STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205166	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gorham House	50 New Portland Rd Gorham, ME 04038

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy, the facility failed to maintain adequate housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior on 3 of 3 units (Windsor I, Windsor II and Cottage). In addition, the facility failed to ensure a resident's personal belongings are kept safe and secure for 1 of 1 resident reviewed for personal property. (Resident #4) 1.On 2/11/26 at 8:25a.m. surveyor observed the Kitchen for unit Windsor 2, a surveyor observed that the floor was excessively dirty and with a build-up of debris in the corners. It was observed that all of the flat services were covered with a heavy layer of dust. Housekeeper #1, stated that she was here and cleaned this unit yesterday. 2. On 2/22/26 at 8:40a.m. - A surveyor called the Housekeeping Supervisor and he observed and confirmed the condition of the unit kitchen, the dust behind the hallway hand rail, the stain on the front of the Nurses station, the top of the cabinet that holds the floor plan, the top of two different wall hand sanitizer dispensers all covered in enough dust to form a ball and fall to the floor when touched. 3. On 2/9/26 at 10:32 the following was observed on Windsor II unit: room [ROOM NUMBER]- the floor was littered with food debris and wrappers. Above bed A was a stained ceiling tile. Behind the headboard of B bed, the rail was cracked. The heater had peeling paint, the window sill had a large chunk of wood splintered off exposing raw wood, the mirror was missing above the sink and the wall was gouged, the closet threshold had linoleum peeled and rolled up. room [ROOM NUMBER] - next to the bed, the wall had a large gouged area with exposed sheetrock. 4. On 2/9/26 at 9:37 a.m., during an interview, Resident #4 and spouse stated the residents eye glasses have been missing for several weeks and I don't know if they are still looking for them. We are waiting. Review of Resident #4's complete medical record lacked evidence of a personal belongings inventory sheet. A licensed Social Worker note dated 1/29/26 stated, SW [Social Worker] checked with dietary re: [Resident #4's] missing eyeglasses in a rose-colored hard case. Dietary does not have [his/her] eyeglasses. On 2/11/26 at 11:11 a.m., during an interview, Certified Nurses Aid (CNA)#1 stated if a resident was missing a personal item, she would check lost and found and look at the residents personal (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	belongings form to make sure they had the item when they came in. When asked about Resident #4's glasses she stated, I know [he/she] did ask about glasses, [spouse] was aware and nothing came about it. She then looked in Resident #4's medical record and could not locate a personal belongings inventory sheet. At this time, CNA #2 entered the office. CNA #1 asked CNA #2 if they are using inventory sheets and where they are located. CNA #2 stated that inventory sheets are not being used and then opened the file cabinet and removed a blank inventory sheet. She then stated looked into Resident #59's chart and stated [he/she] doesn't have one either and [he/she's] been here for a long time. The surveyor asked CNA #2 about Resident #4's glasses, the CNA stated, That was over a week ago. [Spouse] was gonna order a new pair, I did suggest [he/she] speak to administration. On 2/11/26 at 11:20 a.m., during an interview, the Licensed Social Worker stated she filled out a Missing item/Clothing Form dated 1/24/26 and gave it to maintenance / laundry staff. I don't know if we are responsible for reimbursement, they disappeared. On 2/11/26 at 11:26 a.m., during an interview, the Director of Nursing stated a resident's personal items, upon admission they are to be inventoried. Typically, by the CNA. Fill out inventory, they sign it and it goes in the chart. At this time, the admission Director of 8 years stated, I have not seen it on the Skilled/Long Term Care side and It's not in the admission packet. The facilities Skilled - Resident Personal Belongings Policy last revised on 10/18/25 states, All residents possessions, regardless of their apparent value to others, will be treated with respect. The facility will support the residents right to retain and use personal possessions to promote a homelike environment and maintain their independence. All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record and The facility will exercise reasonable care for the protection of the residents property from loss or theft. 5. On 2/9/26 from 9:50 a.m. to 9:59 a.m., a tour of the cottage's unit revealed: -4 broken floor tiles in room [ROOM NUMBER]. -Marred and chipped paint exposing sheetrock in room [ROOM NUMBER], along the wall of bed 1. -Chipped paint and marred walls exposing sheetrock in the hallway by the kitchenette. -Chipped paint along the door frame to the entrance of room [ROOM NUMBER] -Whirlpool room vent above shower is coated with dust and debris. On 2/9/26 at 10:35 a.m., observations of the above information took place with the Maintenance Director. On 2/11/26 at 11:55 a.m., the above was discussed with Regional Director of Operations.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and interviews, the facility failed to follow a Physician order for 1 of 5 sampled resident reviewed for unnecessary medications (#2), failed to ensure the prescribed medication included a specific, diagnosed, and documented condition with symptoms which may be causing distress to the resident (#67), and failed to monitor side effects of psychotropic medications for 1 of 2 residents reviewed for psychotropic medications (Resident #8 and #42). 1. Resident #2's medical record contained a provider's order dated 6/27/25 for Trazodone HCl 50 mg (milligram). Give 0.5 tablet by mouth at bedtime for insomnia. AND Give 0.5 tablet by mouth every 12 hours as needed for anxiety 0.5 tab = 25mg x 90 days. Review of the medication administration record from October 2025 through February 2026 indicated the as needed Trazadone was still available for administration. On 2/10/26 at 1:31 p.m., during an interview, the above order was reviewed with the Regional Director of Operations and the Director of Nursing (DON) who both confirmed the order for the PRN trazadone was for 90 days and should have ended on September 25, 2025. Further review of the order showed it was transcribed with the end date as indefinite. 2. Resident #67's medical record contained a diagnosis that included Alzheimer's Disease and Depression. Physician orders revealed that on 10/10/25, the following medications were prescribed: Seroquel (an antipsychotic) 25 mg. (milligrams) give one-half tablet in the evening related to Cognitive Communication Deficit, and Trazodone (an antidepressant) 50 mg., give one table in the evening related to Cognitive Communication Deficit. On 2/11/26 at 1:00 p.m., in a discussion with a surveyor, the DON confirmed the diagnosis of Cognitive Communication Deficit was not an appropriate diagnosis for the use of these medications. 3. Resident #8's medical record contained active provider's orders for Remeron 15 mg tablet to be administered at bedtime for depression, Chlorpromazine HCL 200 mg tablet to be administered 4 times a day as needed for anxiety, Ativan 1 mg tablet to be administered 2 times daily as needed for anxiety, Trifluoperazine 1 mg tablet with instructions to give 8 tablets to equal 8 mg for schizoaffective disorder, Duloxetine 30 mg capsules with instructions to give 3 capsules to equal 90 mg daily for depression, clozapine 50 mg tablet with instructions to give 7 tablets by mouth to equal 350 mg in the afternoon for anxiety, Ativan 2 mg tablet to be administered 3 times a day for anxiety, and Buspirone 30 mg tablet to be administered 2 times a day for anxiety. Resident #8's care plan states PSYCHOTROPIC MEDICATION – RISK FOR COMPLICATIONS: r/t Antipsychotics, Antianxiety, Antidepressants for dx of Bipolar Disorder, Anxiety, Depression, Schizoaffective Disorder Goal: [Resident #8] will remain free of psychotropic drug related complications through review date. Interventions: Monitor/report PRN any increased adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Resident #8's Medication Administration Record MAR and Treatment Administration Record TAR dated February 2026 lacked evidence he/she was being monitored for side effects of the medications listed above. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/10/26 at 1:33 p.m., in an interview with Registered Nurse (RN) #1, she states they do not have a place in the MAR or TAR to monitor side effects of psychotropic medications. On 2/10/26 at 1:48 p.m., the DON confirmed there is no order to monitor for side effects of psychotropic medications, stating there should be. 4. Review of Resident #42's active orders revealed orders for Fluoxetine 10 mg tablet to be administered one time a day for schizoaffective disorder, Olanzapine 20 mg tablet to be administered in the evening for schizoaffective disorder, and Sertraline 50 mg tablet with instructions to give 3 tablets one time a day for depression/neurocognitive disorder. Resident #42 care plan states The resident uses psychotropic medications r/t dx Schizoaffective disorder, Anxiety, Insomnia, depression, PTSD with use of ANTI-PSYCHOTIC, ANTIDEPRESSANT. Goal: The resident will be/remain free of psychotropic drug related complications through review date. Interventions: Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Resident #42's Medication Administration Record MAR and Treatment Administration Record TAR dated February 2026 lacked evidence he/she was being monitored for side effects of the medications listed above. On 2/10/26 at 1:33 p.m., during an interview, Registered Nurse (RN) #1, stated they do not have a place in the MAR or TAR to monitor side effects of psychotropic medications. On 2/10/26 at 1:48 p.m., the DON confirmed there is no order to monitor for side effects of psychotropic medications, stating there should be. The facility's Policy and Procedure for the Use of Psychotropic Medication(s), last revised 9/9/25, stated, Policy Explanation and Compliance Guidelines: 2. Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that the resident's environment was free of accident hazards relating to unsafe flooring in resident areas, a broken electrical outlet, and a broken floor heater for 1 of 3 units (Cottage Unit). Findings:On 2/9/26 from 10:14 a.m. to 10:27 a.m., a surveyor observed the following findings in the Cottages Unit:- The flooring was ripped up and curled up in room's 5 and 9.- The flooring in room's 2 and 6 were lifting/bowed.- The flooring in room [ROOM NUMBER]'s bathroom had a hole in front of the toilet, exposing the sub flooring. Around the hole, when stepped on, the flooring sank in. - There was a chipped and loose tile in the Whirlpool room shower.- Resident room [ROOM NUMBER]'s heater was missing the cover exposing piping and sharp metal fins.- The staff breakroom, which is unlocked and the door is kept open, had a broken electrical outlet.On 2/9/25 at 10:28 a.m., in an interview with Registered Nurse (RN) #1 stated she has put multiple work orders in to get the flooring in resident's rooms and the tile in the whirlpool room fixed along with sending emails to the Maintenance Director, but nothing has been fixed. She states this has been going on for a while and when asked when these concerns will be fixed, she has been informed that they are fixing things in phases and these concerns are not apart of phase one.Review of the facilities maintenance work order sheets for the past 6 months along with emails sent to the Maintenance Director shows the following:-On 8/8/25 a work order was requested for the whirlpool room flooring coming up. Notes indicated that the flooring company was notified, but no follow-up or follow through was completed. Furthermore, a follow up email was sent to the Maintenance Director stating Multiple parts of the Cottage are in poor condition. Specifically, the shower room floor. I have put work orders in.-On 11/14/25 2 work orders were requested for floor peeling in cottage apartments and for room [ROOM NUMBER]. Furthermore, a follow up email was sent to the Maintenance Director stating Radiators are exposed due to covers falling off.Flooring peeling in rooms-On 12/7/25 a work order for was requested for Floor peeling up in cottage apartments with a note stating, Floor ripped up near recliner chair, posing a tripping hazard.-On 1/6/26 a work order was requested for floor peeling in rooms #5 and #9.-On 1/14/26 a work order was requested for maintenance to repair floors in room [ROOM NUMBER] and 5.On 2/9/26 at 11:35 a.m., a tour of the cottages took place with the Maintenance Director and the Regional Director of Operations, at this time the above information was observed. When asked questions regarding why the maintenance requests were not being addressed, as the flooring poses serious tripping hazards, the Maintenance Director states it is not apart of phase one. Stating these concerns are in phase two. He then states they have fixed one of the floors, but the floor appears to have become unsafe again. He confirms no audits were being made to monitor and ensure that the floor was safe for residents. He then states a flooring contractor is coming sometime in March to look at the flooring and fix it. At this time, the Maintenance Director confirms that the flooring is an accident hazard and poses a risk of falling/tripping. He then states it should have been fixed sooner, and they will fix it all now.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to follow up on Consultant Pharmacist recommendations timely, and failed to ensure that the Consultant Pharmacist reported on identified ongoing irregularities for 2 of 5 residents reviewed for unnecessary medications (Resident #1 and #2).Findings: 1. On 2/10/26 a review of Resident #1's clinical record was completed. Documentation in the physician orders indicated the resident had a current order for Mirtazapine 15mg (milligrams). Give 1 tablet by mouth at bedtime for depression/anxiety.A review of the Pharmacy Drug Regimen Review dated 12/18/25 indicated a pharmacist recommendation to: This resident has been on Sertraline 100mg qd (daily) and Mirtazapine 15mg qhs (at hour of sleep) and due for annual evaluation. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective or optimal dose. Attempt dose reduction to Mirtazapine 7.5mg qhs as tolerated.As of 2/11/26 the clinical record lacked evidence that the Pharmacist recommendations have been reviewed or responded by the Medical Provider.Further review of the monthly Pharmacy Drug Regimen Review dated 1/21/26 stated the resident's medication regiment contained no new irregularities, although the initial recommendation on 12/18/25 had not been responded to. 2. On 2/10/26 a review of Resident #2's clinical record was completed. Documentation in the physician orders indicated the resident had a current order for Seroquel 25mg. Give 25mg by mouth two times a day for delusions AND Give 75mg by mouth in the evening for Hallucinations and delusions.A review of the Pharmacy Drug Regimen Review dated 10/24/25 indicated a pharmacist recommendation to: This resident has been on Seroquel 25mg BID (twice daily) and 75mg qhs and due for annual evaluation. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective or optimal dose.Attempt dose reduction to: Seroquel 25mg BID and 50mg qhs.As of 2/11/26 the clinical record lacked evidence that the Pharmacist recommendations have been reviewed or responded by the Medical Provider.Further reviews of the monthly Pharmacy Drug Regimen Reviews dated 11/24/25, 12/18/25 and 1/21/26 all stated the resident's medication regiment contained no new irregularities, although the initial recommendation on 10/24/25 had not been responded to. On 2/11/26 at 9:40 a.m., during an interview, the Regional Director of Operations confirmed there was no medical provider follow up to the pharmacy recommendations for both Resident #1 and Resident #2 and the consultant pharmacy should have noted this failure in the future reviews that occurred.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the terms and conditions of a binding arbitration agreement were clearly communicated to the residents or their representatives and not required as a condition of admission due to the agreement being a part of the admission paperwork for 3 of 3 residents reviewed for Arbitration. (Residents 63, 77, 56, and 76) 1- On 2/9/26 at 9:30a.m., during the Entrance Conference, the Acting Administrator and when asked, she stated that there were no residents with a Binding Arbitration Agreement with the facility. 2- On 2/10/26 at 8:30a.m., during a review of the admission Packet, a surveyor discovered a form for Binding Arbitration in the admission Packet. A review of the Electronic Medical Record (EMR) for selected residents, it was discovered that three residents had electronically signed the Binding arbitration agreement. (Residents 77, 56, and 76.) 3- On 2/10/26 at 8:45a.m., during an Interview with the Acting Administrator, when this was called to her attention she stated, that she had no idea that it was part of the admission Packet. She stated that she would make a call to the cooperate office to see what can be done to separate this paper from the packet. She stated that she would review all the admission agreements and report to the team her findings. 4- On 2/10/26 at 9:38a.m., during an interview with the Licensed Social Worker (LSW) and four surveyors, the LSW stated that she was new in her role and had had very little orientation. She stated upon admission she has a meeting with the resident or Person of Authority (POA) and goes through the admission packet. She stated that she goes through the document and fills in all of the needed information prior to the meeting so the resident does not sign a blank document. She places her computer so that the person can read along with her. She goes through each section and explains it and then she clicks on the box to electronically sign the document for the resident. Sometimes family members are out of state, so if they're the responsible person, we could send it electronically. Then I'll let them know to reach out if they have any questions about any part of the packet and then if I'm completing it with them. She was asked by a surveyor to go over the in-person part. She stated, I usually go to their room and introduce myself. If the residents are responsible party, I explained that we have an admission packet, which is essentially the contract for when they're here. That it's a standard thing that everybody usually signs, and then I just take it section by section because typically it's supposed to be completed within the 1st 24 hours of their admission, so. It's quite the packet, so I do my best to try not to overwhelm them. I go through each section and give them a two or three sentence explanation. I'll sit next to them so they can see the screen and explain that I'm just electronically clicking. I have had a couple of folks complete it via paper, having to print it out. A Surveyor handed the LSW the signature page for the arbitration agreement and asked what she does when she gets to this section. She stated, I explained to them that if they want to sign this section, they agree to us providing a lawyer and mediation and essentially settling things out of court. And it's a lifelong agreement between them and [NAME] House and Senior Lifestyle. A surveyor asked, when you say that it's electronic and you're going through and you're clicking their signature, do they initially sign the electronic part of it and then when you click, it fills in their electronic signature? She stated Yes. A surveyor asked, So, who's clicking? She stated that, I usually do the clicking next to them, so, it takes the signature and it plops it into the specified areas that it needs it in. A surveyor asked, Is arbitration part of that? She stated, It's part of the admission packet. so that signature be clicked into that section by a click of a button. A surveyor asked, Do you understand that in arbitration, they have 30 days to revoke it? She stated, Yeah, OK. They have 30 days to sign it and I tell them that. A surveyor asked, How can they revoke it if they decide within that 30 days that they want to, what do they have to do? She stated, that she was unsure of the exact process for them to revoke the agreement. A surveyor stated, With an arbitration, they have 30 days to revoke it, and the only way they can do that is by writing. They need (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to write a letter saying that they revoke it. And if you don't tell them that, then they don't know. So that's part of the arbitration agreement. But if this isn't being explained to them it's just a click of a button. They may be signing up for something that they are not aware of, right, and don't have the needed information to make an informed decision and that's what we're getting at. She stated, Yeah, I was not aware of that. A surveyor asked her to speak to the electronic contract. and how a POA, living away, would do it? She stated, I would get an e-mail address and send the Packet to them. The packet says how it's going to be completed. They need to click to sign in person or remote. So, I would select remote and that person, the system automatically generates the packet and emails it to them and then once it's completed, I receive an e-mail then it's been completed and how do they please also OK, they would just click on the e-mail. She stated, I've actually never seen what they see when it's been generated, but they go through so it's electronic when they when they signed. A surveyor asked, if they couldn't sign the very first thing, and then when hit next or and it goes to the next place to sign. She stated, Yes, it is unknown if they reviewed that and if it is read at all. They just scroll down to read it before they click to sign. She was asked, so you're assuming that they read it. She stated, I mean, I would think any adult knows to. Maybe it's an assumption. Yeah, I'm assuming that they read it. I usually do touch base with them ahead of time and I let them know to reach out if they have questions. A surveyor asked, how do you know that they understand what they are signing, and understand how permanent it is? She stated that she does not know that. A surveyor asked, if this person's been here a week, they get sent back to the hospital, they're admitted to the hospital, they spend 2 weeks at the hospital, and then they come back and they sign a new contract, are they signing a new arbitration? She stated, it's a readmit contract, so it's different. It basically saying that explains that they were out of the hospital and all their back doesn't have any arbitration agreement in the readmission. It's kind of like if it's restating their contract. The readmit contract just references the original contract indicating that they would have already completed the original one OK so they're not resigning all this no it's too it's like 2 pages very brief. 5- On 2/10/26 at 10:57, in an interview with the Administrator and the LSW, A surveyor asked, does the electronic admission Packet allow the signer to skip a section and still progress through the document. The LSW stated the she thinks you can. The Administrator stated that when they come to that page there is a Do box, stating that they want to enter into a Binding Arbitration and a DO NOT box, stating that they want to opt out of the agreement. If they click on the DO Not box, then the document will proceed to the next section. If they click on the DO box then it will electronically sign it and move to the next section. Both the Administrator and the LSW confirmed the surveyors concerns.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of the facility's incident report, record review, interview, and internal investigation, the facility failed to ensure staff spoke to residents in a dignified manner for 1 of 29 residents reviewed in the initial pool sample for abuse (R10).Findings: On 1/30/26, the facility reported an incident to the Division of Licensing and Certification, which stated on 1/30/26, staff had observed a Licensed Practical Nurse (LPN) speak in a verbally inappropriate manner with a resident. On 2/10/26, a review of the facility's internal investigation revealed that on 1/30/26, two staff members entered R10's unit and observed R10 exhibiting agitation and behaviors that are typical for R10. The unit nurse was observed speaking to the resident in a loud voice and was overheard stating ?I don't want to talk to you. Nobody wants to talk to you. I don't want to talk to you (R10), Nobody wants to talk to you. Shut up. Nobody is talking to you, nobody is listening to you.' The resident and nurse were separated and staff removed the resident from the unit to distract and check in with him/her. The nurse was removed from the unit and suspended pending an investigation. The resident later returned to the unit without incident and was unable to recall the incident. A review of R10's clinical record revealed diagnoses including Dementia with behavioral problem, Anxiety disorder, and Depression. A review of the Minimum Data Set (MDS) 3.0 Quarterly Assessment, dated 11/4/25, Section C - Cognitive Patterns, noted R10 had a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment. R10 required partial to moderate assistance of staff for activities of daily living. R10 resided on the facility's secure dementia unit. R10's care plan identified a behavioral problem related to dementia. Interventions included Anticipate and meet the residents needs, i.e., hunger, thirst, boredom, bathroom needs. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Nursing and physician progress notes revealed behaviors including mood lability, irritability, and agitation. R10 could be difficult to calm or redirect when highly agitated. On 2/2/10/26 at 1:50 p.m., in an interview with a surveyor, the Director of Nursing (DON), stated It was a Friday afternoon, about 4 pm, when two staff came down and reported they witnessed an incident on the unit. The acting administrator spoke with them and then spoke with me, and instructed a report be submitted, and the employee would need to be suspended pending an investigation. The (LPN) was interviewed and stated R10 was very behavioral, yelling out, threw coffee at another resident, hitting, kicking, intrusive behaviors, and disruptive, such as closing the laptop on the medication cart during med pass. The LPN reported observing the resident throw coffee at another resident and made the statement to the resident, ?Nobody is talking to you and nobody wants to hear what you have to say.' The LPN denied saying ?shut up' to the resident. A total of 4 staff observed the incident, and 3 of the staff reported hearing the LPN's statements directed to R10. After the incident, R10 was reported to have had a normal evening and had no recollection of the incident. The DON confirmed the facility's investigation resulted in the LPN's termination of employment on 2/6/26.

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	205166	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gorham House	50 New Portland Rd Gorham, ME 04038

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to inform a Resident Representative (RR), in advance, of treatment risks and benefits, options, and alternatives related to use of psychotropic medications for 1 of 5 sampled residents reviewed for psychoactive medication use (R67). Finding: On 2/11/26, a review of the clinical record for R67 revealed that on 10/10/25, orders for new medications, Seroquel (an antipsychotic), and Trazodone (an antidepressant), were to be started in the evening. The medical record lacked evidence that consent was given for treatment with these new medications by the RR and that the RR was informed of the risks and the benefits of treatment with these psychoactive medications, or alternative options. On 2/11/26 at 1:00 p.m., in an interview with a surveyor, the Director of Nursing confirmed the finding.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to issue a written transfer/discharge notice, which included information regarding appeal rights and the name and address of the Office of the State Long-Term Care Ombudsman, and a written bed-hold notice which specifies the duration of the bed-hold for to residents or their representative for 2 of 4 sampled residents transferred/discharged by the facility to an acute care hospital (Resident #67 and #69.)1. Documentation in Resident #67's clinical record indicated that the resident was transferred to the acute care hospital on [DATE]. There was no evidence in the clinical record indicating that Resident #67 or the Resident's Representative was provided with written transfer/discharge notice, which included information regarding appeal rights, the name and address of the Office of the State Long-Term Care Ombudsman or a written bed-hold notice that specified the duration of the bed-hold. On 2/11/26 at 1:00 p.m., during an interview the above was confirmed with the Director of Nursing. 2. Documentation in Resident #69's clinical record indicated that the resident was transferred to the acute care hospital on [DATE]. There was no evidence in the clinical record indicating that Resident #69 or the Resident's Representative was provided with written transfer/discharge notice, which included information regarding appeal rights, the name and address of the Office of the State Long-Term Care Ombudsman or a written bed-hold notice that specified the duration of the bed-hold. On 2/11/26 at 3:43 p.m., during an interview the above was confirmed with the Administrator.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to review, revise and update a care plan in the areas of wound care, psychotropic drug use, and dementia care to reflect the current needs for 1 of 22 sampled residents (R67).Findings:Clinical record review for R67 revealed diagnoses that included Alzheimer's Disease, Depression, Type 2 Diabetes Mellitus, left foot ulcer with 4th and 5th toe amputations, and peripheral arterial disease. 1. On 12/16/25, orders from the wound clinic stated Today we applied Grafix #2 (a bioengineered skin substitute) to the left foot wound then a negative pressure wound dressing called PICO, which should remain in place until Monday, 12/22/25. Caution: The PICO dressing should stay intact the entire time. Please assure that PICO tubing is held against the body INSIDE of tubular compression and INSIDE of pant leg then the PICO battery clipped to the waist band to avoid potential fall hazard. Please assist the patient with all clothing changes and bathroom trips. Do NOT get the dressing wet.It is possible for the PICO dressing to lose a seal, please use the troubleshooting guide provided to get PICO restarted. If seal is lost and does not respond to trouble shooting or if dressing is felt to represent too much of a fall risk for patient, it is okay to remove and dressing with hydrofera blue transfer foam and mepilex border. On Monday 12/22/25, the Grafix and PICO will be one week old and the PICO will no longer function. Please take down the entire dressing on 12/22/25 and cleanse the wound bed thoroughly with vashe or normal saline. Return to previous dressing, Hydrofera Blue Ready Transfer Foam and ABD pad and rolled gauze to secure at this time. Change every other day from 12/22/25 until patient returns to the wound clinic on 12/29/25. On 1/8/26, R67 was treated in the wound clinic. Orders for wound care of the left foot stated Cleanse with vashe to thoroughly cleanse wound bed and skin surrounding. Dressings: Prisma and Hydrofera Blue, change dressing every other day. Protect surrounding skin with Sensicare 3 or other skin barrier.A review of R67's care plan noted a focus area, initiated on 11/3/25, which stated Has wound vac related to left foot wound. Interventions stated, Follow instructions as provided by the wound center. Monitor wound vac for proper functioning. Patient to attend follow-up appointments at wound center as indicated.2. A review of R67's physician orders revealed that on 10/10/25, new psychotropic medications were ordered. These included Seroquel (an antipsychotic) and Trazodone (an antidepressant), both to be started in the evening. A review of R67's care plan did not include a revision for the addition of psychotropic medications. 3. R67's care plan included a focus area, with a revision dated 7/14/25, for Impaired cognitive function/dementia or impaired thought processes related to Alzheimer's disease. Interventions stated break tasks into one step at a time to support short term memory deficits. Ask yes/no questions in order to determine the resident's needs. Engage the resident in simple, structured activities that avoid overly demanding tasks. Speech therapy for evaluation and treatment as ordered.On 2/11/26 at 1:00 p.m., in an interview with a surveyor, the Director of Nursing confirmed that R67's care plan had not been revised to reflect the resident's current needs as evidenced by special wound care instructions had not been included in the care plan, and at this time, R67 no longer had a wound vac in use. The care plan was not revised to include the addition of psychotropic medications requiring monitoring for side effects and efficacy. The care plan was not revised to include R67's specific preferences for activities and interventions to address mood and behaviors associated with dementia.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interviews and record review, the facility failed to make a Good Faith effort to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life, as evidenced by the failure to follow-up on the multiple emails reporting the unsafe conditions of The Cottage unit. Findings:On 2/9/26 at 11:00a.m. - Significant Concerns about the environment at The Cottage brought by Surveyor and two other surveyors observed the environment and found multiple safety concerns. On 2/10/26 at approximately 1:30p.m. this surveyor reviewed the QAPI documentation to find: QAPI Meeting attendance for the past year with all required members were in attendanceQAPI agenda that did not present environmental concerns reported from The Cottage.QAPI Program/PlanOn 2/11/26 at 1:45p.m. in an interview with the Administrator and the Regional Director of Operations, they stated that the concerns that were identified as a need for repairs in the Cottage were slated to be done as a Part of Phase 2 in the facility renovations. When asked what phase 1 consisted of they stated it was an upgrade in the Foyer and expending the Memory care Unit on the Second floor by 10 beds. They stated that it was a Cooperate decision that that was a greater need. This surveyor then asked, So you are saying is that the Facility Environmental observation done to upgrade in the appearance of the facility was given a higher priority than the safety of the residents in the cottage. They stated, Yes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to clean and sanitary seating for residents. (Resident #60).Findings: On 2/9/26 at 10:20 a.m., observation with Certified Nursing Assistant (CNA) #3 of a dark brown and a light brown substance on the seat of a fabric chair in Resident #60's room, along with brown spots on his/her bathroom floor. At this time, CNA #3 states that Resident #60 often is incontinent with diarrhea.On 2/9/26 at 10:30 a.m., the above information was observed and confirmed with the Maintenance Director and the Regional Director of Operations.