STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORONO COMMONS	**117 BENNOCH RD ORONO, ME 04473**

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F 000	INITIAL COMMENTS On 3/27/24 thru 3/28/24, an unannounced visit was conducted at Orono Commons for the purpose of completing the investigations for complaints #ME00042865, #ME00042899, #ME00044669, #ME00046862, and facility reported incident, #ME00044235. It was determined that Orono Commons was in past non-compliance with 483.12(a)(1)-also known as F600 and 483.12(c)(1)-also known as F609 within 42 CFR Part 483, Subpart 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 facility policy review, facility reportable incident review and investigation with written statements, and interview, the facility failed to protect a resident from physical and mental abuse (intimidation) when a Certified Nursing Assistant (CNA) grabbed Resident (R)4's	F 600	Past noncompliance: no plan of correction required.	

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 600	Continued From page 1	F 600		

foot/ankle when R4 attempted to kick CNA1 a second time, after making contact the first time. CNA1 held R4's foot/leg against the bed to stop R4 from kicking, only letting go after R4 said he/she wouldn't kick CNA1 again. The action of CNA1 grabbing R4's foot/ankle resulted in right ankle swelling, bruising, and mild pain to R4.

Finding:

On 7/11/23, the Division of Licensing and Certification (State Agency) received a fax from the facility, alleging that on 7/11/23 at 2:50 a.m., R4 kicked CNA1, attempted to kick CNA1 again, when CNA1 grabbed R4's right foot/leg to stop resident from kicking. CNA 1 was sent home pending investigation and the Medical Provider would see R4 in the morning. Immediate treatment to R4 was his/her right lower leg was elevated, ice applied, with 1 to 1 attention provided to R4 to calm him/her down after the incident.

A review of signed and dated written statements (7/11/23) indicated the following:
- CNA1 - "I heard shouting and I went to see what it was about, R4 was arguing her his/her roommate saying that he/she was not in his/her bed. I tried to reassure him/her that he/he was in the correct room and bed. R4 got aggressive and kicked me in the groin making contact. As I recovered he/she went to do it again and, out of reflex, I grabbed his/her ankle and put it on the bed, and held his/her leg there so he/she couldn't do it again. When he/she told me to let go of his/her leg, I asked if he/she was going to kick me again and he/she said no, so I let go at which point CNA2 came in and I removed myself from the room."

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F 600	Continued From page 2 - CNA2 - "When I walked into the room, CNA1 was trying to get a very distraught R4 to lay down back in his/her bed. I told him to leave the room and let me try to calm her down. R4 told me that the man (CNA1) grabbed his/her legs and that the right one really hurt. Upon looking at it, I did notice it was swollen. I asked R4 again what happened and he/she said the man grabbed her legs. I asked CNA1 if R4 hit his/her legs on anything in the process of trying to get him/her back to his/her room. CNA1 said no, that R4 had tried to kick him in the groin and he grabbed his/her leg to stop him/her." - Charge Nurse (CN) - "When this writer approaches the resident, he/she is ambulating from the bathroom to his/her bed. R4 reports she was in her room and was asked to leave by staff, she didn't want to leave so she kicked him. R4 reports she attempted to kick him again and staff (CNA1) grabbed his/her foot to stop him/her from kicking him. This writer observed his/her right foot which was swollen on the outer ankle and slightly bruised. R4 was assisted to bed, right leg elevated and ice applied." - On 7/11/23, the Medical Provider saw R4 and ordered ice pack to the right distal tibula/fibula twice a day for 2 days and an X-ray to rule out fracture, sub post swelling, pain, and injury. The Medical Provider's progress note stated that R4 was able to weight bear and has ambulated some, but less then baseline. Bruising was noted lateral aspect of distal tibula/fibula, low suspicion for fracture but will order X-ray to make sure. On 7/11/23 at 7:39 a.m., a follow up note to the incident indicated that there was visible swelling,	F 600		

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F 600	Continued From page 3	F 600		

some bruising noted, R4 has complained of pain (mild pain), some discomfort with flexion of foot.

On 7/12/23, the X-Ray was completed and was negative for fracture.

On 7/13/23, a skin check was performed and a nickel size, purple in color, bruise to the right lateral ankle/heel.

On 3/27/24 at 10:55 p.m., during an interview with a surveyor, CNA2's recollection of the incident was that R4 stated that he (CNA1) grabbed his/her leg and R4 was very irate. CNA2 stated that she asked CNA1 what happened and he stated that he did grab R4's ankle because he/she was trying to kick him.

The facility's five day investigation report was faxed to the State Agency on 7/14/23, with the allegation of abuse substantiated and CNA1 was terminated. R4's ankle swelling has resolved.

The facility's policy, Abuse Prohibition, last reviewed 10/24/22, defined Abuse, "as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish" This definition further defined that instances of abuse of all patients, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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F 600	Continued From page 4 Physical Abuse - includes hitting, slapping, pinching, kicking, etc. as well as controlling behavior through corporal punishment. Mental Abuse - includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. As a result of this isolated incident, the following actions were initiated between 7/11/23 and 9/30/23: On 7/11/23 (day of incident), CNA1 was removed from the floor immediately after incident and sent home at 3:12 a.m. On 7/11/23, within minutes of the incident, 1:1 attention was provided to R4 and application of ice and elevation to the right ankle/leg was completed. On 7/11/23 at 7:39 a.m., R4 was examined by the Medical Provider with an order for ice application twice a day for 2 days and X-Ray ordered. On 7/12/23, an X-Ray was completed which was negative for fracture. On 7/14/23, facility investigation completed which resulted in CNA1's termination and notification to the CNA registry. Between 7/5/23 thru 9/30/23, staff completed Code of Conduct training, which included training on Abuse and Neglect. Between August 7, 2023 - August 11, 2023, facility wide dementia training was completed.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		

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F 609	Continued From page 5 §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. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility's Reportable Incident Form, facility investigation, and interview, the facility failed to report an allegation of Abuse to Adult Protective Services (APS) and law enforcement for 1 of 1 investigated allegations of Abuse (7/11/23). Finding:	F 609	Past noncompliance: no plan of correction required.	

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F 609	Continued From page 6 The facility policy, Abuse Prohibition, last revised 10/24/22, indicated that staff are to "report allegations to the appropriate state and local authority(s) involving neglect, exploitation, or mistreatment (including injuries of unknown source) suspected criminal activity, and misappropriation of patient property". The External Abuse Reporting Requirements table indicated reporting to Law Enforcement and Adult Protective Services (APS) was required with the responsible person being the Administator or Director of Nursing. The Division of Licensing and Certification (DLC) received the facility's Reportable Incident Form, dated 711/23, alleging that on 7/11/23 at 2:50 a.m., Resident (R)1 kicked Certified Nursing Assistant (CNA)1 in the groin and attempted to kick CNA1 again, when CNA1 grabbed R4's right foot/leg to stop resident from kicking. CNA1 was sent home pending investigation. This report lacked evidence of APS and Law Enforcement being notified of this allegation of physical abuse. A review of the facility investigation, dated 7/14/23, that included a written statement from CNA1, that read, "R4 got aggressive and kicked me in the groin making contact. As I recovered he/she went to do it again and, out of reflex, I grabbed his/her ankle and put it on the bed, and held [redacted] leg there so he/she couldn't do it again." The facility substantiated the allegation of abuse and CNA1 was terminiated and reported to the CNA registry. The investigation lacked evidence of APS and law enforcement being notified of the allegation of abuse. On 3/27/24 at 9:20 a.m., during entrance with a surveyor, the Administrator stated that the	F 609		

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F 609	Continued From page 7 Director of Nursing that completed that investigation no longer works there but she would provide surveyor with what information she has. A review of the facility's Reportable Incident Form and investigation, dated 7/14/23, both lacked evidence that APS, a State Agency, and local law enforcement were notified of the physical altercation between R4 and CNA1. As a result of this isolated incident, the following actions were initiated: Between 7/5/23 thru 9/30/23, staff completed Code of Conduct training, which included training on Abuse and Neglect. Since this incident occured, new staff are in the role of Administrator and Director of Nursing.	F 609		