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 _____	C 11/14/2023

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

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F 000	INITIAL COMMENTS On 11/14/23, an unannounced on-site visit was conducted at Madigan Estates for the purpose of investigating facility reported incidents #ME00044184, #ME00044724, #ME00045100, and #ME00045384. It was determined that Madigan Estates was in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 607 SS=B	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 607	Continued From page 1 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on facility policy review, the facility reportable incident report, investigation review, employee timecard review, and interview, the facility failed to protect residents from further abuse by allowing the alleged perpetrator to work 2 of 2 scheduled shifts (7/4/23 and 7/5/23), prior to investigation completion. Finding: The facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy, revised September 2022, indicated the following: Under Investigation Allegations, the policy indicated "Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete." On 11/14/23, a surveyor reviewed the initial report dated 7/03/23; the family of Resident [R]1 was concerned because R1 claimed a staff member had hit him/her and caused skin tears to both hands which were found the early morning of 6/29/23. On 7/03/23, the facility faxed to the state agency an allegation of abuse, which identified Certified Nurse Assistant [CNA]1 as the accused staff member. On 7/06/23, the facility faxed in a 5 day follow up report regarding this incident. A review of CNA1's timecard indicated CNA1 clocked in on July 4th at 9:57 p.m. and worked	F 607		

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F 607	Continued From page 2 until July 5th at 7:21 a.m.; CNA1 clocked in again on July 5th at 9:58 p.m. and worked until 6:36 a.m. July 6th. On 11/14/23, at 2:51 p.m., during an interview with the Director of Nursing [DON], the surveyor asked, "why was CNA1 allowed to work before the investigation was completed?" DON stated the facility felt that it was not a valid allegation and it's hard to take a great CNA off the floor when they have no complaints about the care he provides. The surveyor confirmed that CNA1 was allowed to work providing resident care before the investigation was completed.	F 607		
F 689 SS=G	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 facility reported incident review, facility investigation, record review, and interviews, the facility failed to ensure that a resident received the proper level of assistance during a transfer when a Certified Nursing Assistant (CNA) did not review how the resident transferred and used a single assist bear hug method, when the resident was a two person Hoyer Mechanical Lift for 1 of 1 incidents received (10/26/23). The failure to transfer the resident via Hoyer Lift resulted in Resident #2 [R2] requiring transfer to an acute	F 689	Past noncompliance: no plan of correction required.	

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care hospital, sustaining a non-displaced fracture proximal to the right tibia, experiencing pain and anxiety after the injury occurred.

On 11/14/23, the facility reported incident (FRI) and facility investigation sent to the Division of Licensing and Certification (State Agency) were reviewed. The FRI indicated that on 10/26/23 at 8:00 a.m., "CNA #2 attempted to transfer Resident # [R]2 from the bed to a chair. R2 is ordered to transfer via Hoyer (Mechanical) Lift. CNA #2 did a bear hug, stood R2 to his/her feet and heard a crack. R2 complained of right knee pain."

The facility investigation, dated 10/30/23, indicated that CNA #2 reported to the Supervisor immediately and the Medical Provider and nurse went to assess R2 who was sent to the hospital for treatment. At the hospital, an X-ray was completed with a result of a non-displaced fracture proximal to the right tibia metaphysis and R2 returned to the facility with a leg immobilizer and orders for pain management.

On 11/14/23, R2's clinical record was reviewed and included the following:
On 10/26/23 at 2:59 p.m., a nurses note written by Registered Nurse (RN) #2 indicated that R2 was medicated with Tramadol for pain when he/she returned to the floor (unit).
On 10/26/23 at 6:27 p.m., a nurses note written by RN #2 indicated that he had discussed with provider about pain control with concern PRN (as needed) Tramadol may not be enough and an order for scheduled Tramadol three times a day and keeping the PRN for breakthrough pain.
On 10/26/23, a physician order was written for

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Tramadol 25 milligrams (mg) three times a day, resident to be non-weight bearing, and to wear and secure the knee immobilizer at all times.
On 10/27/23 at 9:42 p.m., the resident was medicated for with Ativan for anxiety and Tramadol for pain.
On 10/27/23 at 5:11 a.m., a nurse's note written by RN #3 indicated R2 had been awake all shift and was medicated for pain and anxiety when incontinence care was done at approximately 2:00 a.m. R2 remained awake rest of night fidgeting with knee immobilizer and staff continued to remind him/her of injury to leg. There were no signs of pain without movement and minimal to moderate with movement but subsided when done; R2 was premedicated with little effect. Dark purple bruising to most of right leg noted and large fluid filled blister seen on shin, but RN #3 was unable to view all of the area due to immobilizer. RN #3 ensured straps were not too tight as there was swelling noted to leg/knee area and was unsure of how occurred or just from injury itself. Will continue to comfort resident and monitor for pain and anxiety.
On 10/27/23, order to ice the right leg every 2 hours for swelling was added and discontinued on 11/6/23.

R2's physician orders indicated the resident had an order for Ativan scheduled once a day and a PRN order that could be given every 4 hours. A review of R2's Medication Administration Record (MAR) indicated that R2 received PRN Ativan for the month of October 2 times prior to the incident and 7 times from 10/26/23 thru 10/31/23. A review of November's MAR indicated that R2 had received PRN Ativan thru 11/14/23, 15 times.

R2's physician orders indicated the resident

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already had a PRN order for Tramadol every 4 hours as needed in addition to the new order for the scheduled Tramadol 3 times a day. For the month of October, the PRN Tramadol was used 3 times prior to the incident and 10 times after the incident (in addition to the scheduled Tramadol that was ordered on 10/26/23). A review of November's MAR indicated that R2 had received PRN Tramadol thru 11/14/23, 13 times in addition to the scheduled Tramadol.

On 11/14/23 at 3:33 p.m., during an interview with a surveyor, CNA #2 stated that she usually worked on a different wing than Spruce (which is where R2 resided). She wanted to get R2 up for breakfast and looked around for R2's CNA. She stated she didn't know about the Kardex, that she wasn't trained specifically on it and couldn't find a CNA or nurse. CNA #2 stated, "I helped the patient up, he/she sat fine at the edge of the bed, so I continued to 1 assist transfer." She further stated that R2 had a leg between her legs and one of her legs was between R2's legs. "When I started, I heard a crack and immediately put R2 down". The surveyor asked CNA #2 before this incident occurred, how did you know how a resident transferred and CNA #2 replied, "I didn't know about the Kardex. I wasn't specifically trained. The only training I had with the system was with another CNA."

On 11/15/23 at 2:10 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated that a copy of the paper Kardex that was printed and available at the nurses' station was kept in a binder labeled "Spruce Kardex". Each unit has a binder with printed versions of the online Kardex and that there are also cheat sheets the Unit Manager created to help communicate needs of

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the resident. The DON further stated that staff are provided username and passwords within their first few shifts as a CNA. They were shown the electronic charting system (Point Click Care) via peer-to-peer review where they access the system and were given an overview of how to navigate the documentation.

A review of the electronic Kardex, printed on 5/23/23, indicated that R2 transferred by Mechanical Lift Hoyer with 2 staff assistance; a review of the "paper cheat sheet", last updated 10/3/23, that the CNAs used for residents that resided on Spruce indicated that R2 was transferred with full lift with 2 persons assist. On 11/14/23, a review of the current care plan, included under the Focus of Activities of Daily Living (ADL) Self-care performance, indicated that the resident required Mechanical Lift Hoyer with 2 staff assistance for transfers which was initiated on 8/26/22.

CNA #2 was hired on 4/20/23 as a CNA. Highlighted in the duties of a CNA included, "Review care plans daily to determine if changes in the resident's daily care routine have been made on the care plan." CNA #2 signed this job description on 4/20/23.

As a result of this isolated incident, the following corrective actions were initiated:

- On 10/26/23, CNA #2 immediately notified her supervisor that she heard "a crack" during the transfer. The Medical Provider was in the building and assessed the resident who was sent to the hospital by ambulance for treatment.
- On 10/26/23, education was provided to CNA #2 on the importance of following the Kardex at all

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F 689	Continued From page 7 times, reviewed how to access online, and need to review before each shift. - Between 10/31/23 thru 11/3/23, trainings were provided to staff regarding Kardex review, documentation, and report.	F 689		