure why this room didn't have two on the left window. When asked by the surveyor if the right window had two blocks on it at the time of the elopement, the Administrator could not answer if it did or didn't.

On 6/4/25 at 10:50 a.m., a surveyor interviewed the Director of Operations who stated, "We have since checked all the windows to ensure they have 2 stops on them to only allow the windows to open 4 inches or so." The surveyor asked if the small wooden blocks came with the windows, who made them, who put them on and if the blocks were discussed with the Fire Marshal's office before use. The Director of Operations stated, "No they did not. The maintenance department made them and put them on the windows. As far as I know, all the windows have two stops on them. We did an audit and found some broke and some missing. We have never discussed the blocks with the fire Marshal's office to see if this was allowed or acceptable."

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P 203	Continued From page 4 On 6/4/25 at 2:40 p.m., in an interview with a surveyor, Certified Residential Medication Aide (CRMA) #6, stated during the evening of 5/31/25, R1 was exit seeking. CRMA #6 was passing medications and when he/she went to administer R1's medications, he/she was not in his/her room. CRMA #6 stated R1 wanders into other residents' rooms so he/she started checking and got all staff to begin to search. Every room was checked, every hallway and every bathroom. Then one staff saw R1's hat on the ground outside a window. Several of the staff went outside to search for R1. He/she was found outside in the back area by the bridge. CRMA #6 immediately called 911. R1 was observed sitting on the ground and holding onto the bridge. CRMA #6 noticed blood on the sock around the right ankle and R1 was becoming combative, wanting to get up. CRMA #6 stated he/she kept the resident calm and did not let R1 get up until the ambulance arrived. On 6/4/35 at 2:50 p.m., in an interview with a surveyor, CRMA #5 discussed the incident of 5/31/25, and stated "We were locking all the residents' rooms Saturday night. The residents were getting angry with R1." CRMA #5 stated he/she was continuously wandering into other rooms. The surveyor asked if he/she had given R1 an as needed (prn) medication for behavior. CRMA #5 stated "I didn't think it was necessary." CRMA #5 stated R1 was perseverating over the red truck. "It was constant. I offered him/her a snack, activity. His/her family had been here all day and when they left, he/she started. He/she had been good all day." Record review revealed R1 was admitted to the facility from home on 5/13/25. Diagnoses	P 203		

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included Mixed Alzheimer and Vascular Dementia. On 5/16/25, a Level of Care Assessment was completed which indicated R1 was occasionally resistant to care, independent with ambulation, and identified as needing limited assistance due to seeking non-existent places (such as former home or business.) On 5/27/25, another Level of Care Assessment noted R1 required extensive assistance due to disruptive and socially inappropriate behaviors, resistance to care, and persistent moving and walking without purpose.

On 5/14/25, staff documentation noted R1 began to become restless and perseverate about a red truck outside which he/she believed belonged to him/her. R1 became agitated and aggressive towards staff, and "eventually tired him/herself out."

On 5/16/25, the documentation revealed R1 became involved in an altercation with another resident. R1 threw an Amazon Alexa ball at the resident and then threatened to throw it at a staff member's face. R1 became combative during staff attempts to intervene and sustained skin tears on his/her arms. Staff attempts to redirect were unsuccessful.

A review of staff documentation beginning on 5/17/25 revealed the effects of R1's behavior on another resident, R2, whom R1 engaged in pacing and exit seeking every evening. R2 verbalized that he/she had been losing sleep and was growing agitated regarding R1's care. Progress notes from 5/21/25 and 5/22/25 discussed that R2 was visibly exhausted and agitated after walking the halls the whole evening with R1. On 5/25/25, R2 stated how difficult it was to tell R1 not to open doors and to have to

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take care of R1 all the time.

A review of provider documentation noted on 4/8/25, R1 was seen by his/her primary care physician who noted "Ongoing issues regarding day/night reversal and poor sleep, with wandering and other unsafe behaviors overnight." On 5/27/25, the facility's provider visited R1 and noted a history of difficult to manage behaviors in the evening, including elopement from home, and multiple medication adjustments. On 5/30/25, the facility's medical director visited R1 and added an as needed medication to be given every 8 hours for severe agitation.

Provider orders were reviewed and noted to include: an order dated 5/14/25 for Lorazepam (an antianxiety) 0.5 mg/ml (milligrams per milliliter) - apply topically every 8 hours as needed. An order dated 5/22/25 for Seroquel (an antipsychotic) to increase from 75 mg to 100 mg by mouth at bedtime. In addition, on 5/14/25, the provider ordered Seroquel 25 mg by mouth every 24 hours as needed for agitation, and on 5/30/25, increased this dose to 50 mg by mouth every 8 hours as needed for agitation.

A review of R1's medication administration record revealed that staff administered only 3 doses of lorazepam as needed on 5/16/25, 5/17/25, and 5/23/25. The record shows staff did not administer a single dose of as needed Seroquel at any time during R1's stay.

R1's service plan was initiated on 5/16/25 and revised 5/27/25. An Interdisciplinary Team Meeting (IDT) was held on 5/28/25 with R1's family members in attendance, at which time R1's behaviors were discussed. The family requested adjustment of the administration time for the

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P 203	Continued From page 7 bedtime medications, and this was done. Documentation stated the "Health and Wellness Director suggested to family the resident "may need a little more one on one care in the evening due to increased agitation and showing aggression, that they should consider hiring private care giver for the evenings. Family states this week is the private caregiver's last week." After the IDT meeting, R1's service plan was not revised to include resident specific interventions, approaches or strategies to address identified changes in mood and behaviors, exit seeking, when to administer as needed medications at the onset of escalating agitation or anxiety, or the effects R1's behaviors had on other residents. On 5/14/25, staff identified the red truck outside as a trigger for R1, but the service plan did not address specific approaches to relieve the accompanying agitation.	P 203		
P 326	7.2.4.1 Medications and Treatments PRN Psychotropic medications. Psychotropic medications ordered "as needed" by the duly authorized licensed practitioner, shall not be administered unless the duly authorized licensed practitioner has provided detailed behavior-specific written instructions, including symptoms that might require use of medication, exact dosage, exact time frames between dosages and the maximum dosage to be given in a twenty-four (24) hour period. Facility staff shall notify the duly authorized licensed practitioner within twenty-four (24) hours when such a medication has been administered, unless otherwise instructed in writing by the duly authorized licensed practitioner.	P 326		

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P 326	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure a resident receiving an as needed psychotropic medication had a valid order, signed by an authorized licensed practitioner, which included the detailed requirements under the regulation, for 1 of 1 residents reviewed. Finding: A review of the clinical record for Resident #1 noted the medication administration record (MAR) with the following entry: Lorazepam (an antianxiety) 0.5 mg/ml (milligrams per milliliter) Gel, apply to wrist topically every 8 hours as needed for agitation may titrate per provider written script. The actual physician's order, dated 5/13/25, stated "Apply 1 ml topically as needed. Apply every 8 to 12 hours, may titrate to every 4 to 6 hours. Apply to inner wrist, wearing gloves." The order was renewed on 5/27/25. The order did not include specific instructions for the symptoms that might require use of the medication, exact time frames between doses, and maximum dosing in a 24 hour period. In addition, the order does not specify indications for when titration would be necessary.	P 326		