Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0355	A. BUILDING: _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADIGAN HOUSE	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) COMPLETE DATE
P 000	Initial Comments On 11/5/24, an unannounced on-site visit was conducted at Madigan House to investigate facility reported incident's #ME00048680, #ME00048520, #ME00048520, and #ME00047765. It was determined that Madigan House was not in substantial compliance with 10/144, Chapter 113- Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 494 SS=D	12.3 Standards for Resident Care Service plan: A service plan shall be developed and implemented within thirty (30) calendar days of admission for each resident based upon the findings of the resident assessment instrument (RAI). The plan shall address those areas in which the resident needs encouragement, assistance or an intervention strategy. The resident, his/her legal representative (if applicable) and others chosen by the resident shall be actively involved in the development of the service plan, unless he/she is unable or unwilling to participate. There shall be documentation in the resident's record identifying who participated in the development of the service plan. The service plan shall describe strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Residents shall be encouraged to be as independent as possible in their functioning, including ADLs and IADL's if they choose, unless contraindicated by the resident's duly authorized licensed practitioner. The service plan shall be modified, as necessary, based upon identified changes. Residents shall	P 494		

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P 494	Continued From page 1 never be required to perform activities specified in the residential service plan or any other activities and cannot be used to replace paid staff. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident had a service plan and care plan to include strategies and approaches to meet the resident's needs for monitoring of a wander guard for resident at risk for elopement for 1 of 3 sampled residents (Resident #1, [R1]). Findings: R1 was admitted to Madigan House on 6/29/24, review of R1's clinical record, states a note from Social Service on 6/25/24 that R1 is a "known wander risk" prior to admission. R1's progress notes dated 6/27/24 at 10:22 a.m. states, "He/she has been wandering around the unit, ..." "Code alert is on his/her right wrist for elopement risk." There is no evidence of a service plan or care plan for R1. The medication administration record lacks evidence of monitoring of the "code alert", wander guard bracelet, and was confirmed at time of interview. On 11/5/24 at 11:16 a.m., in an interview with a surveyor, the Assistant Administrator, and Registered Nurse, Director of Nursing stated they were unable to find a completed service plan, completed care plan, or medication administration record to monitor for a wander guard for R1.	P 494	All residents will have an elopement risk evaluation completed. New residents to facility will have an evaluation completed within 7 days of admission. All residents be reevaluated at least once per calendar year or as necessary. If evaluation indicates that a "wanderguard" is to be used to aid in the prevention of an elopement the resident will wear the device and it will be tested weekly. There will be an entry on the MAR to check once on the day shift and once on the night shift that the device is present on the resident. This check will be preformed by the CRMA. This will be documented in the MAR The DON will monitor for compliance and submit an audit monthly to the Administrator. The audit will be continue for 6 months.	1/1/25