



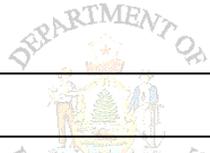
MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES LICENSING AND CERTIFICATION ASSISTED HOUSING

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION Monitoring Survey and Case Investigation: 2025-AHP-42039		Completion Date 9/30/2025
Name of Facility: Magnolia Assisted Living – Tall Pines Building 2 Administrator: Sara Jordan PNMI Level IV Residential Care Facility. Census: 28 Total Capacity: 53 License Number: PND39807	Address: 34 Martin Ln Belfast, ME 04915	
Summary Statement of Deficiencies	Plan of Correction	Completion Date

<p>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.</p> <p>The following was not met:</p> <p>3. Licensing</p> <p>3.31 Administrative and resident records.</p> <p>3.31.1 Confidentiality. All administrative and resident records shall be stored in such a manner that unauthorized persons cannot gain access to them.</p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop and implement a written procedure to ensure confidentiality in the facility as required by the 5/7/2025 Directed Plan of Correction.</p> <p>Finding:</p> <p>On 8/5/2025, 8/6/2025 and 8/18/2025 a review of the facility’s written procedures was completed. A written procedure on confidentiality could not be located in the record.</p>	<p>Click or tap here to enter text.</p>	<p>Click or tap here to enter text.</p>
--	---	---



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>The Administrator confirmed that a written procedure had not been completed for confidentiality.</p> <p><u>This is a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></p> <p>5. Resident Rights</p> <p>5.12 Right to confidentiality. Residents' records and information pertaining to their personal, medical and mental health status is confidential. Residents and their legal representatives shall have access to all records pertaining to the resident at reasonable times, in the presence of the provider or his/her representative, within one (1) business day of the request. Residents and their legal representatives are entitled to have copies made of their record within one (1) business day of the request. The licensee and employees shall have access to confidential information about each resident only to the extent needed to carry out the requirements of the licensing regulations or as authorized by any other applicable state or federal law. The written consent of the resident or his/her legal representative shall be required for release of information to any other person except authorized representatives of the Department or the Long Term Care Ombudsman Program. The Department shall have access to these records for determining compliance with these regulations. Records shall not be removed from the facility, except as may be necessary to carry out these regulations. Upon admission, each resident shall sign and date a written consent which lists individuals, groups, or categories with whom the program may share information (e.g., sons, daughters, family members or duly authorized licensed</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>practitioners, etc.). A written consent to release of information shall be renewed and time dated every thirty (30) months, pursuant to 22 M.R.S.A. §1711-C (4). Consent may be withdrawn at any time. <i>[Class IV]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on observation, record review and interviews, the facility failed to have dated written consent to release information for 1 of 6 resident records reviewed (Resident #5). Additionally, the facility failed to develop and implement a written procedure related to written consent that was a requirement of the 5/7/2025 Directed Plan of Correction.</p> <p>Finding:</p> <ol style="list-style-type: none">1. On 8/5/2025, 8/6/2025 and 8/18/2025 a review of resident records was completed. For Resident #5 there was a release of information form that was not dated. <p>This finding was confirmed with the Administrator at the time of the survey and with the Owner and Administrator at the exit survey on 8/18/2025.</p> <ol style="list-style-type: none">2. On 8/18/2025 a review of facility's written procedures was completed. A written procedure related to written consent requirements was not located with the written procedures. <p>At the time of the survey, the Administrator confirmed that this written procedure had not been completed as required by the 5/7/2025 Directed Plan of Correction.</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies and a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></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. [Class II]</p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to implement a procedure with input from the pharmacist in relation to controlled substance medications and failed to implement a thorough procedure in relation to medications and a written procedure on continually assessing competency of unlicensed assistive personnel regarding medications as required by the 5/7/2025 Directed Plan of Correction.</p> <p>Finding:</p> <p>On 8/6/2025 and 8/18/2025 a review of procedures related to medications was completed. The record did not contain procedures with input from the Pharmacist in relation to controlled substance medications or procedures with input from the RN regarding</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>medications and continued competency assessment of unlicensed assistive personnel.</p> <p>At the time of the survey, the Administrator confirmed that these procedures had not been completed.</p> <p><u>This is a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></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. <i>[Classes II]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to administer a medication as ordered by the duly authorized licensed practitioner (Resident #4).</p> <p>Finding;</p> <p>On 8/6/2025 and 8/18/2025 a review of Resident #4 duly authorized licensed practitioners' orders, Medication Administration Records (MAR) from June 2025 – August 2025 was reviewed with the following information found:</p> <p>Resident #4 had a duly authorized licensed practitioner ordered written on 6/23/2025 for Morphine 30 mg/8 to 12 hr. oral tablet, extended release 1 tab PO every 12 hours.</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>On 6/29/2025 Resident #4 Medication Administration Record (MAR) indicated 1 tab Morphine Sul tab 30 mg ER was administered at 8:00 a.m. only, and not as prescribed every 12 hours by the duly authorized licensed practitioner.</p> <p>This finding was confirmed with the Administrator and Owner at the exit interview on 8/18/2025.</p> <p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies.</u></p> <p>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: <i>[Class III]</i></p> <p>7.1.4.1 Dietary requirements;</p> <p>7.1.4.2 Anti-Diabetic Oral medications – inclusive of adverse reactions and interventions, hyper and hypo glyceemic reactions;</p> <p>7.1.4.4 Insulin storage;</p> <p>7.1.4.6 Treatment and prevention of insulin reaction including signs/symptoms;</p> <p>7.1.4.7 Foot care;</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>7.1.4.8 Lab testing, urine testing and blood glucose monitoring; and</p> <p>7.1.4.9 Standard Precautions.</p> <p>Documentation of training shall be included in the employee record.</p> <p>Review of this training shall be on an annual basis.</p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to ensure unlicensed assistive personnel were trained by a registered professional nurse regarding the management of person with diabetes for 3 out of 7 employee records reviewed (Staff # 2, Staff #5 and Staff #6).</p> <p>Finding:</p> <p>On 8/5/2025 and 8/18/2025 a review of employee records was completed. For Staff #2, Staff #5 and Staff #6 the training records provided and reviewed did not include diabetes training.</p> <p>This finding was confirmed with the Administrator and Owner at the exit interview on 8/18/2025.</p> <p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies and a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<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. <i>[Class III]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to keep physical separation for the storage of resident's Schedule II medications.</p> <p>Finding:</p> <p>On 08/5/2025 and 8/6/2025 an inspection of the facility's medication carts was completed. The medication carts contained residents' Schedule II medications stored together with no physical separation or label.</p> <p>This finding was confirmed with the CRMAs on duty at the time of the survey and at the exit interview with the Administrator and Owner on 8/18/2025.</p> <p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies and a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>7.10 Schedule II controlled substances. Schedule II controlled substances listed in the Comprehensive Drug Abuse Act of 1970, Public Law 91-513, Section 202 and as amended pursuant to Section 202 are subject to the following standards. <i>[Class II]</i> –</p> <p>7.10.1 For all Schedule II controlled substances, there shall be an individual record in which shall be recorded the name of the resident, prescription number, the date, drug name, dosage, frequency and method of administration, the signature of the person administering it and verification of the balance on hand. <i>[Class II]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to follow the Directed Plan of Correction when documenting a review of residents' individual record for all prescribed Schedule II controlled substances.</p> <p>Finding:</p> <p>On 8/5/2025 and 8/6/2025 a review of the facility's documentation regarding the Directed Plan of Correction was completed. The facility documented a review of the residents' individual records for all prescribed Schedule II controlled substances but failed to include a column to indicate corrective action for any issues identified.</p> <p>This finding was confirmed with the Administrator at the time of the survey and at the exit interview with the Administrator and Owner on 8/18/2025.</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p><u>This is a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></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. <i>[Class III]</i></p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to document a review of the residents individual Medication Administration Records (MAR) to include specific information that was required by the 5/7/2025 Directed Plan of Correction. In addition, the facility failed to transcribe a medication correctly to the MAR for 1 of 7 records reviewed (Resident #4).</p> <p>Finding:</p> <ol style="list-style-type: none">1. On 8/5/2025 documented reviews of the residents individual MARs was completed. The reviews did not include the name of		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>the resident, date of review, findings and action taken as required by the 5/7/2025 Directed Plan of Correction.</p> <p>This finding was confirmed with the Administrator at the time of the survey and at the exit interview on 8/18/2025.</p> <p>2. On 8/5/2025 and 8/18/2025 a review of Resident #4 duly authorized licensed practitioner's orders, Medication Administration Records (MAR) from June 2025 – August 2025 was reviewed with the following information found:</p> <p>Resident #4 had a duly authorized licensed practitioner order written on 6/23/2025 for "Morphine 30 mg/ 8 to 12 hour extended release 1 tab every 12 hours for chronic pain". Resident #4's June 2025 MAR indicated a change order transcription for Morphine 30mg 1 tab every 12 hours PRN only and discontinued the scheduled q 12 hours without a written order.</p> <p>This finding was confirmed with the Administrator and Owner at the exit interview on 8/18/2025.</p> <p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies and a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></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</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>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 review and interview the facility failed to ensure the full signatures of those administering medication were present on the Medication Administration Records (MARs) for 2 of 6 resident records reviewed (Resident #3 and Resident #6). In addition, the facility failed to ensure Medication Administration Records (MAR's) contained documentation of whether medication was administered or refused in 1 of 7 resident records reviewed (Resident #7).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident #3 and Resident #6's August 2025 Medication Administration Record (MAR) was completed and did not include documentation of the full signature for Staff #7 who initialed the MAR as administering medications. <p>This finding was confirmed with the Administrator at the time of the survey and at the exit interview with the Administrator and Owner on 8/18/2025.</p> <ol style="list-style-type: none"> 2. A review of Resident # 7 July and August 2025 MAR found an unexplained blank for Pramipexole tab 1 mg tab at 8:00 a.m. on 7/31/2025 and Olanzapine 10mg ODT at 8:00 p.m. on 8/4/2025. 		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>This finding was confirmed with the Administrator at the time of the survey and at the exit interview with the Administrator and Owner on 8/18/2025.</p> <p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies and a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></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</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>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> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop mandatory training provided to staff and agency personnel in relation to incident reporting as required by the 5/7/2025 Directed Plan of Correction.</p> <p>Finding:</p> <p>On 8/18/2025 a review of mandatory training of staff was completed. There was no evidence in employee records of mandatory training regarding incident reporting.</p> <p>This finding was confirmed with the Administrator at the time of survey.</p> <p><u>This is a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></p> <p>12. Standard for Resident Care</p> <p>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,</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>unless otherwise specified by the licensed medical professional.</p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to draft and implement a written procedure and a documented review that will ensure the facility promptly coordinates and assists in accessing appropriate services for residents as required by the 5/7/2025 Directed Plan of Correction.</p> <p>Finding:</p> <p>On 8/18/2025 a review of the facility's written procedure and documented reviews for the Directed Plan of Correction was completed. The facility did not have evidence of a written procedure or documented review regarding promptly coordinating and assisting in accessing appropriate services for residents.</p> <p>This finding was confirmed with the Administrator at the time of the survey.</p> <p><u>This is a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></p> <p>13 Staffing</p> <p>13.5 Employee records. Facilities must maintain individual records on all related and unrelated employees. Records shall contain the initial date of employment, date of birth, home address and telephone number, experience and qualifications, social security number, copy of current occupational license (if applicable), references and reference</p>		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>check information, job description, record of participation in in-service, orientation or other training programs, results of annual personnel evaluations, disciplinary actions, illness and injury records and date of and reason for termination. Records may be computerized.</p> <p>This has not been met as evidenced by:</p> <p>Based on record review and interview, the facility failed to have evidence of job descriptions for 3 of 7 staff records reviewed (Staff #1, Staff #2 and Staff #6). In Addition, the facility failed to develop and implement a written policy that includes all items that need to be maintained in an employee record as required by the 5/7/2025 Directed Plan of Correction.</p> <p>Findings:</p> <ol style="list-style-type: none">1. On 8/6/2025 and 8/18/2025 a review of employee records was completed with the following identified:<ul style="list-style-type: none">• For Staff #2 and Staff #6, the job description did not match the facility's job title and duties of the staff members.• For Staff #1, there was no job description in the employee record. <p>This finding was confirmed with the Administrator at the time of the survey and at the exit interview on 8/18/2025 with the Administrator and Owner.</p> <ol style="list-style-type: none">2. On 8/18/2025 a review of written procedures related to the Directed Plan of Correction was completed. The Facility failed to have evidence of a completed policy regarding employee records.		



Summary Statement of Deficiencies	Plan of Correction	Completion Date
<p>This finding was confirmed with the Administrator at the time of the Survey.</p> <p><u>This is a repeat deficiency from the 2/14/2025 Statement of Deficiencies and a failure to meet the conditions of the 05/7/2025 Directed Plan of Correction and Conditional License.</u></p>		