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 _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADIGAN ESTATES	93 MILITARY STREET HOULTON, ME 04730

(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 From 3/18/24 through 3/21/24, on-site visits were conducted at Madigan Estates for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined that Madigan Estates was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the State Mental Health authority for Pre-Admission Screening and Resident Review (PASRR) was notified of a newly added mental health disorder diagnosis to determine from a PASRR Level I screen if a	F 644	F 644 Coordination of PASSAR and Assessments R74's PASSAR was updated and to include Diagnosis of Bipolar Disorder and re-submitted. Report run for any new diagnosis that may require updating PASSAR. Applicable staff re-educated on PASSAR requirements. Administrator or Designee will complete weekly audits x 4 and then monthly x 2 reporting to QAPI Committee	3/27/24 04/05/24 4/09/24 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: April 5, 2024

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.

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F 644	Continued From page 1 change in level of service is required for 1 of 3 sampled residents reviewed for PASRR (Resident #74 [R74]). Finding: On 3/21/24, R74's clinical record was reviewed. Documentation indicated that R74 was admitted on 3/3/22 with a PASRR Level I screening that did not include the diagnosis of bipolar disorder. A review of the the resident information sheet dated 12/22/23, indicated the resident had a diagnosis of bipolar disorder, unspecified added to his/her diagnoses list 9/13/22. There was no evidence in R74's clinical record that the State Mental Health authority for PASRR was notified of this newly added diagnosis. On 3/21/24 at 10:28 a.m., in an interview with a surveyor, the Licensed Social Worker confirmed that the diagnosis was missed and the State Mental Health authority for PASRR was not notified.	F 644		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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F 684	Continued From page 2 Based on interviews, record review, and observation, the facility failed to ensure that a physician order for a mechanical soft diet was followed for 1 of 3 residents reviewed for nutrition (Resident #5 [R5]). Findings: On 3/18/24 at 10:34 a.m., in an interview with the surveyor, R5 stated, "The food is good most of the time, but I have a hard time chewing it." On 3/19/24 at 8:24 a.m., review of R5's clinical record indicated the physician's diet order initiated on 4/26/23 was "mechanical soft" diet texture for "trouble chewing, poor dentition". The care plan was updated on 4/27/23 to include a diet of "Regular Diet, Mechanical Soft. Cottage Cheese with all meals", for "nutritional problem or potential nutritional problem [related to] Diabetes, chronic illness, ..., failure to thrive, weight loss." On 3/19/24 at 11:55 a.m., the surveyor observed a CNA serve R5 a lunch consisting of a pork chop, a half of a baked potato with skin on, squash and pudding for dessert. The diet order displayed on the tray card read "consistency/regular". The resident requested it be replaced with a tuna sandwich. On 3/19/24 at 12:01 p.m., in an interview, a surveyor confirmed with Registered Nurse #1 that the diet order on the tray for R5 did not match the physician orders, and the physician's diet order for R5 was not followed. On 03/21/24 at 9:15 a.m., in an interview with a surveyor, Cook#1 stated he/she does not know the residents personally but knows their order by	F 684	F 684- quality of care R5's diet has been updated according to facility procedure to reflect the MD order. All Dietary orders for the facility have been reviewed for accuracy Review of facility procedure for diet changes and review will be completed during the next licensed staff meeting. Audits will be conducted by DON or designee weekly x 4, then monthly x 2 with reports to QAPI and CQI for further recommendations.	3-29-24 3-29-24 4-11-24 Ongoing

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F 684	Continued From page 3 name, unless it is a new resident, or the order has changed recently. Cook#1 stated "[R5] has a regular diet, regular consistency", and has been for the past year. On 3/21/24 at 11:05 a.m., in an interview with a surveyor and the Dietary Supervisor, Cook #2 stated R5 was on a regular consistency diet "for a while." On 3/21/24 at 11:10 a.m., in an interview with the surveyor, the Dietary Supervisor stated the diet orders for the trays are made by a staff member not in the kitchen. "If a resident's diet order changes over the weekend it could be two days before the diet changes." The surveyor confirmed with the Dietary Supervisor that R5's diet order was not followed.	F 684	F 695 - Respiratory Care R143's Respiratory equipment was observed to be connected correctly following the findings. Oxygen set up for all active users was reviewed for proper set up. Oxygen administration skills checklists will be reviewed and completed for all licensed staff	3-19-24 4-1-24 4-11-24
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to ensure respiratory care equipment was hooked up properly for 1 of 1 resident reviewed for respiratory care (Resident #143 [R143]) Finding:	F 695	Oxygen set up audits will be completed by DON or designee weekly x 4, then monthly x 2 to monitor compliance and knowledge of licensed staff. Results reported to QAPI and CQI for further recommendations.	ongoing

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F 695	Continued From page 4 R143 was admitted on 3/14/24 with diagnosis of hypoxic and hypercapnic respiratory failure secondary to cor pulmonale, sleep apnea and Chronic Obstructive Pulmonary Disease On 3/18/24 at 1:41 p.m. during resident interview and observation. The surveyor observed R143 was on oxygen at 2 liters/minute via nasal canula (NC), there was a humidification bottle that was not attached to the NC tubing. R143 NC was hooked up directly to the oxygen concentrator at 2 liters/minute. The clear tubing on top of the humidification bottle was sticking straight up in the air. On 3/19/24 at 7:30 a.m. an observation by a surveyor of R143 was that he/she was sitting in his/her recliner chair with the trilogy breathing apparatus on using a full mask. The oxygen concentrator was set on 2 liters, the oxygen tubing was attached to the humidifier bottle and the humidifier bottle was not attached to the concentrator. At 7:33 a.m. a second surveyor observed the set-up of R143's trilogy and oxygen concentrator and that the oxygen tubing was not attached correctly. At 7:36 a.m. the charge nurse RN#2 was asked to come review set up, she stated she replaced the humidification (water) bottle yesterday and the clear tube was already sticking straight up so she thought that was how it was supposed to be. The Minimum Data Set (MDS) nurse came into the room, RN#2 showed the MDS nurse how it was hooked up and the MDS nurse acknowledged that the clear tubing of the water bottle needed to be attached to the concentrator.	F 695		

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F 695	Continued From page 5 On 3/19/24 at 7:36 a.m. the surveyor confirmed the respiratory equipment was not hooked up properly with RN#2 and the MDS nurse.	F 695	F 761 Labeling and Storage of Drugs and Biologicals	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure expired medications and topicals were removed from the supply available for use in 2 of 2 treatment carts (#1 and #2), 1 of 1 medication carts (#2) and 2 of 2 medication	F 761	The identified expired medications have been removed from use. All medication storage areas have been reviewed for any further expired medications. Temperature logs have been replaced for the medication storage refrigerators. New thermometers to be installed allowing for computer tracking for compliance. Monthly audits to be completed by DON or designee to monitor for expired medications and proper storage conditions. Results reported to QAPI and CQI for further recommendations.	3-20-24 4-1-24 3-21-24 4-2-24 ongoing

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F 761	Continued From page 6 storage rooms (#1 and #2) reviewed. In addition, the facility failed monitor temperatures in a medication refrigerator that insulin was stored in for 1 of 2 medication storage rooms (#1). Findings: 1. Treatment Cart #1 On 3/20/24 at 1:20 p.m., a surveyor and Registered Nurse (RN)2 observed a tube of Medihoney Gel (used for wounds) with an expiration date of 2/1/24, a tube of Hydrophilic wound dressing with an expiration date of 1/24, and a tube of Aquaphor healing ointment with an expiration date of 11/22. 2. Treatment Cart #2 On 3/20/24 at 12:17 p.m., a surveyor and Licensed Practical Nurse observed a tube of Medihoney Gel with an expiration date of 2/1/24 and BioFreeze pain roll on with an expiration date of 2/23. 3. Medication Cart #2 On 3/20/24 at 10:25 a.m., a surveyor and Certified Nursing Assistant-Medication observed a tube of Benadryl Gel with an expiration date of 7/23. 4. Medication Storage Room #1 On 3/20/24 at 1:30 p.m., a surveyor and RN 2 observed in the cabinet, a bottle of Echinacea with an expiration date of 12/23 and in the medication refrigerator, a box of Bisacodyl suppositories with an expiration date of 11/22 and a box of Preparation H suppositories with an expiration date of 9/23. 5. Medication Storage Room #2	F 761		

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F 761	Continued From page 7 On 3/20/24 at 12:25 p.m., a surveyor and Licensed Practical Nurse observed 2 vials of Procrit (used to treat anemia) with an expiration date of 11/23. These findings were confirmed by the surveyor at the time of the observations. 6. Medication Refrigerator - Medication Storage Room #1 On 3/20/24 at 2:00 p.m., a surveyor and RN2 were unable to find the temperature log sheet for the medication refrigerator that insulin was stored in. On 3/20/24 at 2:38 p.m., during an interview with a surveyor, the Director of Nursing stated she was unable to find the temperature log sheet. On 3/20/24 at 3:15 p.m., during an interview with a surveyor, the DON stated that they were not able to find any temp sheets and when she asked a staff member if they were writing down the temps, they said that there wasn't a new sheet so it hasn't been documented. On 3/21/24 at 8:15 a.m., during an interview with a surveyor, the DON stated that after speaking with staff, they did have a temperature log but it was soiled and destroyed, so it was thrown away.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		

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F 812	Continued From page 8 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview facility failed to enure that food products were dated and labeled, and failed to ensure dented cans were taken out of circulation for use on 2 of 4 days of survey (3/18/24; 3/21/24). Findings: 1. On 3/18/24 at 10:00 a.m., a surveyor observed the following available for use on the shelves in dry storage: 2- 6 pounds 12 ounces (oz) cans of tapioca pudding; both cans were dented on the bottom seal. 1- open package of Roast Pork Gravy mix (11.3oz), undated. 1- open package of Imperial Cream Soup Base (28oz), undated. On 3/18/24 at 10:15 a.m., in an interview, a surveyor observed and confirmed these findings with the Dietary Supervisor. 2. On 3/21/24 at 9:30 a.m., a surveyor observed	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary Dietary Supervisor removed all dented cans from use. Disposed of any open packages without dates. Dietary Supervisor checked all storage for dates and dented cans. Review policies and procedures for sanitary storage/preparation/service with dietary staff during staff meeting Dietary Supervisor or designee to complete weekly audit x 4 then monthly x 2 reporting to QAPI Committee	3/21/24 03/21/24 04/05/24 ongoing

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F 812	Continued From page 9 the following: 1- bag of crinkle cut fries, open and undated, in the walk-in freezer. 1- package of unidentified meat, open, unlabeled, and undated in walk-in refrigerator. 1- open head of lettuce, undated and open to environment, in the walk-in refrigerator. On 3/21/24 at 9:30a.m., in an interview, the surveyor observed and confirmed the above findings with Cook #1.	F 812	F 842 Physician orders Order signatures obtained for orders recognized as being unsigned for R144 and R83. All orders reviewed for having either an electronic or wet signature present. Education provided to all licensed staff regarding order entry for verbal/phone vs prescriber written orders. Order audits to be completed by DON or designee weekly x 4, then monthly x 2 for signed order present. Findings to be reported to QAPI and CQI for further recommendations.	3-27-24 3-29-24 3-25-24 ongoing
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		

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F 842	Continued From page 10 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842		

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F 842	Continued From page 11 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 20 residents reviewed for catheter use and for medication and treatment administration (Resident #144 and #83 [R144, R83]). Findings: A review of R144's clinical record, a nursing noted dated 3/17/24 at 9:55 p.m. for communication - with Physician that addresses R144 removing their foley catheter with balloon intact, this was the second time R144 had removed the foley. Recommendations from the provider was for a bladder scan at 2:00 a.m. Nursing note dated 3/18/24 at 3:37 a.m. of communication with physician with recommendations to hold catheter until morning care or scan shows above 400 cubic centimeters (cc) On 3/19/24 Review of R144's clinical record lacks evidence of the verbal order being written and entered into R144s physician orders. On 3/19/24 during an interview with the Director of Nursing (DON) the surveyor confirmed there was no written order for the discontinuation of the foley or the bladder scan to be completed with morning care. On 3/19/24 at 10:51 a.m. a nursing note was written that a provider ordered 40 milliequivalent (mEq) of potassium by mouth once at 8:45 a.m.	F 842		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADIGAN ESTATES	93 MILITARY STREET HOULTON, ME 04730

(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 842	Continued From page 12 then ordered another dose of 40 mEq to be given 4 hours later at 12:45 p.m. and a potassium level to be drawn at 4:00 p.m. On 3/21/24 at 12:00 p.m. during record review R144s clinical record lacked evidence of a verbal order being written for the use of potassium supplement to address a critical potassium lab level. On 3/21/24 at 12:05 P.M. during an interview with the DON the surveyor confirmed that there was no written order for the use of the potassium supplement. On 3/21/24 during a record review for R83 it was noted that he/she had an order for insulin Glargine 20 units subcutaneous every am. R83 has not received any insulin since 2/12/24. The clinical record lacks evidence of a physician order being obtained to discontinue the insulin order. On 2/21/24 at 10:00 a.m. during an interview and record review with the DON and Assistant DON the clinical record lacked evidence of an order being written to discontinue the use. The clinical record had a nursing note dated 2/12/24 at 10:46 showing documentation that the nurse practitioner was made aware and the nurse received a new order to discontinue fingerstick and insulin. There was no evidence of this order being written. On 2/21/24 at 10:00 a.m The surveyor confirmed the above finding at this time.	F 842		