STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205176	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Manor	25 Bolduc Ave Fort Kent, ME 04743

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 35904 Based on the facility reported incident dated 9/17/24, review of the facility's investigation report dated 9/17/24, facility's investigation follow-up report dated 9/20/24, facility policy, record review, and interviews, the facility failed to protect a resident from being sexually harmed, and potentially being emotionally harmed and causing the resident to sustain emotional fear, sadness, and embarrassment for 1 of 1 resident sampled for abuse (Resident #1 [R1]). A reasonable person could have psychosocial harm. Finding: On 9/17/24, the facility reported to the Maine Department of Health and Human Service, Division of Licensing and Certification a facility reportable incident of staff to resident sexual abuse. Documentation in the facility's Investigation Summary Report indicates that on 9/17/24, a Certified Nursing Assistant #1 (CNA1) reported to the facility's Director of Nursing (DON) that on 9/17/24 at 10:30 a.m. CNA1 noted R1's room door was closed and noted she had not seen R1 recently. CNA1 entered the room without knocking and states she saw an employee, the Transporter, [Facility] Activities sitting in front of R1 and describes that the Transporter, [Facility] Activities appeared to be startled to see CNA1 entering the room and removed his hands from under R1's shirt. CNA1 states, I saw [the Transporter] had his hands in R1's shirt on [his/her] breast. Documentation in R1's clinical record, under a physician progress note indicates that R1 has diagnoses to include generalized anxiety disorder, major depressive disorder, PTSD [post-traumatic stress disorder], agitation, dementia, major neurocognitive disorder, Alzheimer's disease, and vascular dementia. Documentation in the resident's clinical record, showed no outward signs of emotional distress from the incident. R1 is incapable of giving his/her consent to sexual activity. It would be reasonable that R1 would be very distraught that his/her dignity was violated by a staff placing his hands on R1's breast. Documentation in the facility's current Abuse, Neglect, Exploitation and Misappropriation of Property policy indicates that residents will be free from sexual abuse. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/30/24 at 12:00 p.m., in an interview with a surveyor, CNA1 states that she was searching for R1, went into R1's room and observed the Transporter, Activities staff with his hands up the front of R1's shirt, under R1's clothing on his/her breasts. CNA1 states the Transporter, Activities staff removed his hands from under R1's shirt, then fixed R1's shirt when she entered the room. CNA1 took R1's hand and led him/her to the hallway where R1 continued to walk down the hallway. CNA1 states that R1 had a dazed look on his/her face, and she immediately reported the incident to the Director of Nursing (DON). On 9/30/24 at 11:36 a.m. in an interview with a surveyor, the Administrator, Chief Operating Officer confirmed that the Transporter, Activities staff admitted to him that, he [Transporter, Activities staff] had his hands between R1's breasts and touching his/her breasts. He did admit to me that [R1] was not of [his/her] normal state of mind, could not consent. R1 did not have the cognitive ability to get out of the situation of being sexually touched and was under the control of the Transporter [Facility] Activities. Potential long-lasting embarrassment and emotional distress would occur knowing that he/she was sexually touched. A reasonable person would suffer from anger and deep sadness due to lack of control over the situation and would experience fear of the Transporter [Facility] Activities. As a result of the facility's investigation the following correction actions were immediately taken on 9/17/24: -The facility immediately took action by ensuring the resident was safe and the resident was assessed and showed no signs of distress. - The Transporter [Facility] Activities was immediately terminated from employment on 9/17/24 after meeting with the Administrator, Chief Operating Officer, and the DON. The local police were notified, Licensing and Certification and the Adult Protective Agency were notified, the resident's physician and the resident representatives were notified. -The DON began to hold in-service education reviewing Abuse Reporting and Investigation, with more training to take place next week. The DON documented on an attendance record, which contained staff names, and the completion of the in-services attended. Additionally, based on the above information, Immediate Jeopardy (IJ) at past non-compliance was called on 10/15/24 for the facility's failure to ensure that a resident was free from abuse [sexual]. Please see F-0000-Initial Comments related to the IJ removal plan.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 35904 Based on interview and record review, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, neglect, exploitation and misappropriation of resident property by failing to ensure that 2 of 3 unlicensed staff reviewed for in-service training completed the required training (Staff #1, and Staff #2). Findings: During a review of facility staff education records the following was identified: 1. Transporter, [Facility] Activities, staff #1 was hired on 3/28/16. The education record lacks evidence of mandatory abuse, neglect, exploitation and misappropriation of resident property education/training in within the past year. 2. Housekeeping and Engineer Services, Handyman, staff #2 was hired on 1/5/23. The education record lacks evidence of mandatory abuse, neglect, exploitation and misappropriation of resident property education/training in within the past year. On 9/30/24 at 4:44 p.m. in an interview with a surveyor, the Director of Nursing confirmed that not all of the mandatory training required was completed for Staff #1, and staff #2 within the past year.