



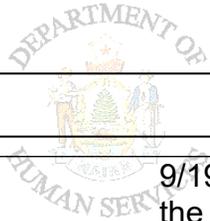
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES LICENSING AND CERTIFICATION ASSISTED HOUSING

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION Biennial Survey		Completion Date 10/11/2024
Name of Facility: Coastal Shores, Inc Administrator: Wendy Rider PNMI Level IV Residential Care Facility. Census: 39 Total Capacity: 40 License Number: PND2380	Address: 142 Neptune Dr Brunswick, ME 04011-2882	
Summary Statement of Deficiencies	Plan of Correction	Completion Date

<p>Coastal Shores, Inc, a Level IV Residential Care Facility, is not in compliance with the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level IV Residential Care Facilities and Infection Prevention and Control, Part of 10-144, Chapter 113.</p> <p>The following was not met:</p> <p>7 Medications and Treatments</p> <p>7.1 Use of safe and acceptable procedures. The administrator shall ensure that all persons administering medications and treatments (except residents who self-administer) use safe and acceptable methods and procedures for ordering, receiving, storing, administering, documentation, packaging, discontinuing, returning for credit and/or destroying of medications and biologicals. All employees must practice proper hand washing and aseptic techniques. A hand-washing sink shall be available for staff administering medications. [Classes I]</p> <p>This has not been met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to use safe and acceptable procedures for storage and when documenting and administrating a resident's medication. (Resident #4.)</p>	<p>Click or tap here to enter text.</p>	<p>Click or tap here to enter text.</p>
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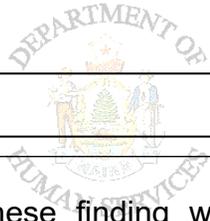
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<p>Findings:</p> <ol style="list-style-type: none">1. On 10/2/2024 an inspection of the medication cart was completed. The medication cart contained a pill crusher that had medication debris in it that had not been cleaned out. <p>An interview was conducted with the Resident Care Director (RCD) who confirmed this finding.</p> <ol style="list-style-type: none">2. On 10/2/2024 Resident #4's duly authorized licensed practitioner orders, 7/1/2024 through 10/1/024 Medication Administration Records (MAR), individual count sheet and medication inventory was reviewed. The following information was obtained:<ul style="list-style-type: none">• Resident #4 had a signed doctors order from 6/27/2024 for Lorazepam 2 mg/ml oral concentrate, take 0.25 ml by oral route once a day and may repeat every 6 hours as needed. Resident #4's MAR for July 2024 showed the Lorazepam 2 mg/ml oral concentrate to be discontinued on 7/2/2024. There was no evidence of discontinued order in the record or as requested for review.• Resident #4's medication administration individual count sheet listed Lorazepam 2 mg/ml oral concentrate as being given on 7/25/24, 7/30/24, 8/31/2024, 9/1/2024 through 9/8/2024, 9/10/2024 through 9/17/2024 and 9/19/2024 through 10/1/2024. Resident #4's MARs from 8/1/2024 through 10/1/2024 did not contain Lorazepam 2 mg/ml oral concentrate as a medication given to Resident #4.• Resident #4's MARs from 7/1/2024 through 10/1/2024 contained Lorazepam oral tablet 0.5 mg take 1 tablet by mouth once a day. On 7/30/2024, 8/31/2024, 9/1/2024 through 9/8/2024, 9/10/2024 through 9/17/2024, and		



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<p>9/19/2024 through 10/1/2024 the MARs were initialed as the Lorazepam oral tablet 0.5 mg's being given, however the medication administration individual count sheet record indicated Lorazepam oral concentrate was administered on those days, not the tablets. The Lorazepam oral concentrate liquid and tablet inventories at the time of survey indicated the MAR documentation for Lorazepam tablet administration was not consistent with staff administration of the concentrate liquid Lorazepam.</p> <p>On 10/2/2024 at approximately 11:30 AM an interview was conducted with the Residential Care Director (RCD) and Employee # 8. Both confirmed that Resident #4 had just been receiving the Lorazepam Oral Concentrate in place of the Lorazepam Oral Tablet.</p> <p>7.1.1 Residents shall receive only the medications ordered by his/her duly authorized licensed practitioner in the correct dose, at the correct time, and by the correct route of administration consistent with pharmaceutical standards. [Class II]</p> <p>This has not been met as evidenced by:</p> <p>Based on record review, observation, and interview the facility failed to follow duly authorized licensed practitioner orders for a medication, resulting in the resident receiving the incorrect dose of a prescribed medication for 1 of 4 resident records reviewed. (Resident #4)</p> <p>Findings:</p> <p>On 10/2/2024 a review of Resident #4's doctors' orders, 7/1/2024 through 10/2/2024 Medication Administration Records (MAR), and</p>		



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<p>Schedule II bound book/ individual count sheet were reviewed. The following information for two medications was obtained:</p> <ol style="list-style-type: none">1. Resident #4's duly authorized licensed practitioner order written on 7/3/2024 was for the following "Morphine Concentrate 20mg/ml give 5 mgs PO at 12PM and 8PM, may give 5mgs Q1 hour PRN for pain". Resident #4's individual count sheet in the Scheduled II bound book showed that Resident #4 received Morphine Concentrate scheduled 3 times a day (11:00 a.m., 4:00 p.m., and 8:00 p.m.) from 9/22/2024 through 9/23/2024 and 9/25/2024 through 10/1/2024. The individual count sheet was consistent with the observed inventory amount of Morphine. On 10/2/2024 an interview was conducted with the Residential Care Director (RCD) and Staff #8 who confirmed that the Morphine Concentrate had been given 3 times a day scheduled from 7/3/2024 through 10/1/2024 and inconsistent with the signed doctors order.2. Resident #4 had a duly authorized licensed practitioner order written on 7/2/2024 for "Lorazepam 0.5 mg tab once/day at 4pm." Resident #4's 07/03/2024 through 10/1/2024 Medication Administration Record (MAR) was initialed as this medication being given on the dates indicted above. The Individual count sheet for Lorazepam 20 mg/ml Oral Concentrate indicated that it was given on 7/30/2024, 8/31/2024, 9/1/2024 through 9/8/2024, 9/10/2024 through 9/17/2024, and 9/19/2024 through 10/1/2024. On 10/2/2024 at approximately 11:30 AM an interview was conducted with the Residential Care Director (RCD) and Employee # 8. Both confirmed that Resident #4 had been receiving the Lorazepam Oral Concentrate in place of the Lorazepam Oral Tablet on the dates indicated above.		



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<p>These finding were confirmed with the Administrator at the exit interview on 10/2/2024.</p> <p>7.1.7.1 Upon admission to another facility, all existing orders are no longer in effect. Upon return to the facility, all orders must be reviewed and approved by the resident's duly authorized licensed practitioner within 72 hours. During that timeframe, orders that are signed and dated by the discharging duly authorized licensed practitioner are the current acceptable orders. Prior to admission to another facility all medications must be removed from service and placed in a locked area in accordance with Section 7.7.</p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview a resident's discharging duly authorized licensed practitioner orders from another facility were not reviewed and approved by the resident's duly authorized licensed practitioner within 72 hours for 1 of 4 Resident records reviewed. (Resident #1.)</p> <p>Finding:</p> <p>On 10/2/2024 a review of Resident #1's September 2024 Medication Administration Record (MAR), duly authorized licensed practitioner orders and Point Click Care (PCC) notes was completed. The following information was obtained:</p>		



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<p>Resident #1's September 2024 and PCC notes indicated that the resident was hospitalized from 9/20/2024 through 9/25/2024. The facility had discharging duly authorized licensed practitioner orders dated 9/25/2024 from the hospital that included Resident #1's medication orders, but there was no evidence that these orders had been reviewed and approved by the resident's duly authorized licensed practitioner.</p> <p>On 10/2/2024 interviews was conducted with the RCD (Residential Care Director) and Registered Nurse (RN) at the time of the survey, who confirmed that the facility had not obtained updated orders for any of Resident #1's medication orders after the resident's discharge from the hospital.</p> <p>This finding was also reviewed with the Administrator at the exit interview on 10/2/2024.</p> <p>7.3 Medication storage.</p> <p>7.3.2 Medications administered by the assisted living program, residential care facility, or private non-medical institutions shall be kept in their original containers in a locked storage cabinet. The cabinet shall be equipped with separate cubicles, plainly labeled, or with other physical separation for the storage of each resident's medications. It shall be locked when not in use and the key carried by the person on duty in charge of medication administration. [Class III]</p> <p>This has not been met as evidenced by:</p>		



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<p>Based on observation and interview, the facility failed to ensure resident medications were stored separately.</p> <p>Finding:</p> <p>On 10/2/2024 at 10:30 AM an inspection of the medication cart was completed. Multiple Resident nasal sprays, vitamins, and inhalers were observed to be stored loosely with no separation in a compartment in the medication cart.</p> <p>On 10/2/2024 at 10:30 AM an inspection of the controlled medications kept doubled locked were observed to be stored with no separation between residents in the compartment in the medication cart.</p> <p>This finding was confirmed with the Residential Care Director (RCD) at the time of survey and reviewed with the Administrator at the exit interview on 10/2/2024.</p> <p>7.7 Expired and discontinued medications. For all medications administered by the residential care facility, 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]</p> <p>This has not been met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure that a discontinued medication was removed from use and properly destroyed for 1 of 4 residents reviewed. (Resident #1.)</p> <p>Finding:</p>		



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<p>On 10/2/2024 Resident #1's medication orders were reviewed, and medication inventory observed. One medication (Jardiance) discontinued on 9/20/2024 was stored with resident's active medications.</p> <p>This finding was confirmed with the RCD at the time of the survey and reviewed with the Administrator at the exit interview on 10/2/2024.</p> <p>7.12 Medication/treatment administration records (MAR) for medications administered by the residential care facility.</p> <p>7.12.1 Individual medication/treatment administration records shall be maintained for each resident and shall include all treatments and medications ordered by the duly authorized licensed practitioner. The name of the medication, dosage, route and time to be given shall be recorded in the medication/treatment administration record. Documentation of treatments ordered and time to be done shall be maintained in the same manner. These rules apply only to treatments ordered by licensed health care professionals. [Class III]</p> <p>This has not been met as evidenced by:</p> <p>Based on record reviews and interview, the facility failed to ensure that all treatments ordered by a duly authorized licensed practitioner were included on the Medication Administration Records (MAR) for 2 of 4 resident records reviewed (Resident #2 and Resident #4).</p> <p>Findings:</p>		



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<p>1. Resident #2's duly authorized licensed practitioner orders were reviewed. A signed order from 9/5/2024 contained Una Boots, change once a week and PRN if soiled. A review of Resident #2's MAR from 9/5/2024 through 10/1/2024 did not list this treatment.</p> <p>2. Resident #4 order for "Morphine Concentrate 20mg/ml give 5 mgs PO at 12PM and 8PM, may give 5mgs Q1 hour PRN for pain" was incorrectly transcribed to the MAR as "Morphine Concentrate give 5mg's by mouth three times a day for SOB."</p> <p>This finding was confirmed with the Residential Care Director (RCD) at the time of the survey and with the Administrator at the exit interview on 10/2/2024.</p> <p>7.12.2 Whenever a medication or treatment is started, given, refused or discontinued, including those ordered to be administered as needed (PRN), the medication or treatment shall be documented on the medication/treatment administration record. It shall be initialed by the administering individual, with the full signature of the individual written on the first page of each month's MAR. A medication or treatment shall not be discontinued without evidence of a stop order signed and dated by the duly authorized licensed practitioner. <i>[Class III]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on record reviews and interview, the facility failed to ensure that all medications signed by a duly authorized licensed practitioner were not discontinued without evidence of a stop order for 1 of 4 resident</p>		



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<p>records reviewed. (Resident #4). In addition, the facility incorrectly initialed medications as being given for 1 of 4 resident records reviewed. (Resident #4.)</p> <p>1. Resident #4's duly authorized licensed practitioner orders were reviewed. A signed order from 6/27/2024 contained Lorazepam 2mg/ml, take 0.2 ml once a day and may repeat every 6 hours as needed. A review of Resident #4's MARs for 7/1/2024 through 10/1/2024 showed the medication as being discontinued on 7/2/2024 and on 8/1/2024 through 10/1/2024 MARs, the medication was not listed. There was no evidence in the record of a stop order signed by the practitioner.</p> <p>On 10/2/2024 an interview was completed with the Residential Care Director (RCD) who confirmed that the facility did not have evidence of a stop order for the Lorazepam oral concentrate.</p> <p>2. Resident #4's individual count sheet and MARs for 7/1/2024 through 10/1/2024 showed the following: Resident #4's MAR from 7/1/2024 through 10/1/2024 contained a transcription for Lorazepam oral tablet 0.5 mg take 1 tablet by mouth once a day. On 7/30/2024, 8/31/2024, 9/1/2024 through 9/8/2024, 9/10/2024 through 9/17/2024, and 9/19/2024 through 10/1/2024 the MAR was initialed as the Lorazepam oral tablet 0.5 mg's as administered. The Lorazepam tablet inventory was inconsistent with the MAR documentation and the Lorazepam Oral concentrate 0.25 ml individual count sheet showed that oral concentrate was administered and documented as tablets on the MARs.</p> <p>A bubble pack of Resident #4's Lorazepam oral tablets was located in the cart, labeled as filled on 9/9/2024, and showed that the bubble pack had only been used on 9/18/2024.</p>		



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<p>On 10/2/2024 at approximately 11:30 AM an interview was conducted with the Residential Care Director (RCD) and Employee # 8. Both confirmed that Resident #4 had been receiving the Lorazepam Oral Concentrate in place of the Lorazepam Oral Tablet.</p> <p>11 Administrative and Resident Records</p> <p>11.1.7 Incident reports. An incident report shall be completed for any resident who has sustained or caused a fall, injury or accident in the facility, while being transported by the facility, or in an activity supervised by facility staff, who unsafely wanders from the facility, who is involved in an altercation with another resident, who has a medication reaction, or when an error is made in the documentation or administration of medication. The report shall describe the incident and indicate the extent of the injury or reaction and necessary treatment. The dispensing pharmacy shall be consulted regarding incidents involving medications, in order to assist in assessing adverse drug reaction, drug-drug interaction, drug-food interaction and allergies/sensitivities. If, in the opinion of the administrator or person in charge, the incident is not serious enough to call an examining duly authorized licensed practitioner, an incident report shall still be recorded in the resident's record. The administrator shall initial the record within seventy-two (72) hours. If examination and treatment by a duly authorized licensed practitioner is necessary as a result of an incident, the facility shall notify the guardian or conservator as soon as possible, within seventy-two (72) hours.</p>		



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<p>This has not been met as evidenced by:</p> <p>Based on record review and interview incident reports were not initialed by the Administrator within 72 hours of the incident occurring.</p> <p>Finding:</p> <p>On 10/1/2024 a review of Point Click Care historical incident reports from 7/30/2024 through 10/1/2024 was completed. 20 incident reports were not initialed, during the timeframe above, by the Administrator within 72 hours of the incident occurring. Examples are as follows:</p> <ol style="list-style-type: none">1. 7/22/24 unwitnessed fall signed off by Administrator on 8/5/20242. 7/24/2024 unwitnessed fall signed off by Administrator on 8/5/20243. 7/30/2024 unknown incident signed off by Administrator on 8/5/20244. 8/1/2024 unwitnessed fall signed off by Administrator on 8/5/20245. 8/26/2024 unwitnessed fall signed off by Administrator on 9/9/20246. 8/27/2024 self-inflicted injury signed off by Administrator on 9/9/20247. 9/11/2024 unwitnessed fall signed off by Administrator on 9/27/2024 <p>An interview was completed with the Administrator at the time of the survey who confirmed these findings.</p>		



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<p>Sanitation/Physical Plant Requirements</p> <p>16.10 Water temperatures. Water temperatures in resident areas shall not exceed one hundred twenty degrees (120°) Fahrenheit. Hot water shall be supplied in adequate quantities. <i>[Class III]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on observation and an interview, the facility failed to ensure water temperatures in resident areas did not exceed 120 degrees Fahrenheit.</p> <p>Finding:</p> <p>On 10/2/2024 at approximately 12:30 PM, the surveyor measured and observed the facility hot water temperature to exceed 120 degrees Fahrenheit. In the downstairs bathroom, the water temperature was measured at 122.5 degrees Fahrenheit.</p> <p>These findings were confirmed by the Administrator at the time of survey. The Administrator was able to contact maintenance, who were immediately able to adjust the water temperature to an acceptable range.</p> <p>16 SANITATION/PHYSICAL PLANT REQUIREMENTS</p> <p>16.3 Heating systems. There shall be a central heating plant connected to each room or area used by residents or staff by means of a radiator, convector or register. The heating system must be capable of maintaining a temperature of seventy-five degrees (75°) Fahrenheit throughout resident areas of the facility. Alternate types of heating systems may be approved by</p>		



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<p>the Department, if a uniform temperature of seventy-five degrees (75°) Fahrenheit can be maintained. Systems other than electric heating shall have an annual inspection and the heating source shall be tagged as being inspected.</p> <p>This has not been met as evidenced by:</p> <p>Based on observation and staff interview the facility failed to ensure the facilities fuel boilers were tagged as inspected annually.</p> <p>Finding:</p> <p>On 10/9/2024 at approximately 11:30 a.m. the facilities two (2) fuel boilers were observed. Boilers were not tagged as inspected in the last year and no evidence was provided that boilers were inspected within the last year.</p> <p>This finding was confirmed with Maintenance Director at the time of observation and reviewed with Maintenance Director and Office Manager at exit interview on 10/9//2024 at approximately 1:00 p.m.</p> <p>16.6 General condition of the facility and surrounding premises.</p> <p>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.</p> <p>This has not been met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to ensure bedroom windows were maintained.</p>		



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<p>Findings:</p> <p>On 10/9/2024 a toured the facility was completed. Six (6) bedroom windows were tested for operability.</p> <p>Four (4) of the bedroom windows: Room # 1143,1139,1133 and 1124 would not open and one (1) window in bedroom 1135 was difficult to open.</p> <p>This finding was confirmed with Maintenance Director at the time of observation and reviewed with Maintenance Director and Office Manager at exit interview on 10/9//2024 at approximately 1:00 p.m.</p>		