STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205117	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARIBOU REHAB AND NURSING CENTER	**10 BERNADETTE ST CARIBOU, ME 04736**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/5/25, an unannounced on-site visit was conducted at Caribou Rehab and Nursing Center to investigate facility reported incident #ME00051763. It was determined that Caribou Rehab and Nursing Center was not in compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility incident report, observation, and interviews, the facility failed to monitor an unlocked and/or non-alarmed door to prevent a resident identified as an elopement risk from leaving the building unnoticed. A staff member, who was informed by a visitor, told staff she saw a resident outside, unattended. The failure to have monitoring of unlocked, and/or non-alarmed doors, resulted in an avoidable elopement for 1 of 3 resident reviewed for elopement risk (Resident # 1 [R1]). Finding: R1 was admitted to the facility in February 2025 with a diagnosis of Dementia. R1 was identified as an elopement risk and wears a wander guard	F 689		

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
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F 689	Continued From page 1 alert (a safety device that alarms if resident wanders too close to a door). Review of R1's "Reportable Incident Form" dated 5/26/25 indicates that on 5/25/25 at approximately 3:15 p.m., "R1 was outside for thirty-three minutes and he/she was sitting in a wheelchair near the gazebo on the lawn across the employee parking lot". Another residents family member saw him/her outside ...R1 was wearing a wander guard, but the door was unlocked, and the wander guard did not alarm. On 6/5/25 at 3:15 p.m. in an interview with a surveyor, the Licensed Practical Nurse stated that on 5/25/25 she observed R1 outside with in a wheelchair, "stuck in the mud" we alerted other staff, and ran to bring R1 inside. On 6/5/25 at 5:00 p.m. in an interview with a surveyor, the Director of Nursing (DON) states the facility was able to determine through video surveillance footage that R1 exited the building from the D Wing door, it did not appear that the alarm from his/her wander guard went off or locked the door. R1 was returned to the facility on 5/25/25 at approximately 3:51 p.m., thirty-three minutes after elopement. R1 was outside on a day that was mild in temperature. R1 was assessed, and monitored, there were no lasting effects to R1. During this interview a surveyor confirmed that R1 had elopement unnoticed by staff.	F 689		