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

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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 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		

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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

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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

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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		

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P 523	Continued From page 4 required ..." Further review of PSS #1's personnel file lacked evidence of completion of a PSS course or prior completion of a Certified Nursing Assistant (CNA) course. On 10/7/25 at 1:30 p.m. the above finding was discussed with the Residential Care Director (RCD). At this time, the RCD stated PSS #1 did not complete a PSS course and was working full time until 1/13/24, then cut down to under 20 hours per week until June 2024. The RCD then confirmed that PSS #1 resumed full time status and worked over 20 hours per week providing direct services to residents from June 2024 until her employment was terminated in September 2024 and never completed a PSS or CNA course.	P 523		