

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 04/17/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540</p> <p>Based on clinical record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 2 sampled residents admitted for skilled care services (Resident #2[R2]).</p> <p>Finding:</p> <p>Review of R2's clinical record noted that he/she was initially admitted to the facility on [DATE], discharged on [DATE] and returned on 2/27/25. The clinical record lacked evidence that the base line care plan was developed with instructions needed to provide minimum healthcare information necessary to properly care for R2 until 3/3/25.</p> <p>On 4/17/25 at approximately 10:15 a.m., during an interview with the Assistant Director of Nursing, the surveyor confirmed that that baseline care plan was not developed/initiated until 3/3/25 4 days after admission and not within the 48 hours after admission.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>49635</p> <p>Based on interview, observation, and record review, the facility failed to consistently provide Activities of Daily Living (ADL) care in the area of oral hygiene for 1 of 1 residents reviewed for dental care [Resident #58 (R58)].</p> <p>Finding:</p> <p>On 4/15/25 at 10:15 a.m., during an interview with a surveyor, R58 stated staff do not soak or wash his/her dentures at night. At that time the surveyor observed the denture to be soiled with food debris.</p> <p>On 4/16/25, R58's clinical record was reviewed. The clinical record indicated R58 is cognitively intact. The Care Plan indicates a focus of [R58] has an ADL self-care performance deficit [related to] . hemiplegia affecting left non-dominant side . need for assistance with personal care. The Care Plan intervention for this focus states PERSONAL HYGIENE/ORAL CARE: the resident requires limited to extensive assist. Review of Oral Hygiene documentation indicates oral hygiene was not completed after the evening meal for 13 out of 31 days in March (3/1/25, 3/3/25, 3/5/25, 3/7/25, 3/9/25, 3/10/25, 3/14/25, 3/15/25, 3/16/25, 3/21/25, 3/22/25, 3/28/25, and 3/30/25).</p> <p>On 4/16/25 at 10:55 a.m., during an interview with a surveyor and the Director of Nursing (DON) the Oral Hygiene documentation was reviewed. The DON stated evening shift would document Not Applicable if they did not provide this service and she would not expect evening shift to complete this task if the previous shift had already documented it as completed. At this time the surveyor confirmed that oral hygiene was not provided consistently after the evening meal.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>32540</p> <p>Based on clinical record reviews and interviews, the facility failed to follow physician orders for 2 of 19 residents reviewed. (Resident #64 [R64] and R90).</p> <p>Findings:</p> <p>1. On 4/14/25 at 2:52 p.m. during a clinical record review for R64 there is documentation that shows he/she had an order for Levofloxacin 750 milligrams (mg) by mouth every 48 hours until 4/22/25 with a start date of 4/2/25.</p> <p>Review of the electronic medication administration record (MAR) shows documentation that R64 received a dose of Levofloxacin on 4/2/25 at 6:33 a.m. and he/she received an additional dose on 4/3/25 at 3:18 p.m. which was not 48 hours after the previous dose as ordered.</p> <p>On 4/16/25 at 1:00 p.m. during an interview with LPN1 and LPN 2, they stated the facilities Pyxis does not have that dose of Levofloxacin and thought the medication would come early in the morning the next day 4/3/25. Review of the MAR with LPN1 and LPN2 the surveyor confirmed that R64 received a dose of Levofloxacin two days in a row (4/2 and 4/3) and not every 48 hours as ordered by the Provider.</p> <p>2. On 4/15/25 at 12:49 p.m., during a clinical record review for R90, the Treatment Administration Record for April shows that on 4/12/25, R90 had a Blood Sugar (BS) result of 422, per his/her sliding scale insulin coverage the facility would need to give R90 12 units of insulin and call the Medical Doctor (MD). Clinical record shows that they did call the MD and received an order to give an additional 3 units of insulin and to recheck BS in 2 hours.</p> <p>On 4/16/25 at 12:35 p.m. during an interview with LPN1 and LPN2 the surveyor confirmed there was no evidence in R90's clinical record that his/her BS was not rechecked in 2 hours as ordered.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540</p> <p>Based on clinical record reviews, and interviews, the facility failed to provide physician ordered respiratory services for 1 of 1 resident (Resident [R2]) reviewed with a continuous positive airway pressure (CPAP) machine when the facility failed to obtain missing tubing for R2's machine.</p> <p>Finding:</p> <p>On 4/15/25 during a record review for R2, he/she was admitted with an order to apply CPAP every evening with a start date of 2/21/25. Nursing progress note dated 2/21/25 documents that the CPAP was not used, no tubing with machine. His/her clinical record documents that R2 was hospitalized on [DATE] with a return date of 2/27/25, he/she was hospitalized on [DATE] with a return date of 4/4/25 and was sent to the hospital on 4/6/25 with a return date of 4/10/25. All admission orders had the order to apply CPAP every evening.</p> <p>Documentation in the nursing progress notes and on the electronic treatment administration record (ETAR) shows that R2 was not using the CPAP as ordered due to missing parts. The facility did not assist the resident to obtain the missing parts which resulted in R2 having hospital readmissions. R2's last hospitalization was from 4/6/25 to 4/10/25 and since his/her return, the facility was able to obtain the missing part and R2 has been using it daily since receiving the part.</p> <p>On 4/15/25 at 10:00 a.m. during an interview with the Assistant Director of Nursing (ADON) she stated that when R2 first came to the facility, his/her CPAP was brought in and did not have the tubing, when the facility contacted the previous place of residence, they said R2 didn't have any parts there. The facility contacted the previous medical equipment provider (Lincare), and they said he/she was not allowed to get parts until September, the facility then contacted a local medical equipment provider (Americoast) and was able to get the parts (tubing) on 4/11/25. It was stated that R2 was refusing to use their CPAP or had stated they would not use it. During this interview the surveyor confirmed that if R2 wanted to use their CPAP they were not able to due to the missing part.</p> <p>On 4/15/25 at 10:00 a.m. during the interview with the ADON, the surveyor confirmed that for all admissions R2 was not able to use his/her CPAP as ordered due to missing parts and the facility had failed to obtain the missing part since his/her admission on 2/20/25 resulting in R2 having 4 hospital admissions relating to hypoxia (low oxygen levels). The missing part was ordered and received by 4/11/25 (50 days after initial admission)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32540</p> <p>Based on observations and interviews, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 3 kitchen equipment that require a 1 air gap on 4 of 4 days of survey.</p> <p>Finding:</p> <p>On 4/14/25, at 12:05 p.m. during the initial kitchen tour, a surveyor observed there was an improper air gap provided on the drain lines of the ice machines, one located in the hallway leading to the kitchen and one located in the kitchen. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm).</p> <p>On 4/14/25, at 12:05 p.m., a surveyor confirmed this finding with the Food Service Director (FSD).</p> <p>On 4/15/25 during a second visit to the kitchen, to observe meal preparation a surveyor observed the ice machines continued to have an improper air gap on the drain lines.</p> <p>On 4/16/25, during a third visit to the kitchen to observe a meal service, a surveyor observed the ice machines continued to have an improper air gap on the drain lines.</p> <p>On 4/17/25, during a final kitchen tour a surveyor observed the ice machines continued to have an improper air gap on the drain lines and the vegetable sink had the proper 1 air gap.</p> <p>On 4/17/25 at 10:00 a.m., during an interview with the FSD, a surveyor confirmed the improper air gaps remained on the ice machines.</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</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 a clinical record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 19 sampled residents (Resident #2 [R2], and [R1]).</p> <p>Findings:</p> <p>1. On 4/15/25 at 10:00 a.m., during a clinical record review for R2 there was an order dated 2/21/25 which instructed nursing to apply continuous positive airway pressure (CPAP) daily at bedtime.</p> <p>Review of the Treatment administration record (TAR) for March 2025 has documentation of the CPAP being applied on 3/3, 3/4, 3/5, 3/13, 3/18 and 3/19/25. Documentation in R2's clinical record indicates that the CPAP had missing parts and was not able to be used.</p> <p>On 4/15/25 at 10:00 a.m., during an interview and clinical record review with the Assistant Director of Nursing (ADON), she stated that when R2 first came to the facility, his/her CPAP was brought in and did not have the tubing (had missing part). The surveyor confirmed that documentation on the TAR was inaccurate when it was signed off as the CPAP being applied on the above dates when the missing part was not received until 4/11/25.</p> <p>49635</p> <p>2. On 4/16/25, R1's clinical record was reviewed. Review of the Medication Administration Record (MAR) indicated that R1 was prescribed Benzotropine Mesylate (used to treat Parkinson's disease and side effects of other drugs) for Parkinson, and Ziprasidone (used to treat schizophrenia and bipolar disorder) for psychosis. Review of the active diagnosis list for R1 did not include a diagnosis of Parkinson's disease or Psychosis. Review of the provider notes indicated Benzotropine Mesylate was prescribed to treat drug induced tremor, and Ziprasidone was prescribed for a diagnosis of bipolar disorder.</p> <p>On 4/16/25 at 2:45 p.m., during an interview with a surveyor and the Director of Nursing (DON), R1's clinical record was reviewed. The DON stated R1 does not have a diagnosis of Parkinson's or Psychosis. At this time a surveyor confirmed the MAR contained inaccurate information related to the diagnosed indication for the medications Benzotropine Mesylate and Ziprasidone.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635</p> <p>Based on observations and interviews, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections for 3 of 4 days of survey (4/14/25, 4/15/25, and 4/16/25).</p> <p>Findings:</p> <p>On 4/14/25, a surveyor observed the following:</p> <ul style="list-style-type: none"> -In the shared bathroom for Rooms 302A and 302B, a commode seat in use as an elevated toilet seat was observed over the toilet bowl. Dried blood was observed on the right side of the seat, and stool was observed smeared on the front of the commode seat. Dried blood droplets were observed on the floor in a trail leading toward the bathroom sink. A bed pan was observed unlabeled and exposed to the environment, resting against handrail and the bathroom wall. -In the shared bathroom for Rooms 303A and 303B, a large bed pan was observed to be soiled with stool, unlabeled, and exposed to the environment. -In room [ROOM NUMBER]B, a soiled linen bed chuck was observed on the floor. -In the bathroom of room [ROOM NUMBER], a surveyor observed a hole in the floor of the shower creating an uncleanable surface. -In room [ROOM NUMBER]A, a soiled linen bed chuck was observed on the floor. -In room [ROOM NUMBER] blood was observed on the bed frame of Resident #63 (R63) <p>On 4/14/25 at 11:43 a.m., during an interview with a surveyor and a Registered Nurse (RN2), the following were observed and confirmed:</p> <ul style="list-style-type: none"> -In the shared bathroom for Rooms 302A and 302B, a commode seat in use as an elevated toilet seat was observed over the toilet bowl. Dried blood was observed on the right side of the seat, and stool was observed smeared on the front of the commode seat. Dried blood droplets were observed on the floor in a trail leading toward the bathroom sink. A bed pan was observed unlabeled and exposed to the environment, resting against handrail and the bathroom wall. -In the shared bathroom for Rooms 303A and 303B, a large bed pan was observed to be soiled with stool, unlabeled, and exposed to the environment. <p>RN2 stated bed pans should be in a bag until they are used, they should be labeled to identify who they belong to; after a bed pan is used it should be sanitized, then bagged for future use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/14/25 at 1:00 p.m., during an interview with a surveyor and a Certified Nursing Assistant (CNA), the blood on R41's bed frame was observed and confirmed, the CNA was unable to identify where the blood came from.</p> <p>On 4/15/25 at 7:05 a.m., a surveyor observed residual blood dried on R63's bed frame.</p> <p>On 4/15/25 at 7:22 a.m., a surveyor observed CNA2 assist Resident #60 (R60) with using a bed pan. After CNA2 assisted R60 with peri care, CNA2 returned R60's toiletries to drawers while still wearing soiled gloves. CNA2 then began handling R60's clean clothing while still wearing soiled gloves, at this time the surveyor intervened and confirmed that CNA2 did not remove the soiled gloves or perform hand hygiene before contacting drawers and the resident's clean clothes.</p> <p>On 4/15/25 11:19 a.m., a surveyor observed opened dressing wrappers on Resident #41 (R41) blankets. At 11:27 a.m., this observation was confirmed with RN2.</p> <p>On 4/15/25 at 11:44 a.m., a surveyor observed Resident #47 (R47) in the hall, self-propelling in a wheelchair. R47's foley bag was observed dragging on the floor under the wheel chair. A surveyor observed and confirmed this finding with CNA-M.</p> <p>On 4/16/25 at 11:03 a.m., in an interview with the Director of Nursing (DON), a surveyor reviewed and confirmed the above findings. During the interview the surveyor and the DON observed and confirmed the following:</p> <ul style="list-style-type: none"> -In the bathroom of room [ROOM NUMBER], the floor of the shower has a hole creating an uncleanable surface. -The commode seat used as a raised toilet seat in the shared bathroom, for Rooms 302A and 302B, was observed to have blood on the left side of the seat. This was confirmed at the time of the observation. -The bed frame in room [ROOM NUMBER]A was observed and confirmed to have residual blood on it (consistent with the original observation on 4/14/25). 		