STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205149	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katahdin Health Care LLC	22 Walnut Street Millinocket, ME 04462

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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record reviews, facility policy review, and interviews, the facility failed to ensure that physician orders were followed for 1 of 5 residents reviewed for unnecessary medications (Resident #19 [R19]). Finding: On 3/18/26, R19's clinical record was reviewed. The surveyor observed on March's Treatment Administration Record (TAR) that orders for insulin and blood sugar checks were not completed on the evening shift of 3/2/26 and 3/10/26. On 3/18/26 at 10:10 a.m., the surveyor and Director of Nursing (DON) reviewed R19's March's TAR for the evening of 3/2/26 and noted that insulins and blood sugar checks were not completed by Licensed Practical Nurse #1 (LPN1). The DON stated that she would look into this further. On 3/18/26 at 10:47 a.m., during an interview with a surveyor, the DON stated that there was nothing documented to indicate why these treatments were not completed, and she had called LPN1 and left a message. The physician orders not completed were as follows:- Check blood glucose at 7:30 p.m. - Sliding scale Humalog insulin before meals and at bedtime to be administered at 8:00 p.m. based on the blood sugar results at 7:30 p.m. - Scheduled Lantus insulin 24 units to be administered at 8:00 p.m. The facility's policy, Prescribing, Obtaining, Dispensing, Administering, Controlling, storing, and Disposing of all drugs and biologicals, revised 10/11/22, indicated that a record shall be kept of all medications administered, including name of drug, route, dosage, and time given. The surveyor had reviewed the process for completing blood sugars and administering insulin the day before, on 3/17/26 between 4:00 p.m. and 4:25 p.m., when a surveyor observed a Registered Nurse completing a couple of medication administrations. The insulin was kept in the Nurse's treatment cart, and a laptop was on top of the cart so staff could see what medication and dose was needed, and staff would document as given accordingly. It was explained by staff that once you enter the blood sugar results into the TAR, the amount of sliding scale insulin needed highlights automatically, and then you document accordingly. On 3/18/26 at 12:50 p.m., during an interview with the DON, a surveyor stated that LPN1 also had not completed the same orders for R19 on 3/10/26 either.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205149	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katahdin Health Care LLC	22 Walnut Street Millinocket, ME 04462

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on facility policy review, record reviews and interviews, the facility failed to ensure that the Consultant Pharmacist (CP) reported an irregularity to the Director of Nursing (DON) and Physician after completing the monthly medication regimen review (MRR) for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #19 [R19]). Finding: The facility policy, Medication Regimen Reviews, revised 3/2025, indicated that within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. On 3/18/26, R19's clinical record was reviewed. The electronic record indicated that the CP completed the MRR for January on 1/7/26 with a note that stated, Please evaluate for potential GDR [gradual dose reduction]. Thank you. On 3/18/26 at 10:59 a.m., the DON and surveyor reviewed R19's paper chart, and the DON was unable to find the Physician's response to the CP's request based on the MRR note left by the CP in R19's electronic record. The DON also looked in a binder that contained January's MRR that was provided by the CP for all residents, and still was unable to locate the written request form for R19. On 3/18/26 at 12:15 p.m., during a telephone interview with the CP, DON, and surveyor, the CP stated that due to a computer issue that she was unaware of until today (3/18/26), R19's January MMR irregularity written report was not sent anywhere and therefore neither the DON nor the Physician received a copy for evaluation. The CP stated she has corrected this setting as of today.