 STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION Biennial Survey		Date Completed: 1/23/2024
Name of Facility: CREST VIEW MANOR Administrator: ALYSIA SUTHERLAND PNMI LEVEL IV RESIDENTIAL CARE FACILITY Census: Total Capacity: 20 License Number: PND249		Address: 361 COURT ST HOULTON, ME 04730-1957
Summary Statement of Deficiencies	Plan of Correction	Completion Date

CREST VIEW MANOR, a PNMI LEVEL IV RESIDENTIAL CARE FACILITY, is not in substantial compliance with Part of 10-144, Chapter 113, Regulations Governing the Licensing and Functioning of Assisted Housing Programs: PNMI LEVEL IV RESIDENTIAL CARE FACILITY.

The following requirements were not met:

7 Medications And Treatments

7.1.2 No injectable medications may be administered by an unlicensed person, with the exception of bee sting kits and insulin.

This has not been met as evidenced by:

Based on record review and interview, unlicensed facility staff administered a non-insulin injectable diabetes medication.

Finding:

On 1/23/24 a review of Resident #5 January 2024 Medication Administration Record (MAR) was completed. Unlicensed Staff #4 initialed the January MAR on the 3rd and 17th as administering a Trulicity injection. Unlicensed Staff #5 initialed the January MAR on the 10th as administering a Trulicity injection.

This finding was confirmed with the Administrator at the time of survey and at the exit interview on 1/23/24.



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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 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 record review and interview, the facility failed to modify service plans based on identified changes for 2 of 4 resident records reviewed.

Finding:

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On 1/23/24 four resident records were reviewed. For Resident #3, the service plan dated 5/4/23 was not modified for ADL goal shower at least 2x weekly to sponge baths. For Resident #3 the service plan was not modified to include a dietary goal for a prescribed diet (cardiac, thin liquids, moist meat, alternate liquids and/with, sit up 30 minutes after each meal) signed by the primary practitioner on 1/11/24. For Resident #4, the service plan was not modified for hospice care needs that began in November of 2023.

This finding was confirmed with the Administrator at the exit interview on 1/23/24.

13 Staffing

13.6 Staff training, education and qualifications.

13.6.1 Within one hundred twenty (120) days of hiring, all staff, other than CNA's and licensed professional staff whose job responsibilities include direct service to residents for at least twenty (20) hours per week, shall successfully complete a certification course approved by the Department.

This has not been met as evidenced by:

Based on record review and interview, the facility failed to ensure within 120 days, completion of a certification course approved by the Department for 1 of 6 staff providing direct care services to residents for at least twenty (20) hours per week.

Finding:

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On 1/23/24 six staff records were reviewed. For Staff #4, working at least 20 hours a week for more than 120 days, there was no record of completion of a Department approved training.

This finding was confirmed at the exit interview with the Administrator on 1/23/24.

14 Dietary Services

14.6 Therapeutic diets. Therapeutic diets are considered treatments and shall be ordered in writing by the duly authorized licensed practitioner. Menus for medically prescribed therapeutic diets shall be planned in writing and approved by a qualified consultant dietitian.

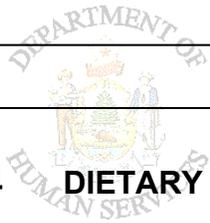
This finding was not met as evidenced by:

Based on record review and interview, the facility failed to have dietitian approved menus for prescribed therapeutic diets for 2 of 4 resident records reviewed.

Finding:

On 1/23/24 facility menus were reviewed. The facility menus dated on 7/10/2013 signed by a licensed dietician did not include therapeutic diets. Resident #1 had a low fat, low salt diabetic prescribed diet signed by the primary practitioner on 8/11/2023. Resident #3 had a cardiac diet prescribed and signed by the primary practitioner on 1/11/2024. This finding was confirmed by the facility cook at the time of survey.

This finding was reviewed with the Administrator on 1/23/24.

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14 DIETARY SERVICES

14.7 Diet manual. Each facility shall have a current (not more than five [5] years old) therapeutic diet manual that is recommended or approved by a qualified consultant dietitian.

This has not been met as evidenced by:

Based on observation and staff interview, the facility failed to ensure there was a diet manual that was no more than five (5) years old.

Findings:

On 1/19/2024 the Health Facility Specialists requested to see the facility diet manual. Diet manual provided was from 2007.

15 SANITATION/DIETARY SERVICES

15.10 Refrigerated storage.

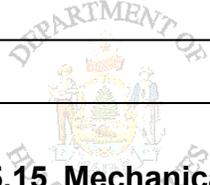
15.10.5 Conspicuous, easily readable thermometers shall be provided for each refrigerator and freezer in the facility.

This has not been met as evidenced by:

Based on observation and staff interview, the facility failed to ensure a refrigerator was equipped with a thermometer.

Findings:

On 1/19/2024 the Health Facility Specialist observed a facility refrigerator that stored snacks. There was no thermometer located in the refrigerator.

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15.15 Mechanical dishwashing. When mechanical cleaning and sanitizing is used, the following standards shall be met:

15.15.1 The wash-water temperature shall be at least one hundred thirty (130°) Fahrenheit. When hot water is relied upon for sanitization, the final or fresh rinse water shall be at least one hundred eighty degrees (180°) Fahrenheit, unless otherwise stated in the manufacturer's specifications.

15.15.2 When chemicals are relied on for sanitization, they shall be applied in such concentration and for such a period of time as to provide effective bacterial treatment of the equipment and utensils.

15.15.3 Machines (single-tank, stationary rack, door-type machines and spray-type glass washers) using chemicals for sanitization may be used, provided that the wash-water is kept clean, chemicals added for sanitization are automatically dispensed and the chemical sanitizing rinse-water temperature is not less than seventy-five degrees (75°) Fahrenheit, nor less than the temperature specified by the machine manufacturers.

This has not been met as evidenced by:

Based on observation and staff interview, the facility failed to ensure a dishwasher that relied on chemicals for sanitation had chemicals applied in such concentration to provide effective bacterial treatment of equipment and utensils.

Finding:

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On 1/19/2024 the Health Facility Specialist observed the facilities chemical sanitizing dishwasher. Health Facility Specialist and on duty cook both tested the chemical concentration with test strips. Test strips did not change color to an acceptable level. A solution line on the dishwasher was identified as damaged.

15.16 Testing of chemical sanitizers. When chemical sanitizing solutions are used for either manual or mechanical sanitization, an approved test kit shall be used to measure the residual of the sanitizing solution.

This has not been met as evidenced by:

Based on observation and interview, the facility test kit was expired.

Finding:

On 1/19/2024 the Health Facility Specialist observed to facilities test kit strips. Test kit strips were available however they had expired on October 1, 2023.

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:

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Based on observation and staff interview, the facility failed to ensure there was evidence of routine maintenance and housekeeping in some areas.

Findings:

On 1/19/2024 the Health Facility Specialist toured the facility and observed the following:

- 1) Baseboard heater covers in bathroom across the hall from shower room and in resident bedroom bathroom 11 were observed to be worn creating a difficult to clean surface.
- 2) Carpet in lobby was observed to be worn and have stains.
- 3) Kitchen refrigerator at small amount of white residue on upper walls.

16.7 Toilets and bathing facilities.

16.7.1 In existing facilities, a bathroom equipped with flush toilets and hand-washing facilities at a ratio of at least one (1) flush toilet for each six (6) users shall be available. Users include residents, as well as staff on duty. Facilities shall have adequate toilet facilities for staff and visitors separate from those toilets in private resident rooms. There shall be a mirror over each sink. All facilities are required to have hard-wired, wireless or battery-operated call bell systems in bathrooms, unless the bathroom is designated for non-resident use.

This has not been met as evidenced by:

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Based on observation and staff interview, the facility failed to ensure mirrors were over each sink facility.

Findings:

On 1/19/2024 the Health Facility Specialist observed bedroom 106 and 108 that each had a handwashing sink.

Both were unequipped with a mirror over the sink.

16.7.6 In order to accommodate resident privacy, doors or stalls shall have locks.

This has not been met as evidenced by:

Based on observation and staff interview, the facility failed to ensure a resident accessible bathroom had a lock on the door.

Findings:

On 11/19/2024 the Health Facility Specialist observed a resident accessible bathroom across the shower room. Bathroom was observed to not have a lock to accommodate privacy.

All Health Facility Specialist findings were reviewed with Administrator at the time of survey and again at exit interview on 1/19/2024.