STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205011	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barron Center	1145 Brighton Ave Portland, ME 04102

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility's policy, record review, and interviews, the facility failed to investigate an allegation of potential misappropriation of a resident's loss of personal property, and failed to ensure that the facility's investigation was sent to the State Agency within 5 business days of the incident for 1 of 6 intake investigations reviewed during an annual survey.A review of the facility's policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, Section G. Reporting and Response, stated All allegations of abuse or neglect will be reported to the Administrator or designee at the time the allegation is made. The facility will: Immediately report all alleged violations to the administrator.Take all necessary actions as a result of the investigation, which may include, but are not limited to the following: Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent future occurrences. Procedure. Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator or designee. b. The Administrator or designee will involve key leadership personnel as necessary to assist with reporting, investigation and follow-up. External Reporting: Report the results of all investigations to the Administrator or designee and to other officials in accordance with State law, and follow-up report to the State Survey Agency within 5 working days of the incident. The Administrator or designee will inform the resident or resident's representative of the report of an incident and that the investigation is being conducted. On 4/8/25, the Division of Licensing and Certification received the facility's report that Resident #30 (R30) was missing 2 cell phones, a [NAME] case containing the resident's identification, Medicare card and a small amount of cash. A copy of an email, dated 4/8/25, sent to the social worker from R30's son stated he/she has never lost these items before and is usually mindful of where they are, because he/she uses them regularly every day for entertainment and contacting family. I believe on possible theory that was mentioned to us was that maybe these items fell into the trash can, which he/she keeps beneath the bedside tray. Although, this is possible, it feels unlikely, especially that all three items would fall into the trash and go unnoticed. A follow-up email, dated 4/8/25 from the social worker to R30's son stated when the items were discovered missing, staff searched trash, the resident's room, and notified the kitchen and laundry departments. The social worker notified the local police department via an online crime report. On 4/10/258, the police department replied and stated the report had been rejected because We do not complete police reports for missing or lost property. A review of R30's medical record noted a personal effects inventory, dated 2/5/25, which included an android phone with green wallet case, and an IPhone with charger and cord. On 8/19/25 at 2:20 p.m., in an interview with a surveyor, the facility's Social Services Director stated she was not able to locate evidence that an investigation had been completed, or that a 5-day report was sent to the State Agency on this incident. On 8/20/25 at 2:00 p.m., in an interview with a surveyor, the facility's Administrator stated the incident had never been reported to her. At this time, the facility's Director of Nursing stated she had no knowledge of the incident either and that it had not been discussed at morning staff meetings.