Department of Health and Human Services

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 10/07/2025

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 10/7/25, an unannounced, onsite visit was made to Pinnacle Health & Rehabilitation-Canton, for the purpose of complaint investigation #ME00052628, #ME00052650, and #ME00052695. It was determined that Pinnacle Health & Rehabilitation-Canton 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 000: Please find our plan of correction to the stated deficiencies dated 10/07/2025. This plan of correction is required by law and is in no way an admission to the deficiencies outlined. P. 203: All residents could potentially be affected by this deficiency.	
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, interviews, the facility's report and investigation, and facility policy, the facility failed to protect a resident from physical abuse when a Personal Support Specialist (PSS) pushed a resident to the floor. Additionally, the facility failed to follow their own policy for investigating and reporting the incident for 1 of 3 residents sampled for abuse (Resident #2). Finding: Facility policy "Recognizing Signs and Symptoms of Abuse/Neglect," revised 1/1/25 states, " ... 'Abuse' is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish ..." Facility policy "Abuse Investigations," revised	P 203	P 203: The RCD held a staff meeting on 10/14/25 (see attached minutes) we discussed incidents, incident reports, reporting abuse, neglect, falls, elopements amongst other agenda items. Reinforce respect. amongst other topics. The RCD held a staff meeting on 10/23/24 (see attached minutes) we discussed: Classes are being added to our on line education tool called Healthcare academy, these will be avail to start on 10/27 with a target end date 11/10/25 the classes being added are: Med assist, deescalation, substance use amongst co workers, med errors and Narcan/opiod use amongst other topics. Another meeting will be held on 11/06/2025 with a reminder of progress and completion of HCA classes. P. 203 RCD met with TS, SS dept on 10/9/25 and was mentored on how to do proper follow up investigations from a reported incident. Investigation forms from .gov given for review.	11/10/25

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P 203	Continued From page 1 1/1/25 states, "All reports of resident abuse ...shall be promptly and thoroughly investigated ...During abuse investigations, residents will be protected from harm by the following measures ... Employees accused of participating in the alleged abuse will either be immediately removed from direct contact with that resident, reassigned to non-resident care duties, or will be suspended until the findings of the investigation have been reviewed by the Administrator. Should the employee(s) be reassigned ...such assignment will not be in any part of the building which the resident frequents ... Should a suspected violation ...or abuse be reported, the facility Administrator, or his/her designee will within two hours notify the following persons or agencies ...Department of Licensing and Adult Protective Services ...The Resident's Attending Physician ..." Facility policy "Accidents and Incidents," revised 7/2/21 states, " ... Regardless of how minor an accident or incident may be ...it must be reported to the department supervisor as soon as such accident/incident is discovered ...A Report of Incident/Accident form must be completed for all accidents or incidents ...The charge nurse, nurse on call, or designee shall: Examine all accident/incident victims ...Notify the victim's physician, of the accident or incident ...The charge nurse and/or the department director must conduct and investigation ..." On 9/6/24 at 2:15 p.m., the Division of Licensing and Certification received the following facility-reported incident, "Multiple reports of verbal abuse, neglect from several staff members and resident at Pinnacle ..." Review of the facility's investigation revealed a written statement by PSS #2, dated 9/4/24, that	P 203	P 203: Meetings and classes being held as stated. P. 203: The progress of education will be reported to QAPI quarterly for the next year and will automatically load into the employees HCA yearly starting on their next anniversary date.	

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P 203	Continued From page 2 states, " ... [Resident #2] reported to me that this employee [PSS #1] pushed him into dinning [dining] room, and he fell to floor." Further review of the investigation lacked evidence that the alleged abuse was reported to the required persons and agencies within 2 hours and lacked evidence that PSS #1 was removed from direct contact with Resident #2 following the allegation. A review of Resident #2's clinical record revealed a progress note by Licensed Practical Nurse (LPN) #1, dated 9/3/24 that states, "was told by 2 staff members ... was pushed by a staff and resident fell to the floor, nurse sent staff member to SS [social services] ..." Further review of the clinical record lacked evidence that Resident #2 was examined by the charge nurse following the incident or interviewed about the incident and lacked evidence that his/her physician was notified of the incident. A review of PSS #1's timecards indicated that she worked on the Residential Care unit on 9/3/24 (date of alleged abuse) from 10:42 p.m. to 7:07 a.m. and on 9/4/24 from 10:14 p.m. to 7:00 a.m. Review of PSS #1's employee file indicated she was terminated by the facility on 9/7/24. On 10/7/25 at 12:24 p.m. during an interview, Resident #2 stated that on the day of the incident, PSS #1 was ordering him/her to do something that he/she didn't want to do (go into the dining room) and that when he/she did not comply, PSS #1 pushed him/her to the floor. Resident #2 then stated it upset him/her that PSS #1 was trying to force him/her to do something he/she didn't want to do. On 10/7/25 at approximately 1:00 p.m. during an interview with 2 surveyors, the above concerns	P 203	P 203: meeting was held and followed up on 10/23/25 with RCD and education: add classes to HCA and create a video for staff review/inservice on how to : Identify abuse, neglect, trauma and how to complete the incident paperwork, who to notify and how the follow up is handled and completed.	11/10/25

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P 203	Continued From page 3 were discussed with the Residential Care Director (RCD). At this time, the RCD stated there should have been an incident report filled out and that LPN #1 was the charge nurse and should have assessed and interviewed Resident #2 following the incident and that she has no evidence of an incident report being completed.	P 203		
P 523	13.6.1 Staffing Within one hundred twenty (120) days of hiring, all staff, other than CNA ' s and licensed professional staff whose job responsibilities include direct service to residents for at least twenty (20) hours per week, shall successfully complete a certification course approved by the Department. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff whose job responsibilities include direct services to residents for at least twenty (20) hours per week have successfully completed a certification course approved by the Department for 1 of 4 personnel records reviewed (Personal Support Specialist [PSS] #1) during a complaint investigation. Finding: A review of PSS #1's personnel file indicated a hire date of 10/2/23. A review of the facility's job description acknowledged by PSS #1 on 10/2/23 states, "Training ... Required ... Residential Care Aides working more than 20 hours per week will complete the Personal Support Specialist (PSS) course within 120 days of employment as	P 523	P 523: Meeting was held and followed up on 10/23/25, between RCD and Education and scheduling staff to reinforce/better tracking of the process of RCA to PSS certification. (see attached meeting follow up notes) When an RCA is hired, the RCA will be enrolled into the PSS class within 14-30 days. if the class is not completed in the 120 days, the employee's hours will be decreased to 16-20 hours per week, (typically 2x 8 hr shifts) until the PSS class is completed. P. 523: All residents could potentially be affected by this deficiency.	