STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205151	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maine Veterans Home - Caribou	163 Van Buren Rd Suite 2 Caribou, ME 04736

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician of significant change in condition for 1 of 1 resident reviewed for Abuse [Resident #16 (R16)]. This failure delayed physician intervention that resulted in harm to R16 when R16 had requested to go to the hospital on 1/27/26 while experiencing respiratory distress which included needing increased supplemental oxygen above physician order, increased anxiety and restlessness which required frequent staff intervention and redirection. The Medical Provider was not notified of the change in condition until 1/29/26. Findings: R16 is a [AGE] year-old resident with diagnoses to include, but not limited to, Congestive Heart Failure Systolic Acute, Chronic Idiopathic Pulmonary Fibrosis, Pulmonary Hypertension, Chronic Respiratory Failure and a Right Humerus Fracture. On 2/5/26, review of R16's clinical record indicated the following:-R16's oxygen order, start date 12/30/25, directed staff to administer oxygen (O2) continuously up to 5 Liters Per Minute (LPM) via nasal cannula to keep O2 saturation greater than 88%.-On 1/26/26 at 10:45 a.m., a nurse note indicated the physician (MD) spoke to/with resident examined resident at 9:32 a.m., and there were no new orders.- Provider progress note, dated 1/26/26, indicated R16 was seen for acute shortness of breath, oxygen saturation not improving despite increased O2, and feeling weak. R16 had diffuse crackles, rhonchi (snore-like lung sounds heard with a stethoscope, often described as a wet or rattling sound caused by air passing through mucus or narrowed, obstructed airways) at that time.-On 1/26/26 at 3:42 p.m., a nurse note indicated R16's oxygen was increased to 8 LPM. The clinical record lacked evidence that the provider was notified of R16's change in condition that required increased oxygen LPM above what the physician ordered (See F695).-On 1/27/26 at 2:05 p.m., a late entry nurse note stated, Time: 11:40 [a.m.] REGARDING: [R16's Power of Attorney (POA)] stated that another family member had called [him/her] and told [him/her] that R16 had been requesting to go to the hospital and [he/she] was wondering if any staff had been with [R16] recently. The nurse indicated R16 had increased anxiety and restlessness requiring frequent staff intervention/redirection, that R16 was on 8L via non-rebreather mask, but resident also appears to be having some anxiety [related to] having to use the mask - however, [R16] has been consistently [dropping oxygen saturation to [80% range (80's)] or lower on nasal cannula. The nurse stated that comfort measures meant that nursing staff would try to keep resident comfortable here at facility without further interventions that would be an option at the hospital. [the nurse] informed [R16's POA] that changing [R16's] code status or treatment goals is [his/her] choice/right as [R16's] POA, but that this would also involve communicating with emergency department staff as [R16's] POA that there were changes to resident's code status per [his/her] wishes. At Time [1:15 p.m. (13:15)] the nurse called R16's POA with an update, indicating the resident had settled down after the 12:00 p.m. scheduled dose of Ativan and [as needed (PRN)] options for pain/anxiety such as morphine discussed at this time and [R16's POA] was receptive to these options if the provider would like to try them. The clinical record lacked evidence that the provider was notified of the resident's change in condition and that the resident had requested to transfer to the hospital. Additionally, a change in code status is not required to receive treatment for (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 0580 Level of Harm - Actual harm Residents Affected - Few	respiratory distress in the emergency room.-On 1/27/26 at 6:50 p.m., a late entry nurse note indicated, spoke with attending [MD] at [2:02 p.m. (1402)] REGARDING: increased agitation RESULT: new orders received and noted 01/27/2026 discontinue scheduled Oxycodone, start Morphine Sulfate Concentration 5mg [by mouth every 4 hours as needed. The clinical record lacked evidence that the provider was notified of the increase oxygen demand or that the resident had requested to transfer to the hospital.-On 1/29/26 at 7:51 a.m., a nurse note indicated, spoke with attending physician [Family Nurse Practitioner (FNP)] REGARDING: blood sugar of 39 and administration of glucagon injection and blood sugar now 42 RESULT: order to administer second glucagon injection. requested to be called back after next blood sugar check. The clinical record lacks evidence that the provider was notified of the resident's change in condition regarding oxygen needs.-On 1/29/26, the Provider (Family Nurse Practitioner [FNP]) progress note stated when I entered the room [R16] was struggling to breath - oxygen mask on [he/she] was trying to take it off - using accessory muscles to breath - [R16's] eyes were wide looking at me. [R16] is not speaking to me. [R16] does not appear comfortable. If we cannot get R16 comfortable the next step would be the house of comfort. On 2/5/26 at 3:18 p.m., during an interview with 3 surveyors, the Provider (FNP) stated she entered R16's room at approximately 1:00 p.m. to follow up on R16's low blood glucose results from that morning. FNP stated she was not aware R16 was uncomfortable or in respiratory distress until she entered R16's room. FNP stated when she entered the room, [R16] looked at her wide eyed, was in respiratory distress, using accessory muscles to breathe, and that R16 was anxious and trying to remove his/her oxygen mask. The FNP stated she was not aware that R16's oxygen demand had increased to 8 LPM, and she had to order a loading dose of morphine in addition to the existing order to get R16 comfortable. The FNP stated, people starving go to the House of Comfort or the hospital when we couldn't get them under control like that. During the interview, FNP reviewed the Provider records and stated the last communications with a Provider prior to FNP entering the room on 1/29/26, were with the Medical Doctor (MD) on 1/26/26 at 9:32 am for the in-person visit, and the phone call on 1/27/26 at 1:59 p.m. regarding the prescription change from Oxycodone to Morphine. At 3:36 p.m., the surveyor confirmed with FNP that the Medical Providers were not made aware of R16's request to go to the hospital on 1/27/26, R16's oxygen increase to 8 LPM via non-rebreather or incidents of discomfort / respiratory distress prior to FNP entering the room on the 1/29/26.On 1/29/26 at 1:40 p.m., a written order listed the following new orders:- 0.5 [milliliters (mL)] morphine concentrate (100 [milligrams (mg)]/5ml). Give 0.5mL (10mg) [one time] (loading dose) [orally].- Morphine concentrate (100mg/5ml). Give 0.25mL (5mg) [orally(PO)] [every(Q)] 1 hour [as needed (PRN)] [Diagnosis (Dx)]: Difficulty breathing - comfort care- [Discontinue (D/C)] Lorazepam patch (gel)- Lorazepam (2mg/mL) solution - 0.5mL (1mg) [orally every] 4 hours [as needed] AgitationOn 1/29/26 at 2:42 p.m., a nurse note stated, OTHER Hospice information for an urgent admission sent in to [Northern Light (NL)] Hospice. On 2/5/26 at 3:55 p.m., during an interview with a surveyor, Registered Nurse (RN4) stated R16 had shortness of breath with minimal exertion but appeared comfortable at rest and was observed sitting in bed and able to speak with the provider during the visit on 1/26/26. RN4 stated the visit on 1/26/26 was nothing compared to the absolute distress R16 was in on 1/29/26. On 2/5/26 at 3:45 p.m., during an interview with the Director of Nursing (DON) and 2 surveyors, R16's clinical record was reviewed regarding the above findings. The DON stated that she was unaware that R16 had requested to go to the hospital and should have been permitted the choice, and that staff need more education. At this time 2 surveyors confirmed the providers were not notified of R16's change in condition or R16's request to go to the hospital.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, facility policy reviews, and interviews, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to ensure staff wore the proper personal protective equipment (PPE) in enhanced barrier precaution and contact precaution rooms and failing to ensure staff discarded a medication pill after if fell on top of the medication cart on 3 of 4 days of survey (2/2, 2/4 and 2/5/26). Findings: The facility policy, Enhanced Barrier Precautions indicates that Enhanced Barrier Precautions (EBP) expands the use of PPE beyond situations in which exposure to blood and bodily fluids is anticipated, and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of [Multidrug-resistant organisms (MDROs)] to staff hands and clothing. 1. On 2/2/26 at 1:22 p.m., a surveyor observed an EBP sign outside R41's room. R41 was observed lying in bed while working with Physical Therapist Assistant (PTA) and Occupational Therapy Assistant (OTA). PTA observed to be sitting on R41's bed next to R41's foley bag, while assisting R41 with foot and leg exercises. PTA was not wearing PPE to prevent contamination of his/her clothing while providing care. OTA observed to be kneeling next to R41's bed and leaning his/her upper body and arms on the bed while massaging lotion onto R41's arm. OTA was not wearing PPE to prevent contamination of his/her clothing while providing care. On 2/2/26 at 1:30 p.m., during an interview with a surveyor, a Certified Nursing Assistant (CNA) stated R41 is on EBP related to his/her foley. PPE is needed when providing direct care like bathing or when draining the foley collection bag but not when resident is up in his/her chair. The facility policy, Infection Prevention and Control Program indicated that Contact Precautions were used for residents that have an infection that can be spread by contact with the person's skin, mucous membranes, feces, vomit, urine, wound drainage, or other body fluids or contact with equipment or environmental surfaces. In addition to standard precautions, wear a gown and gloves upon room entry. 2. On 2/4/26 at 9:30 a.m. a surveyor observed Certified Nursing Assistant - Medications (CNA-M) giving Resident #35 (R35) their medications; CNA-M was not wearing a gown or gloves during this interaction. When CNA-M exited the room, a surveyor asked CNA-M if she knew why R35 was on contact precautions? CNA-M stated, I don't know, I think a rash and that you would need to wear PPE when doing care. Surveyor pointed to the sign that on the wall outside the door that stated, Contact Precautions and that Staff and Medical Providers were to wear gown and gloves when entering the room. The surveyor explained to CNA-M that R35 was on contact precautions because he/she had shingles. On 2/4/2026 at 9:36 a.m., during an interview with a surveyor, the Infection Preventionist stated that CNA-M should have worn PPE (gown and gloves) when giving R35 their medications. 3. On 2/5/26 at 7:33 a.m., during a medication observation pass for a resident, CNA-M tipped over a medication cup with a couple of pills in it, causing one pill to fall on the top of the medication cart. CNA-M picked up the fallen pill with a spoon and was in the process of putting the fallen pill back into the medication cup when the surveyor stopped CNA-M, explaining that the top of the medication cart was considered contaminated (not clean). After this interaction, CNA-M picked up an empty medication cup and then placed the fallen pill into this cup for disposal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/26 at 8:30 a.m., during an interview with a surveyor, the Infection Preventionist stated that the fallen pill should be thrown away once it fell on top of the cart. 4. On 2/5/26 at 2:45 p.m., a surveyor asked RN3 why a room had a Contact Precautions sign outside the door which directed Staff and Providers to wear gowns and glove when entering the room; RN3 explained that one of the residents was suspected to have shingles and was placed on precautions yesterday afternoon. At this time, a surveyor observed Provider and RN4 in the room as the Provider was removing her gloves and moving away from the resident suspected of having shingles. The Provider was not wearing a gown and RN4 was not wearing the appropriate PPE either. On 2/5/26 at 2:55 p.m., during an interview with a surveyor with RN4 present, the Provider stated that she just diagnosed the resident with having shingles. The surveyor confirmed that there was a contact precaution sign outside the door that directed Staff and Providers to wear gowns and gloves before entering the room, but they were not wearing the proper PPE.

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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 record reviews and interviews, the facility failed to implement the written policy and procedures for preventing the abuse and neglect of residents after a resident reported an allegation of abuse [Resident #41 (R41)]. This had the potential to affect all residents.Findings: Review of the facility's Abuse, Neglect, Exploitation and Misappropriation of Property, dated November 19, 2025, states the following:Under the 5.4 Identification/Detection heading:- 5.4.2.1 Resident complaints of abuse.- 5.4.2.4 Unexplained bruises or other injuries- Resident's apparent fear of another person, whether staff, resident or visitor.- Resident refusal to be with a specific personUnder the 5.6 Protection heading:- 5.6.1 Staff will intervene immediately to protect the resident(s) in any situation of actual or potential abuse, neglect, exploitation, or mistreatment.- 5.6.2 If the person accused of the abuse is an employee, that person will be suspended with pay pending the outcome of the investigation.Under the 5.7 Reporting and Response heading:- 5.7.1 Staff members will be expected to report actual or suspected abuse, neglect, exploitation or misappropriation of property to their supervisor immediately with subsequent reports to the Administrator and [Director of Nursing Services (DNS)]. On 1/27/26 at 9:24 p.m., Certified Nursing Assistant #2 (CNA2) emailed a reported allegation to the DNS stating, [R41] made me lean in and whispered watch that nurse, she scares me, I watched her be rough with [R16] (pointing at R16) If you hear me yell please come, I am scared of her while [R1] was on the other side of the curtain putting [R16's] oxygen back on telling [him/her] to leave it on. On 1/28/26 at 9:40 p.m., CNA3 emailed a reported allegation to the DNS stating, I wanted to let you know a concerns a resident is having. [R41] whispered to me that [he/she] doesn't feel safe around the nurse [RN1]. [R41] stated that she was being too rough towards [his/her] roommate [R16]. [R41] also said if you hear screaming run to my room because [he/she] doesn't know what is going to happen. The DNS confirmed with CNA3 that this email was a delayed report for an allegation made on 1/27/26. On 2/5/26 at 9:05 a.m., during an interview with a surveyor, R41stated that R16 was confused and had an oxygen mask but he/she kept trying to take it off. RN1 came into the room and was scolding R16 to leave the mask on. R41 stated the nurse used both hands on R16's shoulder and pushed R16 back into bed so forcibly that RN1 was over R16 in the bed. R41 stated she is afraid of RN1. R41 stated he/she reported the incident to the CNAs. On 2/5/26 at 10:59 a.m., during an interview with 2 surveyors, the DNS stated RN1 was the only nurse on as it was the night shift. The facility's scheduled on-call nurse could have come in to cover the remainder of the shift, but CNAs are not typically aware of the on-call schedule or how to contact them. At this time 2 surveyors confirmed that CNAs were unable to report an allegation of abuse immediately to a supervisor as they did not have access to the on-call information, and that RN1 was permitted to continue working the remainder of her scheduled shift after an allegation of abuse (See F600).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on record review and interviews, the facility failed to provide respiratory care as order by the Provider for 2 of 16 residents reviewed on survey [Resident #61 [R16] and R5).Findings: 1. On 2/2/26 at 12:04 p.m., during a dining observation, a surveyor observed R5 sitting at a table in the dining room wearing nasal cannula tubing connected to an empty oxygen tank. At this time the surveyor observed and confirmed with RN2 that R5's portable oxygen tank was empty. RN2 stated R5 is supposed to be on 2 Liters (L) oxygen continuously. 2. On 2/5/25, clinical record review indicated R16 had orders, dated 12/30/25, Administer [oxygen (O2)] Therapy [continuously/daily (cont/daily)] up to 5 [Liter Per Minute (LPM)], nasal cannula continuous to keep O2 [greater than (>)] 88%, and Albuterol Sulfate (2.5 [milligrams (MG)]/3 [milliliters (ML)]) 0.083% Nebulization Solution Dose: (3ml) inhalation three times a day [as needed (PRN)] . For Dyspnea (difficult or labored breathing). Review of R16's Treatment Administration Record indicated from 2/26/26 through 1/29/26 R16 received continuous oxygen at 8 LPM. The clinical record lacked evidence that new orders were obtained for the increased administration of oxygen, that PRN nebulizer treatments were given for dyspnea, or that the provider was notified of the change in condition (See F580). On 2/5/26 at 3:45 p.m., during an interview with Director of Nursing (DON) and 2 surveyors, R16's clinical record was reviewed. At this time 2 surveyors confirmed that respiratory care was not implemented as directed.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interviews, the facility failed to ensure a clinical record contacted accurate and complete information for 3 of 17 sampled residents (Resident #41 [R41], R5, and R16).Findings: 1. On 2/5/26 at 12:08 p.m., during an interview with a surveyor and the Director of Nursing Services (DON), R41's clinical record was reviewed. The DON confirmed R41 was admitted with an indwelling foley catheter and that the nurse documentation, dated 1/28/26 at 1:02 a.m., stating Resident does not have an indwelling catheter in place at present. Sudden onset of incontinence was inaccurately documented. At this time the surveyor confirmed the above finding with the DON. 2. On 2/4/25, R5's clinical record was reviewed and indicated that R5 had a pressure injury to the right Achilles heel according to physician orders dated 12/2/25 and 12/16/25. Review of the weekly wound documentation for 1/27/26 contained documentation that this was a healing stage 2 to the back of the left ankle/Achilles and the care plan, dated 2/2/26, also indicated the pressure was on the left Achilles heel. On 2/5/26 at 8:56 a.m., during an interview with a surveyor, Registered Nurse #2 (RN2) stated that the pressure injury was on the right heel and not the left heel and that she documented incorrectly on 1/27/26 on the weekly wound documentation. The care plan was also reviewed and the surveyor confirmed that both the 1/27/26 documentation and the care plan identified the wrong heel as having the pressure injury. 3. On 2/5/26, R16's activities documentation was reviewed and contained the following documentation: Activity attended: One to one socialization Hung Activities Calendar Activity Type: PM (afternoon) activities Date: 2/1/26 Participation: Active On 2/5/26 at 4:00 p.m., during an interview with a surveyor, the Staff Development Coordinator stated that R16 passed away on 1/30/26. The surveyor confirmed R16's clinical record was inaccurately documented.