

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Madigan Estates		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on clinical record reviews and interviews, the facility failed to follow physician orders or enter treatment orders for wounds when found for 5 of 20 residents reviewed (Resident #9 [R9], R62, R63, R39, and R98). Findings: 1. On 7/28/26, R9's clinical record was reviewed and included an order to administer Humalog Mix insulin with breakfast and supper but to hold it if blood sugar was less than 100. A review of R9's blood sugars and Treatment Administration Record [TAR] indicated that on 7/23/26 at 7:54 a.m., R9's blood sugar was 88 but the TAR indicated the insulin was still administered. On 7/29/26 at 1:55 p.m., during an interview with the Director of Nursing [DON], a surveyor confirmed this finding. 2. On 7/27/26 at 11:11 a.m., a surveyor observed R62 in his/her room and noticed a straw in a pink drink. Review of the clinical record indicated that speech therapy assessed R62 on 6/30/26 and the physician order was changed to Soft & Bite Sized texture, Nectar/Mildly Thick consistency, *NO STRAWS* ENSURE COMPLETE W/ ALL MEALS. 10AM HEALTH SHAKE. On 7/27/26 at approximately 11:30 a.m., during an interview and observation of R62 with Registered Nurse #1 (RN1), a surveyor confirmed the straw was in the drink at this time. 3. On 7/28/26 at 7:44 a.m., a surveyor observed Certified Nursing Assistant-Medications [CNA-M] administer Lubricant Eye Drops to R63; CNA-M instilled 1 drop to each eye. On 7/28/26 at 9:40 a.m., a surveyor observed CNA-M instilled 2 drops in both of R63's eyes. After this administration, the surveyor asked CNA-M to review the order again which indicated 2 drops were to be given in the left eye only. The surveyor confirmed that both administrations of the Lubricant Eye Drops were not completed as ordered. 4. On 7/29/26, R39's clinical record was reviewed and indicated that R39 had 2 current wounds, one on the right upper arm with orders entered on 7/6/26 for daily dressing changes and one on the left forearm with orders entered on 7/26/26 for daily dressing changes. A review of the clinical record included a nursing progress note that indicated on 7/4/26 at 4:30 p.m., Licensed Practical Nurse #1 (LPN1) went in to see R39 and noticed a dressing on the right upper arm coming off. LPN1 changed the dressing and indicated that the night supervisor was made aware and would enter a dressing change order in R39's treatments. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record included a nursing progress note that indicated on 7/25/26 at 6:42 p.m., Licensed Practical Nurse #2 (LPN2) went in to change the daily right forearm dressing. LPN2 changed the bandage and noted a bandage on the left forearm with no date on the bandage. LPN2 removed the bandage to assess and noted a small skin tear that skin had not been reapproximated and has hardened with a scab sticking up with heavy old blood drainage noted to bandage when it was taken off. LPN2 changed the dressing and wrote that she entered an order for daily dressing changes and would send a message to unit manager to assess the open area and dressing order when she is back Monday. On 7/29/26 at 2:08 p.m., during an interview with a surveyor, the DON stated that she read the notes regarding R39's wounds and also observed that dressings were found on R39's arms but there were no indication on when they were originally found or treatments ordered prior to the discovery of dressings by LPN1 and LPN2. 3. On 7/28/26, R98's clinical record was reviewed and that R98's active orders included an order for Intake and Output Monitoring (I&O, which is the measurement of all fluids that enter and leave a patient's body) and an order for weekly weights to be obtained on Fridays (start date 6/26/26). The clinical record lacked evidence that I&O monitoring was completed or that weekly weights were obtained as ordered. On 7/28/26 at 4:49 p.m., during an interview with a surveyor and the Pine Unit Manager, R98's clinical record was reviewed. The Pine Unit Manager was unable to find oral intake documentation related to beverage consumption between mealtimes and stated that staff do not measure output on incontinent residents. At this time, the surveyor confirmed with the Pine Unit Manager that the clinical record does not contain I&O documentation and that weekly weights were not completed as ordered. On 7/28/26 at 5:02 p.m., during an interview with the DON and the Administrator, R98's clinical record was reviewed. At this time the surveyor reviewed and confirmed that the clinical record lacked evidence that I&O monitoring and weekly weights were completed as ordered.		