STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION **Case Investigations: 2025-AHP-40587, 2025-AHP-40580, 2025-AHP-40653, 2025-AHP-40676, 2025-AHP-40878**	Completion Date 5/1/2025
Name of Facility: Magnolia Assisted Living – Tall Pines Building 2 Acting Administrator: Michaelene Achorn PNMI Level IV Residential Care Facility. Census: 33 Total Capacity: 53 License Number: PND39807	Address: 34 Martin Ln Belfast, ME 04915

Summary Statement of Deficiencies	Plan of Correction	Completion Date
Magnolia Assisted Living – Tall Pines Building 2, a PNMI Level IV Residential Care Facility, is not in compliance with the Regulations Governing the Licensing and Functioning of Assisted Housing Programs: PNMI Level IV Residential Care Facilities and Infection Prevention and Control, Part of 10-144, Chapter 113. The following was not met: **5.25 Mandatory report of rights violations**. Any person or professional who provides health care, social services or mental health services or who administers a long term care facility or program who has reasonable cause to suspect that the regulations pertaining to residents' rights or the conduct of resident care have been violated, shall immediately report the alleged violation to the Department of Health and Human Services (800 383-2441) and to one or more of the following: Disability Rights Center (DRC), pursuant to Title 5 M.R.S.A. §19501 through §19508 for incidents involving persons with mental illness; the Long Term Care Ombudsman Program, pursuant to Title 22 M.R.S.A. §5107-A for incidents involving elderly persons; the Office of Advocacy, pursuant to Title 34-B M.R.S.A. §1205 for incidents involving persons with mental retardation; or Adult Protective Services, pursuant to Title 22 M.R.S.A. §3470 through §3487.	Click or tap here to enter text.	Click or tap here to enter text.

 Signature of Administrator: _____ Date: _____ ALLS 17 (R1002)
(Signature binding on all 16 page(s))

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Reporting suspected abuse, neglect and exploitation is mandatory in all cases. Documentation shall be maintained in the facility that a report has been made. Mandated reporters shall contact the Department of Health and Human Services (800 383-2441) immediately after receiving and/or obtaining information about any rights violations. *[Class IV]* This has not been met as evidenced by: Based on record reviews and interviews, the provider failed to ensure a known conduct of care violation was immediately reported to the Department of Health and Human Services, Division of Licensing and Certification (800) 383-2441), and one other entity. Finding: On 3/26/2025 an onsite visit was completed at the facility. Interviews were conducted with the Administrator, Property Manager and Resident #3 regarding a medication administration incident. Resident #3's Point Click Care (PCC) notes and incident reports were reviewed. The following information was found: On 3/26/2025 at approximately 12:00 p.m., The Administrator was interviewed about the report. The Administrator confirmed that they interviewed Staff #1 about a reported concern regarding Resident #3. The Administrator confirmed that Staff #1 admitted to administering a broken capsule of Fluoxetine to Resident #3. Staff #1 admitted that they were aware the medication capsule was broken, but they still administered the medication. The Administrator stated that Staff #1 was disciplined and did have training regarding how to dispose of a broken medication capsule.		

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On 3/26/2025 at approximately 2:00 p.m. an interview was completed with Resident #3 who confirmed that a broken capsule of Fluoxetine was given to them and powder got in their eye and mouth when taking the medication. Resident #3 stated that after ingesting the broken medication capsule it caused burning in their throat and on their tongue. Resident #3 reported needing ice to cool her mouth and tongue down. Resident #3 stated that Staff #1 did not offer them medical attention and Resident #3 was not seen by their doctor until days later. Resident #3's roommate was also present and confirmed the statements that Resident #3 reported. On 3/26/2025 at approximately 3:00 p.m. an interview was completed with the Property Manager who confirmed that the day after this incident occur, Resident #3 came to the Property Manager and reported the incident with Staff #1. The Property Manager reported that Resident #3 told the Property Manager that powder from the broken capsule got in their eye when they took the medication, causing burning in the eye. The Property Manager reported that Resident #3 did not receive any medical attention for the incident. The Property Manager was able to verify that the incident with the Medication happened on 2/17/2025 and Resident #3 was not seen for a doctor's appointment until 2/21/2025 for a separate issue not related to the burning sensation. A review of the record did not show evidence of a completed incident report and did not show evidence that a report had been submitted by the facility to the Department regarding this incident. This finding was confirmed with the Administrator at the exit interview on 3/26/2024. **7 Medications and Treatments**		

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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. [Class II] This has not been met as evidenced by: Based on observation, record review and interview, the Administrator failed to ensure safe and acceptable procedures for ordering and administration of medications. Findings: 1. On 3/26/2025 a review of Resident #2's Medication Administration Record (MAR), duly authorized licensed practitioner orders and Controlled Substance Count Book were reviewed. Resident #2's had a duly authorized licensed practitioner order for Diazepam 5 mg tablet take 1 tab PO q 12 hours PRN. Resident #2's March 2025 showed Resident #2 getting the medication on March 1st and March 2nd, then not again until March 23rd due to being unavailable. On 3/9/2025 Resident #2 reported concerns of their body shaking due to being 8 days without their Diazepam PRN medication.		

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On 3/26/2025 an interview was completed with the Property Manager who confirmed that Resident #2 was without their Diazepam for a total of 19 days. 2. On 3/26/2025 a review of Resident #3's record and interviews with the Administrator, Property Manager and Resident #3 were completed. Resident #3 reported that they were given a Fluoxetine medication capsule that was broken. Resident #3 stated that the medication powder went in their eye, mouth and throat causing a burning sensation. The Administrator was also interviewed during the survey who spoke with Staff #1 about the concern and the Administrator stated that Staff #1 confirmed giving the broken medication capsule to Resident #3. This is considered an unsafe administration procedure. These findings were confirmed with the Administrator at the time of the survey and at the exit interview on 3/26/2025. **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. *[Classes II]* This has not been met as evidenced by: Based on record review and interviews, the facility failed to administer a medication to a resident that was ordered by the duly authorized licensed practitioner. (Resident #2.) Finding:		

Date Completed:

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On 3/26/2025 a review of Resident #2 duly authorized licensed practitioner orders, Medication Administration Records (MAR) for March 2025, and progress notes were reviewed with the following information found: Resident #2 had a duly authorized licensed practitioner order written on 10/14/2024 for “Methylphenidate 20 mgs, 1 tab by mouth 2 times per day.” This order stated that it was good for 1 year. Resident #2 had a duly authorized licensed practitioner order written on 02/10/2025 for “Methylphenidate 20 mgs, 1 tab by mouth 2 times per day.” The order was written for a thirty (30) day supply of medication. Documentation on Resident #2 March 2025 MAR showed the medication was unavailable for administration from 3/14/2025 through 3/23/2025. Point Click Care(PCC) progress notes show that the facility reached out on 3/14/2025 to the new primary care physicians office to try and get Resident #2 seen to get a refill on medications. The next PCC note of contact with the primary care physician was on 3/20/2025 to the current primary care physician requesting refills on the medication for Resident #3. This finding was confirmed with the Administrator at an exit interview on 3/26/2025. **7.2.2.1** Telephone orders shall be accepted only by a registered or licensed nurse or pharmacist. Written dated orders for telephone orders must be signed by the duly authorized licensed practitioner within five (5) working days. [Class III]		

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This has not been met as evidenced by: Based on record review and interview the facility failed to have a telephone order signed by the duly authorized licensed practitioner within five (5) working days. (Resident # 1) Finding: On 3/26/2025 Resident #1's Medication Administration Record, progress notes and Physicians orders for March 2025 were reviewed. Staff RN had taken a telephone order to increase Resident # 1's oxygen from 2LPM to 4LPM on 3/5/2025. The record did not contain a signed order by the duly authorized licensed practitioner within five (5) working days. This finding was confirmed with the Administrator at the exit interview conducted on 3/26/2025. **7.12 Medication/treatment administration records (MAR) for medications administered by the residential care facility**. **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. *[Class III]*		

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This has not been met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Medication Administration Record (MAR) contained documentation to increase oxygen treatment from 2LPM to 4LPM from a telephone order that staff RN received on 3/5/2025. The facility also incorrectly documented a medication administration as given to a resident. Findings: Resident #1's MAR, progress notes and physician orders for March 2025 were reviewed with the following found: On 3/5/2025, Staff RN had taken a telephone order to increase Resident #1's oxygen from 2LPM to 4LPM. Staff RN did not update Resident's MAR to reflect this change of treatment order. Resident #1's MAR was initialed indicating Albuterol NEB 0.083% was given on 3/5/2025, 3/7/2025, and 3/11/2025. The Property Manager confirmed that Resident #1 did not have a nebulizer machine since Resident #1 arrived at the facility in October of 2024. The Property Manager also confirmed that the initials for administration of the Albuterol Nebulizer were documented incorrectly and were administrations of an Albuterol Inhaler that was a PRN medication prescribed for Resident #1. These findings were confirmed with the Administrator at the exit interview on 3/26/2025. **7.12.3** Medication errors and reactions shall be recorded in an incident report in the resident's record. Medication errors include errors of omission, as well		

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as errors of commission. Errors in documentation or charting are errors of omission. *[Class II]* This has not been met as evidenced by: Based on record review and interviews the facility failed to record medication error reports when a medication was unsafely administered to a resident (Resident #3) and the facility failed to complete medication error report for a medication that was not administered per doctor's orders. (Resident #2.) Findings: 1. On 3/26/2025 a review of Resident #3's record and interviews with the Administrator, Property Manager and Resident #3 were completed. Resident #3 reported that they were given a Prozac medication capsule that was broken. Resident #3 stated that the medication powder from the broken capsule went in their eye, mouth and throat causing a burning sensation. The Administrator was also interviewed during the survey who spoke with Staff #1 about the concern and the Administrator stated that Staff #1 confirmed giving the broken medication capsule to Resident #3. A review of Resident #3's record did not contain a medication error/incident report in the record. This finding was confirmed with the Administrator at the time of the survey and at the exit interview on 3/26/2025. 2. On 3/26/2025 a review of Resident #2 duly authorized licensed practitioner orders, Medication Administration Records (MAR) for March 2025 and medication error/incident reports were reviewed.		

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Resident #2 had a duly authorized licensed practitioner order written on 10/14/2024 for “Methylphenidate 20 mgs, 1 tab by mouth 2 times per day.” This order stated that it was good for 1 year. Resident #2 had a duly authorized licensed practitioner order written on 02/10/2025 for “Methylphenidate 20 mgs, 1 tab by mouth 2 times per day.” The order was written for a thirty (30) day supply of medication. Documentation on Resident #2 March 2025 MAR showed the medication was unavailable for administration from 3/14/2025 – 3/23/2025. A review of medication error reports did not include these errors of omission of the medication. This finding was confirmed with the Administrator at an exit interview on 3/26/2025. **7.12.4** Administration of medications ordered as needed (PRN) shall be documented and shall include date, time given, medication and dosage, route, reason given, results or response and initials or signature of administering individual. Treatments ordered PRN shall be documented in the same manner. This has not been met as evidenced by: Based on record review and interviews, the facility failed to Document on the Medication Administration Record (MAR) the time given, reason given and results for PRN medications administered to 1 of 5 resident records reviewed (Resident #2). Finding:		

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On 3/26/2025 a review of Resident #2's March 2025 Medication Administration Record (MAR) was reviewed. On 3/24/2025 the MAR was initialed to indicate an administration of Diazepam 5 mgs ordered as needed. The time given, the reason given, and the result of administering was not documented on the MAR. This finding was confirmed by the Administrator at the time of the survey on 3/26/2025. **11 Administrative and Resident Records** **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		

Date Completed:

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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. This has not been met as evidenced by: Based on record review and interviews, the facility failed to complete an incident report for an error completed in the administration of a medication for 1 of 5 resident records reviewed. (Resident #3.) Finding: On 3/26/2025 a review of Resident #3's record and interviews with the Administrator, Property Manager and Resident #3 were completed. Resident #3 reported that they were given a Prozac medication capsule that was broken. Resident #3 stated that the medication powder from the broken capsule went in their eye and mouth causing a burning sensation. The Administrator was also interviewed during the survey who spoke with Staff #1 about the concern and the Administrator stated that Staff #1 confirmed giving the broken medication capsule to Resident #3. A review of Resident #3's record did not contain an incident report regarding the resident's reaction to the administration of damaged medication. This finding was confirmed with the Administrator at the time of the survey and at the exit interview on 3/26/2025.		

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12 Standards for Resident Care **12.10 Medical and health care**. The facility is responsible for promptly coordinating and assisting in accessing appropriate services for residents. The health care of every resident shall be under the supervision of a duly authorized licensed practitioner. Each resident shall have an annual physical, unless otherwise specified by the licensed medical professional. This has not been met as evidenced by: Based on record review and interviews, the facility failed to promptly access appropriate services for 1 of 5 resident records reviewed (Resident #2). Finding: On 3/26/2025 a review of Resident #2 duly authorized licensed practitioner orders, Medication Administration Records (MAR) for March 2025, and progress notes were reviewed with the following information found: Resident #2 had a duly authorized licensed practitioner order written on 10/14/2024 for “Methylphenidate 20 mgs, 1 tab by mouth 2 times per day.” This order stated that it was good for 1 year. Resident #2 had a duly authorized licensed practitioner order written on 02/10/2025 for “Methylphenidate 20 mgs, 1 tab by mouth 2 times per day.” The order was written for a thirty (30) day supply of medication. Documentation on Resident #2 March 2025 MAR showed the medication was unavailable for administration from 3/14/2025 –		

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3/23/2025. Point Click Care(PCC) progress notes show that the facility reached out on 3/14/2025 to the new primary care physicians office to try and get Resident #2 seen to get a refill on medications. The next PCC note of contact with the primary care physician was on 3/20/2025 to the current primary care physician requesting refills on the medication for Resident #2. Resident #2 missed a total of 20 doses of this medication. This finding was confirmed with the Administrator at an exit interview on 3/26/2025. **13 Staffing** **13.9 Registered nurse services**. Each facility shall retain a registered nurse, either on staff (other than the Administrator) or on a contractual basis, to provide the following services: **13.9.2** Review resident records for completeness and accuracy; This has not been met as evidenced by: Based on record review and interview the Registered Nurse failed to ensure completeness and accuracy with a resident's Medication Administration Record. (MAR). Finding: On 3/26/25, Resident #1's MAR, progress notes and Physicians orders for March 2025 were reviewed. Staff RN had taken a telephone order to increase Resident # 1's oxygen from 2LPM to 4LPM on 3/5/2025. Staff RN did not update Resident's MAR to reflect this change of physician order.		

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This finding was confirmed with the Administrator at the exit interview on 3/26/2025. **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 interview, the facility failed to ensure there was evidence of routine maintenance. Findings: On 3/26/2025 at approximately 9:45 a.m., a tour of the facility was completed with the following observations: 1) The shower room by Alder wing had damaged and small holes in the wall by the toilet and the paper towel dispenser creating an uncleanable surface. 2) The shower room by Alder wing had an area of wall cover peeling away from the wall by the entrance door. 3) The call bell in the bathroom of bedroom 402/403 would only activate occasionally when tested. This was immediately addressed by maintenance staff who took the call bell within bathroom apart and replaced the cover.		

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4) An overhead call bell light located by the Dogwood dining area call bell panel would not light up. This was immediately addressed by maintenance staff who replaced the light bulb. These findings were confirmed with maintenance staff at the time of survey and reviewed with the Administrator, Property Manager and maintenance staff at exit interview on 3/26/2025 at approximately 1:00 p.m.		

Date Completed: