

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Ross Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 758 Broadway Bangor, ME 04401	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540</p> <p>Based on record review and interviews, the facility failed to ensure that the resident's representative was notified of a change in the resident's discharge plan, failed to notify the representative of the resident going outside the facility and failed to notify the medical provider of resident's elopement risk and exit seeking behaviors for 1 of 1 sampled resident (Resident #1)</p> <p>Findings:</p> <p>On 2/4/25 at 2:50 p.m., during an interview and record review, it was documented that the interdisciplinary team and resident representative made a decision that Resident #1 was going to need 24-hour supervision. A plan was made for Resident #1 to go over to [NAME] Place, an assisted living memory care unit, on Saturday 1/11/25. A decision was made not to transfer Resident #1 to the memory care unit and the facility failed to notify the resident representative of this change.</p> <p>On 2/4/25, during a clinical record review for Resident #1, a nursing note documents that Resident #1 went out the door that morning and attempted to climb over a railing. Resident #1 was redirected back into the facility. The clinical record lacks evidence that his/her representative was made aware of this incident.</p> <p>On 2/4/25 at 12:35 p.m., during an interview with Resident #1's provider, who was involved in his care since admission on 1/2/25, stated that she was not aware of Resident #1 having a wander guard or that he/she was an elopement risk. She examined Resident #1 on 1/16/25 after their elopement.</p> <p>On 2/5/25 at 8:30 a.m., during an interview with the Administrator, the surveyor confirmed that the resident representative was not aware of the change to his/her discharge plan.</p> <p>On 2/5/25 at 9:00 a.m., during an interview with the Director of Nursing and the Unit Manager, the surveyor confirmed the lack of evidence that that resident representative was made aware of the incident on 1/13/25.</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540</p> <p>Based on record reviews and interviews, the facility failed to supervise and monitor 1 of 1 (Resident #1) wandering resident resulting in the resident eloping from the facility; wandered a mile away from the facility in 14-degree Fahrenheit weather, and being found near the Convenient MD building.</p> <p>Finding:</p> <p>On 2/4/25, a review of Resident #1's clinical record was completed. Resident #1 was admitted on [DATE] with a diagnosis of left frontal parietal subarachnoid hemorrhage with history of Alzheimer's disease. A Wandering Risk Assessment was completed the day of admission and indicated Resident #1 was a risk for wandering, a wander guard was put on Resident #1.</p> <p>On 1/3/25, staff observed Resident #1 exit seeking and wanting to leave, the resident was re-directed without incident.</p> <p>On 1/6/25, staff observed Resident #1 exit seeking and wanting to leave, the resident was re-directed without incident.</p> <p>On 1/8/25, the facility spoke with POA, and recommended Resident #1 be moved to the locked Memory Care unit for 24/7 supervision.</p> <p>On 1/9/25, staff observed Resident #1 exit seeking and wanting to leave, the resident was re-directed without incident.</p> <p>On 1/13/25, staff observed Resident #1 exit through the front door and the resident was re-directed back into the facility without incident.</p> <p>On 1/15/25, in the early morning hours staff observed Resident #1 exit seeking with his/her belongings packed in a clear bag and stated they wanted to leave and go home, the resident was re-directed without incident.</p> <p>On 1/15/25 at approximately 10:30 p.m. Resident #1 eloped and was missing for 2-3 hours.</p> <p>Documentation on the facility's elopement investigation indicated that at 10:30 p.m. Resident #1 was observed in their bed with his/her eyes closed. At 11:30 p.m. the nurse found that Resident #1 was not in his/her room. A search of the facility was done, and Resident #1 was not found. Upon inspection of his/her room it was noted the window in his/her room was open and the window screen was on the ground outside. Local law enforcement and management were called, a search of the local area was completed, and Resident #1 was returned to the facility at approximately 1:15 a.m. -1:30 a.m. The facility reports state that a complete assessment was done and did not identify any new injuries or areas of concern. The facility assigned a 1 on 1 staff to sit with Resident #1 for the remainder of his/her stay at the facility.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/4/25 at 8:13 p.m., during an interview with the Charge Nurse, she stated that on 1/15/25 in the early morning before shift change at 6:00 a.m., Resident #1 was carrying around a bag with his/her clothes and trying to get out the door on the 701 and 708 hallway saying that he/she wanted to go home. She stated that she told the Director of Nursing and the Unit Manager that Resident #1 was trying to get out that morning.</p> <p>On 1/16/25 Resident #1 returned to the facility at approximately 1:15 a.m. by the Police, Resident #1 was found at the beginning of the main road near the Convenient MD building (approximately 1 mile from facility). When Resident #1 returned his/her temperature was documented at 93.2. The on-call provider was called and was made aware that Resident #1 eloped from the facility and was out in the community for about 2-3 hours (exact time unknown, last seen at 10:30 p.m.) in 14-degree Fahrenheit weather. A video conference was held with the on-call provider who gave orders to treat his/her hypothermia and to continue the warming blankets and monitoring their vital signs and to notify the provider of any change in condition.</p> <p>During interviews throughout this investigation the surveyor identified that the facility was aware of Resident #1's attempts to leave the facility, with one occasion being successful on 1/13/25 with Resident #1 exiting the building through the door and attempting to climb a railing. They were aware the morning of 1/15/25 that Resident #1 packed his/her belongings and had stated that he/she wanted to go home. In the late night of the 15th with the last visual of Resident #1 being at 10:30 p.m. Resident #1 did elope out his/her bedroom window and was gone/missing for approximately 2-3 hours on a 14-degree Fahrenheit night and who was not dressed in appropriate winter clothing.</p> <p>On 2/5/24 at 9:10 a.m. during an interview with the Director of Nursing and the Unit Manager the surveyor confirmed that they were aware of Resident #1's increased elopement risk and Resident #1 eloping on 1/15/25.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>32540</p> <p>Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 resident reviewed for elopement. (Residents #1).</p> <p>Finding:</p> <p>During an anonymous interview Resident #1 had the following days of exit seeking behaviors:</p> <p>On the afternoon of 1/3/25, on the morning of 1/6/25, on the morning of 1/9/25 and on the morning of 1/15/25 before shift change Resident #1 packed up his/her belongings and was making the statement that he/she was going home.</p> <p>On 2/4/25 at 8:13 p.m. During an interview with the charge nurse, she described what the resident was doing on 1/15/25 in the early morning. Resident #1 packed their clothing and was carrying around this bag that contained his/her clothing and trying to get out the door on the 701 and 708 hallway saying that he/she wanted to go home, this incident was not documented in the clinical record.</p> <p>On 2/5/25 at 9:00 a.m., during a review of Resident #1's clinical records with the Director of Nursing and a Unit Manager the surveyor confirmed the clinical records lacked evidence that a nurse's note was completed for Resident #1 with each elopement/exit seeking attempt.</p>