STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205115	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dexter Health Care	64 Park Street Dexter, ME 04930

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 - 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. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on review of the facility's policy's, review of the Nursing Facility Reportable Incident Form, review of the facility investigative report, review of the clinical record, and staff interviews, the facility failed to ensure a resident's right to be free from mental abuse, physical restraint, and involuntary seclusion. Specifically, Registered Nurse #1 (RN1) engaged in multiple abusive behaviors, including yelling at the resident repeatedly in response to the resident banging on the door and requesting to go outside, resulting in the resident being transferred to an acute care hospital. For 1of 2 residents sampled (Resident #1[R1]) for abuse. Findings:A facility document titled Identifying types of Abuse, revised 3/2025, indicated the following: Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.The facility's policy, Use of Restraints, revised 3/2025, indicated that seclusion, which is defined as the placement of the resident alone in a room, shall not be employed and defines Physical Restraints as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. On 8/18/25, the Division of Licensing and Certification received a Nursing Facility Reportable Incident Form for an incident that occurred on 8/16/25. The report indicated that on 8/16/25, staff reported to the Director of Nursing (DON) that Resident #1 (R1) was agitated and Registered Nurse #1 (RN1) escalated resident's behavior to the point that R1 bit RN1's hand. Per documentation on this incident form, on 8/18/25, staff came to further report additional information to the events that occurred on 8/16/25 between RN1 and R1 that occurred when R1's behaviors were escalating and R1 was exit seeking, which included RN1 put R1 in his/her room and closed and held the door for several seconds up to one minute. On 8/26/25 a review of facility's investigation into the 8/16/25 incident was conducted and indicated the following: On 8/16/25 at 8:41 a.m., Licensed Practical Nurse #1 (LPN1) sent the DON a text message that indicated that RN1 was bitten by a resident which broke the skin on RN1's right hand. On 8/16/25 at 8:41 a.m., the DON responded to this message from LPN1, asking RN1 to complete an incident report and follow up with Work Health on Monday. At 11:04 a.m., Certified Nursing Assistant #1 (CNA1) reported to the DON via text messages that R1 was swinging at RN1 and RN1 was flapping her arms right back at the resident and telling the resident to go ahead and hit her; the DON responded back to CNA1 at 11:11 a.m. At 11:09 a.m., CNA3 texted the DON that she had concerns regarding RN1's behavior towards R1; at 11:12 a.m., the DON spoke with CNA3 via telephone and asked if she [the DON] needed to come in, to which CNA3 responded that R1 was being sent to the hospital.On August 16, 2025, multiple Certified Nursing Assistants (CNAs) observed RN1 forcibly placing R1 in his/her room and holding the door shut, preventing R1 from exiting. CNA1 and CNA3 confirmed witnessing RN1 physically restrain R1 and restrict movement.CNA2 and CNA4 reported that RN1 engaged in repeated verbal altercations with R1, including statements such as you're not going out and you need to stop, delivered in a frustrated and escalating tone.CNA2 described RN1 physically holding R1's arms down and dragging the wheelchair, resulting in R1 biting RN1 during the struggle.CNA4 stated that RN1's actions-including repeated physical redirection and verbal commands-escalated R1's behavior and contributed to emotional distress.RN1 acknowledged during interviews that she fought with [R1] a little bit to remove his/her hands from the wheelchair wheels and admitted to placing R1 in his/her room multiple times. Staff statements consistently indicated that RN1's conduct was not aligned with trauma-informed care or de-escalation practices and contributed to R1's agitation.R1's clinical record indicated R1 was sent to the hospital at 11:30 a.m. on 8/16/25 for an evaluation. On 8/19/25, the Medical Doctor (MD) documented that R1 was evaluated in the emergency room on 8/16/25 for physically assaulting a staff member. Urinalysis was negative and R1 was pleasantly confused, but not combative while there. R1 returned to the facility with improved mood but continued exit-seeking, responsive to re-direction. R1's care plan was reviewed and included a FOCUS, dated 12/8/24, of Resident has a behavior problem, confrontational related to (r/t) dementia with interventions, initiated on 12/8/24, that included: approach/speak in a calm manner, divert attention, and minimize potential for the resident's disruptive behaviors by offering tasks which divert attention. The care plan also included another FOCUS, dated 12/8/24, of Resident has impaired/cognitive function/dementia or impaired thought process r/t dementia with interventions, initiated on 12/8/24, that

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on review of the facility's Nursing Facility Reportable Incident Form and investigation, facility policy review, employee file review, and interviews, the facility failed to ensure a resident was free from involuntary seclusion for 1 of 1 facility reported incidents reviewed (8/16/25).Finding:The facility's policy, Use of Restraints, revised 3/2025, indicated that seclusion, which is defined as the placement of the resident alone in a room, shall not be employed. On 8/18/25, the Division of Licensing and Certification received a Nursing Facility Reportable Incident Form for an incident that occurred on 8/16/25. The report indicated that staff reported that Resident #1 (R1) was exit seeking and escalating and saw Registered Nurse #1 (RN1) bring R1 back to his/her room and closed and held the door for a few seconds, up to a maybe a minute.On 8/26/25, RN1's employee file was reviewed and included a Performance Correction Notice, dated 8/18/25 that indicated RN1 was on leave, pending investigation, because of an incident with an allegation of abuse that included details that RN1 was outside R1's door, holding the door shut for an amount of time while R1 was in his/her room, attempting to get out. On 8/26/25, the surveyor reviewed the written statements gathered by the facility as part of their investigation for the 8/16/25 incident. On 8/16/25, Certified Nursing Assistant #2 (CNA2)'s written statement indicated that on around 8:15 a.m., R1 was at the front door angry, yelling and screaming, kicking the door, and was trying to get out. Multiple staff tried to redirect R1 from this behavior but R1 kept getting louder. RN1 told R1 to stop it, that he/she was not going out and to stop kicking the door. RN1 then grabbed R1's wheelchair to move it away from the door when R1 grabbed the wheels to stop it. R1 yelled I'm not moving you son of a . RN1's response was oh yes you are! CNA2 assisted RN1 to help move R1 from in front of the door and to the hallway. R1 was taken to his/her room by RN1. CNA2 heard loud banging, turned around, and saw RN1 holding R1's door closed. R1 was kicking the door from the inside. RN1 eventually let the door go and went into the nurse's station. On 8/18/25, CNA1's written statement indicated that around 8:30 a.m. that morning (8/16/25), she saw RN1 put R1 in their room, shut the door and held it shut but was not sure how long it was shut because she was in the middle of passing medications. On 8/18/25, CNA3 wrote that on 8/16/25, she had observed RN1 push R1 in his/her wheelchair and then proceeded to hold the door shut not letting R1 out. On 8/26/25 at 12:15 p.m., during an interview with a surveyor, CNA1 stated that R1 had been acting out after breakfast, around 8:30 a.m. on 8/16. CNA1 was passing medications and looked up and saw RN1 put R1 in his/her room and closed the door and held it, but she wasn't sure how long.On 8/26/25 at 1:05 p.m., during an interview with the Administrator and Director of Nursing, the surveyor confirmed that written statements/interviews indicated that RN1 was observed holding R1's door, with R1 kicking the door wanting to get out. On 8/26/25 at 2:04 p.m., during an interview with a surveyor, CNA2 stated that R1 was out front at the door kicking it and yelling. We all tried to redirect R1 but he/she wouldn't stop yelling and kicking and trying to get out the door. CNA2 was able to help RN1 remove R1 from the front entrance area and to the hallway. CNA2 stated that as she was walking away, she saw RN1 hold R1's door closed, and R1 was inside, kicking the door. Once RN1 let go, R1 opened the door and came out. CNA2 stated she didn't know how long she held the door shut.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on review of the facility's investigation/written statements and interviews, the facility failed ensure that a resident was free from restraint when a Registered Nurse used body contact as a method of physical restraint to limit a resident's voluntary movement for 1 of 1 facility reported incidents reviewed (8/16/25). Finding:The facility's policy, Use of Restraints, revised 3/2025, indicated Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. On 8/26/25, RN1's employee file was reviewed and included a Performance Correction Notice, dated 8/18/25 that indicated RN1 was on leave, pending investigation, because of an incident with an allegation of abuse that was considered restraining a resident that included details that RN1 held a resident's arms/hands down while resident was trying to hit staff. On 8/26/25, the surveyor reviewed the written statements and interviews provided as part of the facility's investigation for the 8/16/25 incident. On 8/16/25, Certified Nursing Assistant #2 (CNA2)'s written statement indicated that she heard super loud banging on the door because Resident #1 (R1) was trying to get out and that she ran to the area. Registered Nurse #1 (RN1) came around and yelled at R1, saying I told you to stop it, you're not going out! RN1 proceeded to drag R1's (wheel)chair when R1 threw a cup of coffee at RN1. RN1 was trying to hold R1's hands down because after he/she threw the coffee, R1 tried to hit her (RN1), so she (RN1) kept trying to hold R1's hands down. RN1 stated to R1 that you're not going to hit me. RN1 and R1 argued back and forth and the next thing RN1 screamed, OW, R1 friggen bit me! On 8/18/25, CNA4's written statement for the 8/16/25 incident indicated, RN1 removed R1 away from the front door repeatedly as the situation escalated, CNA4 saw RN1 put her arms around R1's upper chest as she wheeled him away from the door, both of them yelling at each other. On 8/26/25 at 2:04 p.m., during an interview with a surveyor, CNA2 stated at one-point, RN1 held R1's arms down, RN1 was standing from behind the chair because R1 was kicking the door and RN1 didn't want to get hit. She tried to wheel R1 around, she was behind R1, she tried to hold his/her arms down while standing behind, and R1 bit her. On 8/29/25 at 12:47 p.m., during an interview with a surveyor, CNA2 stated that R1 was flailing his/her arms up trying to hit her and then RN1 reached over his/her shoulders, to hold them down and then she heard RN1 say OW but she did not see the action of R1 biting RN1.On 8/29/25 at 1:50 p.m., during an interview with a surveyor, CNA4 stated RN1 just kept saying to R1, you need to stop, you need to stop you can't go outside as RN1 was speaking in a frustrated manner. R1's hands were kind of moving but CNA4 stated that she didn't think R1 could have moved his/her arms because of the way that RN1 had her arms crossed around R1's upper shoulder.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on facility policy review, the Nursing Facility Reportable Incident Form and investigation review, timecard review, and interviews, the facility failed to protect residents after staff notification of concern of behavior by a Registered Nurse towards a Resident for 1 of 1 facility reported incident reviewed (8/16/25). Finding:The facility's Identifying types of Abuse, revised 3/2025, indicated the following: Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.On 8/18/25, the Division of Licensing and Certification received a Nursing Facility Reportable Incident Form for an incident that occurred on 8/16/25. The report indicated that on 8/16/25, staff reported to the Director of Nursing (DON) that Resident #1 (R1) was agitated and Registered Nurse #1 (RN1) escalated resident's behavior to the point that R1 bit RN1's hand. Review of the facility's investigation with written statements and facility interviews that were provided to the surveyor on 8/26/25 indicated the following:On 8/16/25 at 8:41 a. m., Licensed Practical Nurse #1 (LPN1) sent the DON a text message that indicated that RN1 was bit by a resident which broke the skin on RN1's right hand. On 8/16/25 at 8:41 a.m., the DON responded to this message from LPN1, asking RN1 to complete an incident report and follow up with Work Health on Monday. At 11:04 a.m., Certified Nursing Assistant #1 (CNA1) reported to the DON via text messages that R1 was swinging at RN1 and RN1 was flapping her arms right back at the resident and telling the resident to go ahead and hit her; the DON responded back to CNA1 at 11:11 a.m. At 11:09 a.m., CNA3 texted the DON that she had concerns regarding RN1's behavior towards R1; at 11:12 a.m., the DON spoke with CNA3 via telephone and asked if she needed to come in, to which CNA3 responded that R1 was being sent to the hospital. The CNAs were asked to complete written statements regarding what they had seen.On 8/18/25, the DON again asked for written statements from CNA1 and CNA3, which started the facility's investigation. The statements obtained included additional information that RN1 and put her hands on R1 and that RN1 had put R1 in his/her room and closed the door and held it shut.On 8/26/25, a review of RN1's timecard indicated that she worked on 8/16/25 from 6:27 a.m. thru 6:57 p.m., and on 8/17/25 from 6:28 a.m. thru 6:57 p.m.On 8/26/25 at 1:35 p.m., during an interview with the Administrator and DON, the DON stated that we called the staff on 8/16/25 but no one mentioned anything physical. The DON stated that she spoke with Licensed Practical Nurse #1 (LPN1) and asked her to assume care of R1 when he/she returned from the hospital. The surveyor confirmed that RN1's interaction with R1 that was texted on 8/16/25 by staff at 11:04 a. m. was an allegation of a form of abuse but RN1 was allowed to remain at the facility providing patient care throughout the weekend.On 8/27/25 at 2:10 p.m., during an interview with a surveyor, LPN1 stated that the DON asked her to assume care of R1 but RN1 told her no, because R1 was RN1's patient. LPN1 stated that when R1 returned from the hospital, there were no further behaviors. On 8/28/25 at 9:41 a.m., during an interview with a surveyor, RN1 stated that she took care of R1 both Saturday and Sunday because R1 was her patient.

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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 Nursing Facility Reportable Incident Form review and interview, the facility failed to notify the State Agency (Division of Licensing and Certification [DLC]) timely for an allegation of abuse for 1 of 1 facility reported incidents reviewed (8/16/25).Finding:On 8/18/25, the Division of Licensing and Certification received a Nursing Facility Reportable Incident Form for an incident that occurred on 8/16/25. The report indicated that on 8/16/25, staff reported to the Director of Nursing (DON) that Resident #1 (R1) was agitated and Registered Nurse #1 (RN1) escalated resident's behavior to the point that R1 bit RN1's hand. Per documentation on this incident form, on 8/18/25, staff came to further report additional information to the events that occurred on 8/16/25 between RN1 and R1 that occurred when R1's behaviors were escalating and R1 was exit seeking, which included RN1 putting R1 in his/her room, closed the door and held the door for several seconds up to one minute. In addition, on 8/16/25 at 11:04 a.m., Certified Nursing Assistant #1 (CNA1) reported to the DON via text message that R1 was swinging at RN1 and RN1 was flapping her arms right back at the resident and telling the resident to go ahead and hit her. On 8/16/25 at 11:09 a.m., CNA3 texted the DON that she had concerns regarding RN1's behavior towards R1. The facility started an investigation on 8/18/25 for the employee to resident interactions that occurred on 8/16/25. On 8/26/25 at 1:35 p.m., during an interview with the Administrator and DON, the surveyor confirmed that the interactions between RN1 and R1 were allegations of abuse, and the State Agency was not notified timely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, facility investigation with written statements, and interviews, the facility failed to fully develop and implement a care plan for a resident who was agitated and trying to leave the facility for 1 of 1 facility reported incidents reviewed (8/16/25) when staff observed a Registered Nurse yelling at the resident instead of approaching/speaking in a calm manner and for the intervention to distract the resident from eloping, the resident preferences was BLANK. Finding:On 8/18/25, the Division of Licensing and Certification received a Nursing Facility Reportable Incident Form for an incident that occurred on 8/16/25. The report indicated that staff reported that Resident #1 (R1) was exit seeking and escalating.On 8/26/25, R1's care plan was reviewed and included the following:Focus: The resident is an elopement risk/wanderer related to (r/t) safety awareness, dementia with interventions that included distract resident from wandering by offering pleasant diversions, structure activities, food, conversation, television, book. Resident prefers: IS BLANK. This care area was initiated on 12/8/24 and revised on 6/13/25. Focus: The resident has a behavior problem . r/t dementia with interventions that included minimize potential for the resident's disruptive behaviors by offering tasks which divert attention and to intervene as necessary approach/speak in a calm manner. This care area was initiated and revised on 12/8/24. On 8/26/25, a surveyor reviewed the facility's investigation with written statements from staff regarding the incident that occurred 8/16/25Certified Nursing Assistant #4 (CNA4) wrote that she observed Registered Nurse #1 (RN1) remove R1 from the front door numerous times and take him/her back to their room. At one point, RN1 and R1 were yelling at each other. On 8/26/25 at 12:22 p.m., during an interview with a surveyor, CNA1 stated R1 gets in his/her moods but can be easy to calm down but not like that Saturday, CNA1 stated that she thought R1 was provoked with RN1 adding to his/her being aggressive. This all started around 8:30 a.m., when R1 returned from breakfast. CNA1 stated that around 10:30 a.m., she intervened between R1 and RN1 and took R1 back to his/her room after she observed RN1 mimicking R1's flapping arms and telling R1 to go ahead and hit her. On 2:04 p.m., during an interview with a surveyor, CNA2 stated that R1 has dementia, and he/she was triggered on that day (8/16/25) . R1 gets triggered easily and you have to let him/her be. If someone is wound up, you got to leave them alone for a bit. R1 wanted to go outside. and kept yelling and saying this is a prison and he/she has the right to go out.yelling it loudly, disruptive to the other residents. At one point, RN1 was mimicking R1 with the arms and both were yelling. With all of us wanting to defuse it, all you had to do was take him outside, but it was a busy time for us. As a result of this incident and facility investigation, the following corrective actions were initiated:-On 8/17/25, R1's care plan had a new care area developed the resident is/has potential to be physically aggressive strike out related to dementia with an intervention that included staff take turns taking resident outside one on one. -RN1's last day worked was 8/17/25 and was terminated for 8/28/25.-Education to staff on challenging behaviors in dementia care and aggressive or violent behavior was started on 8/19/25 with completion due by 8/29/25.

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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 review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information which included documentation of Resident Representative notification of hospital transfer, charge nurse documentation of resident behaviors as directed per Treatment Administration Record (TAR), and documentation to indicate that a resident returned from the hospital for 1 of 1 facility reported incidents reviewed (8/16/25). On 8/26/25, the surveyor reviewed Resident #1's (R1) clinical record after an incident that occurred on 8/16/25 which resulted in R1 being transferred to the hospital for evaluation of increased behaviors. The clinical record lacked evidence of documentation on 8/16/25 of Resident Representative notification or an attempt to notify, notes from Registered Nurse #1 (RN1) who had signed of the treatment sheet that behaviors were monitored, or information regarding when R1 returned to the facility after being transferred from the hospital. On 8/26/25 at 1:35 p.m., during an interview with the Administrator and the Director of Nursing, the surveyor confirmed RN1 did not document behaviors in the clinical record as directed by a treatment on the TAR, dated 4/5/25, which directed licensed staff to monitor for the following behaviors and to document behaviors in the nurses/progress notes. On 8/16/25, RN1 documented on R1's TAR that behaviors were monitored but lacked evidence of RN1 documenting the behaviors in the nurses/progress notes. In addition, the clinical record lacked evidence of R1 returning to the facility after a hospital transfer. On 8/27/25 at 2:10 p.m., during an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) stated that she did call R1's Resident Representative and left a message; she thought she documented the information in R1's clinical record. The surveyor confirmed with LPN1 that she had not documented this information in the clinical record. On 8/28/25 at 9:41 a.m., during an interview with a surveyor, RN1 stated that (on 8/16/25) she documented on the TAR earlier in the shift on the behavior monitoring treatment but forgot to go back and update the clinical record when R1 started behaviors around 8:30 a.m. In addition, RN1 stated that she was supposed to document information on R1's return from the hospital forgot to document R1's return to the facility from the hospital in the clinical record but forgot to.