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	05/22/2025

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

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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 - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an as needed (prn) psychotropic medication met the required 14-day limit for 1 of 5 Resident's reviewed for unnecessary medications (Resident #5 [R5]). Finding: On 5/20/25, during a review of R5's current Physician Orders, it showed that R5 was using the facility's Palliative care end of life order set. The order set included an order for Haldol (a psychotropic medication), with directions that if a resident is less than or equal to 60 kilograms (kg) or greater than [AGE] years of age to give Haldol 0.5 milligrams(mg) to 1 mg intramuscularly (IM) prn for agitation every hour until calm, then every 6 hours prn with no stop date. The medical record lacked evidence of clinical rational to continue the prn psychotropic medication with an extended time frame. Review of the electronic Treatment Administration Record (TAR) revealed that R5 received a prn Haldol dose of 1 mg on 4/16/25, and a prn Haldol dose of 1 mg on 4/18/25. On 4/19/25 the prn Haldol order was reentered with no stop date, the 14-day limit would be on 5/2/25. R5 required a Provider visit to reevaluate the use or need of the prn Haldol medication. Review of R5's clinical record and TAR revealed that after the date of 5/2/25, R5 received 17 doses of the prn Haldol at 1 mg IM after the 14-day limit. On 5/21/25 at 1:00 p.m., during an interview with the Nurse Manager/Supervisor, a surveyor confirmed that the clinical record lacked the required documentation or the rational for continuing the prn Haldol, and that the Provider had not evaluated R5 for the continued use of the prn Haldol. Review of R5's physician progress notes indicated that R5 was seen by the Provider on 5/20/25, but the use of the prn Haldol was not reviewed by the Provider.

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 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. Based on facility policy review and interviews, the facility failed to ensure an alleged allegation of physical and verbal abuse was reported to the Division of Licensing and Certification for 1 of 2 residents reviewed (Resident #13 [R13]). Finding: A review of the facility's policy, Abuse Prevention Program: Policy Statement, states, 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. On 5/11/25, the Division of Licensing and Certification received from Adult Protective services an allegation of verbal and physical abuse toward R13 by Certified Nursing Assistant #2 (CNA2) who was witnessed raising his/her voice, in a derogatory manner and using profanity while working with R13. A review of a facility-provided written statement from Licensed Practical Nurse [LPN] states, .R13 was having a hard time catching his/her breath and that it felt like [CNA2] was trying to pull his/her catheter out of his/her [insertion site] and was being extremely rough with him/her. As I was walking in, I hear CNA2 say to R13, I'm not being mean you're just a [profanity] jerk. A review of a facility-provided letter, dated 5/13/25, addressed to [CNA2], from [Human Resource Manager] states that, This letter services as formal notice that your per diem status with [facility] is terminated effective immediately due to your use of unacceptable language with a resident and your decision to walk off your shift . and a review of DISCIPLINE notice, The following infractions will result in immediate discharge: . H. Abusive treatment toward a resident. I. Leaving duty station before relief arrives., and The following infractions will result in a written warning: H. Discourteous conducts toward any resident, visitor or employee. A review of a facility-provided email, dated 5/16/25 at 10:57 a.m., addressed to [Director of Nursing (DON)], from [CNA2] states that . all I simply said was you're a jerk nothing more . to R13. On 5/21/25 at 12:35 p.m., in an interview with the Director of Nursing (DON), a surveyor confirmed that staff reported an allegation of verbal and physical abuse of R13 by CNA2 to the DON, and the surveyor confirmed that the facility did not notify the Division of Licensing and Certification of the allegation of alleged physical and verbal abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on facility policy review, record review, and interview, the facility failed to ensure an allegation of physical and verbal abuse was investigated for 1 of 2 complaints reviewed (Resident #13 [R13]). Finding: A review of the facility's policy, Abuse Prevention Program: Policy Statement, states, 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. On 5/11/25, the Division of Licensing and Certification received from Adult Protective services an allegation of verbal and physical abuse toward Resident #13 by Certified Nursing Assistant #2 (CNA2) who was witnessed raising his/her voice, in a derogatory manner and using profanity while working with R13. A review of a facility-provided written statement from Licensed Practical Nurse [LPN] states, .R13 was having a hard time catching his/her breath and that it felt like [CNA2] was trying to pull his/her catheter out of his/her [insertion site] and was being extremely rough with him/her. As I was walking in, I hear CNA2 say to R13, I'm not being mean you're just a [profanity] jerk. During the facility's recertification survey and this investigation, the facility was not able to provide evidence that this allegation of abuse was investigated. On 5/21/25 at 12:35 p.m., in an interview with the Director of Nursing (DON), a surveyor confirmed that the facility did not complete an abuse investigation for the allegation that was brought to their attention by facility staff of physical and verbal abuse of R13 by CNA2.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately on a Significant Change MDS assessment to indicate that a resident had a State Level II Preadmission Screening and Resident Review (PASRR) for 1 of 3 residents reviewed for PASRR (Resident #60 [R60]). Finding: On 5/19/25, R60's clinical record was reviewed and included a Level I PASRR, dated 4/2/24, that indicated that R60 needed a face to face review. On 5/21/25 at 10:09 a.m., the Director of Nursing (DON) provided a surveyor with R60's PASRR Level II, dated 4/15/24. Review of R60's Significant Change MDS, dated [DATE], was coded under Section: A1500 to indicate that R60 did not have a Level II PASRR. On 5/21/25 at 11:10 a.m., the surveyor confirmed with the DON that R60's Significant Change MDS 3.0, dated 12/11/24, was coded incorrectly under section A 1500 for the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition as it was answered no.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on clinical record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours, that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 5 newly admitted residents (Resident #26 [R26]). Finding: On 5/21/25, R26's clinical record was reviewed and indicated that R26 was admitted to the facility in April of 2025 with a Foley catheter in place. The baseline care plan lacked evidence for the use of a Foley catheter. On 5/21/25 at 1:32 p.m., during an interview with a surveyor, the Director of Nursing stated that she could not find the Foley catheter addressed in the baseline care plan. The surveyor confirmed this finding during this interview.

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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 reviews and interview, the facility failed to revise a care plan after a resident qualfied for Preadmission Screening and Resident Review (PASRR) Level II services for 1 of 3 residents reviewed for PASRR (Resident #60 [R60]). Finding: On 5/19/25, R60's clinical record was reviewed. The surveyor noted that the PASRR, dated 4/2/24, stated to Refer for Level II face to face onsite but the surveyor was unable to locate this document. On 5/21/25 at 10:09 a.m., the Director of Nursing provided a surveyor with R60's PASRR Level II, dated 4/15/24. At 11:10 a.m., the surveyor confirmed with the DON that R60's care plan lacked evidence of a care area for the PASRR Level II services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record reviews, policy review, and interviews, the facility failed to follow a policy for completing neurological assessments after a fall for 1 of 2 sampled residents who had fallen and hit their head (Resident #66 [R66]). Finding: The facility's policy, Neurological Post-fall Assessment Protocol, undated, directed staff to assess the resident immediately after a fall. If a resident is believe to have hit his/her head, the Neurological Post-fall Assessment Protocol will be initiated which included assessing the blood pressure, pulse, respiratory rate, pupil assessment, level of consciousness, speech and motor response. The Neurological assessment will be performed as follows: -As soon as it is safe to do so following the incident - Every 15 minutes times (x) 1 hour (hr) - Every 30 minutes x 1 hr - Every 60 minutes x 2 hr - Once per 12 hr shift x 24 hrs - Continue x 72 hrs total if any changes from baseline are observed. On 5/20/25, R66's clinical record was reviewed and indicated the resident had a witnessed fall on 3/6/25 at 10:29 p.m., hitting his/her head on the edge of the bed. On 5/20/25 at 10:48 a.m., during an interview with a surveyor, the Assistant Director of Nursing (ADON) stated that neurological assessments are done on paper; she will look for them for this fall. At 11:07 a.m., during an interview with a surveyor, the ADON stated that R66 was sent to the hospital and had a negative Computed Tomography (CT) scan. At 11:12 a.m., during an interview with a surveyor with the Director of Nursing (DON) present, the ADON stated that R66 was sent to the hospital because they thought R66 was having stroke like symptoms. At this time, the Director of Nursing stated that if the Provider felt that neurological assessments were not needed, then an order should have been received to discontinue them. The surveyor confirmed that neurological assessments were not completed and there was no order to discontinue them for R66's fall on 3/6/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record reviews and interview, the facility failed to ensure the physician orders included an order for the use of a Foley catheter for 1 of 2 residents (Resident #26 [R26]). Finding: On 5/21/25, R26's clinical record was reviewed and indicated that R26 was admitted to the facility in April of 2025 with a Foley catheter in place. A review of the physician orders thru 5/7/25 lacked evidence of an order for the use of a Foley catheter, noting that the Foley catheter was removed on 5/8/25. On 5/21/25 at 1:32 p.m., during an interview with a surveyor, the Director of Nursing stated that she could not find an order for the use of a Foley catheter. The surveyor confirmed this finding during this interview.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure that dented cans were removed from use, the facility failed to ensure products in the reach-in refrigerator located in the kitchens back room were labeled, in addition the facility failed to ensure all kitchen staff were wearing facial hair restraints on 1 of 4 days of survey (5/19/25) Findings: On 5/19/25 at 10:50 a.m., during the initial tour of the kitchen, a surveyor observed in the dry food storage area the following dented cans, on the shelf and available for use: 1 6.56 pounds (lbs.) of diced peaches with a dent on the top seal of the can 2 50-ounce (oz) cans of tomato soup with a dent on the top seal of the can 1 112 oz can of apple filling with a dent on the bottom seal of the can At 10:55 a.m., the surveyor observed that in the reach in cooler near the steam table, on the top shelf was a steamtable pan covered in plastic wrap that was not labeled or dated. At 11:00 a.m., the surveyor observed the reach in cooler that was in the back storage room/break room area that had 4 trays each with dishes of food that were out of their original containers. The trays had a paper towel indicating what meal the trays were to be used for 5/19 supper, breakfast 5/20, lunch 5/20 and dinner 5/20 but were not labeled with what was in the individual dishes. On 5/19/25 at 11:05 a.m. the surveyor confirmed the above findings with the Food Service Director (FSD) At 11:08 a.m., the surveyor observed the cook and another staff member who had facial hair that was not restrained while in the food preparation area. This finding was confirmed at the time of the observation.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews and interview, the facility failed to ensure that a resident's record contained the Power of Attorney paperwork for 1 of 6 residents reviewed for Advance Directives (Resident #60 [R60]). Finding: On 5/20/25, R60's clinical record was reviewed and indicated on the profile section of the electronic record that R60 had a Power of Attorney (POA) but the surveyor was unable to locate this document. On 5/21/25 at 11:10 a.m., during an interview with a surveyor, the Director of Nursing stated they did not have a copy of R60's POA paperwork on file. The surveyor confirmed this finding during this interview.

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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 observation, interview, and record review the facility failed to maintain an Infection Control Program designed to help prevent the development and spread of infection related to Enhanced Barrier Precautions (EBP) for 1 of 2 sampled residents reviewed on EBP (Resident #42 [R42]). Finding: A review of the sign posted on R42's room indicated the following: staff were required to wear personal protective equipment (PPE), a gown, and gloves when providing care. Review of facility policy Enhanced Barrier Precautions, . 3. Contact precautions apply when: . b. A resident is NOT known to be infected or colonized with any MDRO [multi-drug-resistant organisms], has . indwelling medical device ., . indicates that EBP are required for any residents with an indwelling catheter . 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . h. prolonged, high-contact with items in the resident's room, resident's equipment, or with resident's clothing or skin. On 5/20/25 at 11:13 a.m., a surveyor observed CNA3 sitting on R42's bed, not wearing a gown, or gloves. Review of the Electronic Medical Record (EMR) for R42 revealed that he/she is on EBP due to a catheter. On 5/20/25 at 11:16 a.m., in an interview with CNA3, a surveyor confirmed that he was sitting on R42's bed with no PPE for a resident that is on EBPs. On 5/22/25 at 8:17 a.m., in an interview with a surveyor, Registered Nurse (RN) stated that R42 is on EBPs because of a catheter. RN states that she observed CNA3 sitting on R42's bed without gown, or gloves on 5/20/25, and she stated after the observation she asked CNA3 if the linens had been cleaned or if the floor aid changed the bed prior to him sitting on R42's bed. He did not know. RN spoke with CNA3 about using PPE's if completing high contact care or sitting on a bed of a resident that is on EBPs. RN said to the surveyor that CNA3 is aware that R42 is on EBP and what PPE he should have been wearing.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to implement and maintain an effective training program to ensure that a CNA attended the required 12 hours of annual in-service education training, and annual dementia training for 1 of 4 randomly selected CNAs reviewed on survey (CNA #1 [CNA1]). Finding: On 5/22/25, review of CNA1's employee record indicated the date of hire to be 8/16/21. The education file lacked evidence of annual education in the areas of dementia training, resident rights, infection control, and/or the 12 required hours for continuing education annually. On 5/22/25 at 12:45 p.m., during an interview with a surveyor and the Payroll and Resident Accounts Manager, the employee education record was reviewed. At this time the surveyor confirmed that CNA1 had not completed the required 12 hours of annual in-service education.