MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES LICENSING AND CERTIFICATION ASSISTED HOUSING

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION **Biennial Survey**	Date Completed: 3/21/23
Name of Facility: BOLSTER HEIGHTS RESIDENTIAL CARE Administrator: MERISSA POLAND PNMI Level IV Residential Care Facility. Census: 80 Total Capacity: 84 License Number: PND109	Address: 26 BOLSTER ST AUBURN, ME 04210-5302

Summary Statement of Deficiencies	Plan of Correction	Completion Date
Bolster Heights Residential Care, a Level IV PNMI Residential Care Facility, is not in compliance with the "Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level IV PNMI Residential Care Facilities, Part of 10-144, Chapter 113". The following requirements were not met: **Section 7- Medications and Treatments** **7.1.4** Unlicensed assistive personnel must be trained by a registered professional nurse in regard to the management of persons with diabetes. The registered professional nurse must provide in-service training and documentation to include: *[Class III]* **7.1.4.1** Dietary requirements; **7.1.4.2** Anti-Diabetic Oral medications – inclusive of adverse reactions and interventions, hyper and hypo glycemic reactions; **7.1.4.3** Insulin mixing including insulin action; **7.1.4.4** Insulin storage; **7.1.4.5** Injection techniques and site rotation; **7.1.4.6** Treatment and prevention of insulin reaction including signs/symptoms;	Section #7- Document attached from Merissa Poland providing proof of education from instructor [redacted]	10/06/2022

Signature of Administrator: _____ Date: 4/12/23

(Signature binding on all 6 page(s))

Summary Statement of Deficiencies	Plan of Correction	Completion Date
7.1.4.7 Foot care; **7.1.4.8** Lab testing, urine testing and blood glucose monitoring; and **7.1.4.9** Standard Precautions. Documentation of training shall be included in the employee record. Review of this training shall be on an annual basis. *This has not been met as evidenced by:* Based on a review of four employee records and an interview with staff, the facility failed to provide evidence of annual diabetes training. Finding: On 3/21/23 records were reviewed for Employees #1-4. There was no evidence of annual diabetes training found in the records. On 3/21/23 at approximately 2:30pm the Administrator was, who stated that she would have the records sent over from the nurse trainer. As of 3/24/23 the records had not been received by licensing staff.		
7.7 **Expired and discontinued medications**. For medications administered by the assisted living program, residential care facility, or private non-medical institution, medications shall be removed from use and properly destroyed after the expiration date and when discontinued, according to procedures contained in Section 7.9. They shall be taken out of service and locked separately from other medications until reordered or destroyed. *[Class III]*	7.7- Medication was removed from cart on date of Survey by LPN [redacted] D/C med(s) moving forward will be removed at time of noting/ transcription of a D/C order by person transcribing order.	03/22/2023

Date Completed: 4/12/23

Summary Statement of Deficiencies	Plan of Correction	Completion Date
This has not been met as evidenced by: Based on a review of one resident record and an interview with staff, the facility failed to remove discontinued medication from service and lock it separately from in use medication until destroyed. Finding: On 3/21/23 the medication record and storage were reviewed for Resident #3. Discontinued medications were found being stored with active medications. Levothyroxine, Amiodarone, and Atorvastatin were discontinued on 3/9/23 by the duly authorized licensed practitioner. Aspirin, Farxiga, and Losartan were discontinued on 3/2/23 the duly authorized licensed practitioner. Protonix was discontinued on 2/9/23 by the duly authorized licensed practitioner. On 3/21/23 at approximately 1pm Employee #2 was interviewed, who confirmed this finding. **Section 12 - Standards for Resident Care** **12.3 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	12.3 - Service Plan has been corrected to reflect the changes of care. Moving forward these changes will be communicated to MDS coordinato[redacted]n the event of the change.	03/22/2023

Date Completed: 4/12/23

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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 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 has not been met as evidenced by:* Based on a review of one resident record and an interview with staff, the facility failed to modify the service plan based upon identified changes of care needs and services. Finding: On 3/21/23 the record was reviewed for Resident #3. Resident # 3 was admitted to hospice services on 2/22/23. The current service plan for Resident #3 was not updated to reflect care changes related to transitioning to hospice care. On 3/21/23 at approximately 11am Employee #1 was interviewed, who was unable to locate a more current service plan for Resident #3. **15 SANITATION/DIETARY SERVICES** **15.3 Food storage.** All food shall be stored using safe and sanitary methods. *[Class III]* **15.3.3** Shelving in storage areas, refrigerators and freezers shall be in good condition with cleanable surfaces.	15.3 - Refrigerator shelving has been replaced with stainless steel shelving by maintenance Supervisor [redacted].	03/14/2023

Date Completed: 4/12/23

Summary Statement of Deficiencies	Plan of Correction	Completion Date
This has not been met as evidenced by: Based on observation and staff interview, the facility failed to ensure shelving in a refrigerator was in good condition with cleanable surfaces. Finding: On 3/8/23 the Health Facility Specialist observed a facility "Glenco" refrigerator. Refrigerator racks were observed to have worn finish and rusting, creating a difficult to clean surface. **16 SANITATION/PHYSICAL PLANT REQUIREMENTS** **16.6 General condition of the facility and surrounding premises.** **16.6.1** The facility and surrounding premises shall show evidence of routine maintenance and housekeeping and repair of wear and tear shall be made in a timely fashion. *This has not been met as evidenced by:* Based on observation and staff interview, the facility failed to ensure there was evidence of routine maintenance and housekeeping in some areas.	16.6.1- Routine maintenance and housekeeping logs have been implemented and will be kept with maintenance supervisor [redacted] [redacted]	04/12/202

Date Completed: 04/12/23

Summary Statement of Deficiencies	Plan of Correction	Completion Date
Findings: On 3/8/23 the Health Facility Specialist toured the facility and observed the following: 1) Bathroom in Room 2 was observed to have a damaged interior door with chipped paint creating an uncleanable surface. 2) Bathroom in Room 3 was observed to have a small hole in the wall. 3) Bathroom in Room 28 was observed to have yellow stains on the wall vent. 4) Shower room in "Little House" unit was observed to have peeling paint on the wall by the soap dispenser creating an uncleanable surface. 5) Thermostat in Room 47 was missing a cover. 6) Thermostat in the hall by Room 37 was missing a cover. 7) Exterior handrail located at the rear of facility was observed to have a handrail repaired with duct tape and had slight wobble. All Health Facilities Specialist findings were reviewed with Director of Ancillary Services at the time survey and reviewed with Administrator via telephone call at exit interview on 3/8/23.	1) Door has been replaced 2) Hole will be filled temporarily as bathroom is on the remodeling project list. 3) Wall vent has been cleaned 4) Area has since been repainted. 5) Cover has been replaced 6) Cover has been replaced 7) Hand rail has been replaced. For 1-7 above maintenance Supervis[redacted] observed completion of all	03/30/2023 04/12/2023 03/08/2023 04/12/2023 04/05/2023 04/05/2023 04/11/2023

Date Completed: 04/12/23