STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205083	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madigan Estates	93 Military Street Houlton, ME 04730

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record reviews, and interviews, the facility failed to ensure a resident was free from abuse for 1 of 1 residents reviewed for abuse (Resident #1 [R1]). Findings: On 1/22/25, a review of R1's clinical record indicated the following: R1 was admitted on [DATE] with diagnoses including mild dementia without behavioral disturbances and reduced mobility. On 10/23/24, R1 had a Brief Interview for Mental Status which indicated intact cognition. On 1/11/25 nurse notes indicate noises were heard coming from R1's room. Resident stated that [CNA1] threw resident against the wall. [CNA1] was irritable and confused at the time of the incident . Assessed for injuries . Large skin tear noted to left forearm about four inches long and two inches wide. The Monitor for Behavioral Symptoms indicated the resident has not exhibited aggressive behaviors before or after this incident. On 1/22/25, a review of facility records indicated the following: According to the facility's Reportable Incident forms, R1 stated to the Supervisor on 1/11/25 at 2:20 a.m., that CNA1 threw him into a wall resulting in a skin tear measuring 4 inches long by 2 inches wide. During the investigation the supervisor stated she heard banging and when she arrived to the room CNA1 left the scene frustrated and stated [CNA1] seems to be easily frustrated by residents. Review of CNA1's employee file revealed documents written by CNA1 expressing animosity towards residents and the facility. Following a previous allegation of abuse, CNA1 was placed on an Employee Assistance Program to help with stress management and had frequent evaluations that consistently indicated goals to improve upon attitude towards residents and facility. The facility terminated CNA1 as a result of the accumulation of these concerns. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 10:35 am, during an interview with a surveyor, R1 stated after assisting with incontinence care in the bathroom, CNA1 had not pulled up this brief and pants all the way. R1 stated he kept asking and telling CNA1 to pull them up, but CNA1 insisted R1 pull up their own brief. R1 stated he/she would not let go of the walker for fear of falling. R1 stated CNA1 threw a tantrum and grabbed me and threw me into the wall. R1 stated he/she pushed back and CNA1 ran out of the bathroom. R1 repeatedly expressed fear of his family finding out and about CNA1 being assigned to care for R1 in the future. On finding out CNA1 no longer worked for the facility, R1 appeared physically and psychologically relieved, and asked really, he's gone for good? multiple times for confirmation. On 1/22/25 at 11:45 a.m., in an interview with a surveyor, the Unit Manager (UM) stated she interviewed R1 on 1/13/25. At that time R1's recollection of events was consistent with his statements to the Supervisor on 1/11/25 and to the surveyor on 1/22/25. On 1/23/25 at 9:11 a.m., during an interview with a surveyor, CNA1 indicated they argued over R1's brief as CNA1 insisted it was clean and R1 insisted it was dirty. CNA1 stated when he pulled up R1's pants, R1 started to yell out and swung his arm back knocking CNA1 into the wall. CNA1 stated he noticed the skin tear, left the bathroom and went to the Supervisor to explain what happened, told her about the skin tear, and stated I'm gonna remove myself from the situation I haven't had a break yet I'm going to go take my break. CNA1 stated, I just walked back and forth just you know trying to relax any chaos that's going on like in my head and worried about everything going on I did a couple little breathing exercises that I know and went and sat down for 1/2 hour. On 1/24/25 at 11:00 a.m., during an interview with surveyor, CNA2 stated prior to the incident CNA1 had filed a request to not be on the same unit as another resident was too demanding. CNA2 stated he/she recently assisted R1 to the bathroom to urinate, and R1 requested assistance with aiming as he/she did not want to let go of the walker. CNA2 stated the bathrooms are small and if a CNA is squatting to assist with pulling up a brief the distance to fall back to the wall would only be about a foot. CNA2 also stated, on the night of the incident, CNA1 claimed R1 had lost his/her balance resulting in a skin tear. On 1/25/25 at 2:00 p.m., during an interview with the surveyor, the Supervisor stated she heard arguing and heard a bunch of banging, so she went running to investigate. CNA1 came out frustrated and left. At that time R1 stated CNA1 pushed him/her into the wall. The Supervisor stated CNA1 did not stop to talk to her and I didn't want to make him more mad or I didn't want to frustrate him more so I just let him you know de-escalate himself too. The supervisor stated R1 didn't take long to de-escalate and settled quickly after the incident. The supervisor stated the note indicating CNA1 was confused at the time was because he was unsure of what happened and did not know how the skin tear occurred. The Supervisor stated, after providing wound care and settling R1 down, she texted CNA1 to check on him. CNA1's text response identified R1 in a derogatory manner and expressed animosity toward him. On 1/31/25 at 10:55 a.m., during an interview with the Director of Nursing, a surveyor confirmed that after reviewing all the evidence associated with this incident, abuse was substantiated.