STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205137	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgewood Manor	200 Route 115 Windham, ME 04062

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. 44049 Based on record review and interviews, the facility failed to ensure that an alleged violation of resident sexual abuse was reported to the State Agency within 24 hours when an incident occurred for 1 of 6 residents reviewed for neglect/abuse (#1). Findings: A review of the facility's Resident Rights Policy Revised on 9/06, on page 2, #4. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator. Or his/her designee, will notify the following persons or agencies of such incident. A. The State Licensing/certification agency responsible for surveying/licensing the facility; and on page 7, Reporting Abuse to State Agencies and Other Entities/Individuals Policy, revised on 9/13/06, page 7, under #1. A. Should an alleged/suspected violation or substantiated incident of neglect, injury of unknown source, or abuse (including resident to resident abuse) be reported, the facility administrator, or his/her designee, will promptly notify the following person or agencies (verbally and written) of such incident: a. The State Licensing/certification agency responsible for surveying/licensing the facility. On 8/9/24 at 9:07 a.m., the State Agency received a report stating that Resident #1 was currently in Maine Medical Center (MMC) for a Urinary Tract Infection (UTI) and [he/she] reported to a staff member that [he/she] resides at Ledgewood Manor and there is a staff member there that is making [him/her] feel uncomfortable when that staff member made a comment about [his/her] genitalia being pretty. Resident #1 could not remember the Certified Nursing Assistant's (CNA) name, but it is a male from a different country. On 8/14/24, (no time given in the report), A member of the APS staff contacted the Director of Nursing (DON) and informed her of the alleged incident. On 8/14/24, (no time given in the report), the DON went to interview Resident #1 and the resident initially denied the incident. [He/She] then stated that the incident did happen. Resident #1 stated that he [the CNA] says that to a lot of [residents], and he/she did not want to get anyone into trouble and stated that he/she has a brain fog and can't remember the person or what he said. (continued on next page)

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	On 8/16/24, (no time given in the report), the DON interviewed the CNA. He denied being inappropriate and asked what the resident reported that he said. When he was told, he stated that he would never use language like that in any aspect of his life but that he would fully cooperate with the investigation. He stated that he prides himself in being a professional care giver and that this is very upsetting. On 10/8/24, at 11:48a.m. in an interview with the DON, a surveyor asked her what the outcome of the incident was, and she stated that she was convinced that the CNA did not make that remark to the resident, but he was assigned away from [Resident #1s] room and did not make any contact with [Resident #1] after that. She also stated that there was no discipline of the CNA and that he left the facility shortly after the incident to work elsewhere. When asked why she did not report the incident to the State Agency, she said that when the staff member from APS called her, she asked if she needed to report the incident and she was told that she did not because they already knew and they would report it to the SA. On 10/8/24, at approximately 12:00 p.m. this surveyor informed the DON that that information from APS was incorrect and that she should have reported the incident directly to State Agency as the regulations require and as stated in the facility's policy.