STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1960	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGEL PLACE	758 BROADWAY BANGOR, ME 04401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments On 10/28/25 and 10/29/25, unannounced onsite visits were conducted at Engel Place/Assisted Housing for the purpose of completing the State Re-licensure survey and investigating complaints #ME47643 and #ME52724. It is determined that Engel Place/Assisted Housing was not in substantial compliance with 10/144, Chapter 113-Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 318	7.1.7 Medications and Treatments Orders for medications and treatments shall be in writing, signed and dated by a duly authorized licensed practitioner and shall be in effect for the time specified by the duly authorized licensed practitioner, but in no case to exceed twelve (12) months, unless there is a written reorder. Orders for psychotropic medications shall be reissued every three (3) months, unless otherwise indicated by the duly authorized licensed practitioner. Standing orders for individual residents are acceptable when signed and dated by the duly authorized licensed practitioner. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that medications and treatments were written, signed and dated not to exceed 12 months for 1 of 3 sampled residents (Resident #3 [R3]). Finding: On 10/29/25, a review of R3's clinical record was reviewed and in the physician order section, the last annual medication and treatment orders were	P 318		

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P 318	Continued From page 1 dated 7/15/24. On 10/29/25 at 11:10 a.m., in an interview with the surveyor, the Resident Care Director confirmed that there are no new annual orders and the annual orders are late (over 12 months). This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 5 (9a).	P 318		
P 418	10.9.4.5 Administration Medications (administration, ordering, returning, discontinuing, destroying, charting, pharmacy consultation); This STANDARD is not met as evidenced by: Based on record review, medication administration observation, medication administration Policy and Procedure and interviews, the facility failed to follow their Insulin Administration policy for 1 of 1 resident observed for insulin administration (Resident #4 [R4]). Finding: On 10/28/25, a review of R4's clinical record indicated the resident is to receive insulin Glardine 14 units subcutaneous in the am (9:00 a.m.). On 10/28/25 at 9:00 a.m., during a medication pass observation, Certified Residential Medication Aide #1 (CRMA#1) was preparing to administer insulin Glardine 14 units subcutaneous to R4. It was observed that there was no open date or no expiration date per manufactures recommendation on the insulin pen. The expiration date would indicate how many days the	P 418		

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P 418	Continued From page 2 insulin was good for once opened. CRMA#1 confirmed this finding at the time of observation. She stated an open date should have been marked on the pen. On 10/28/25 at 1:30 p.m., in an interview with the surveyor, the Resident Care Director (RCD) confirmed the insulin pen should have been marked with an open date and an expiration date. On 10/28/25, a review of the units Insulin Administration policy and procedure was completed. On page 2 of 4, under the Insulin Delivery, #3 pens are a form of insulin delivery. Under Steps in the Procedure, #4, if opening a new vial (pen) record expiration date on pen (follow manufacturers recommendation for expiration after opening). This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 5(A.1).	P 418		
P 468	11.1.9 Adminsitrative and Resident Records Referral/transfer form. A referral or transfer form shall be prepared when any resident is transferred from one facility to another facility, institution or agency or to another level of care within the same facility. A copy shall be kept in the resident's record at both facilities. The referral or transfer form shall contain a summary of information about the admitted/discharged resident to ensure continuity of care, including a copy of the most recent history, physical examination report, duly authorized licensed practitioner's orders and a copy of the resident's most recent assessment and service plan. [Class III] This STANDARD is not met as evidenced by:	P 468		

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P 468	Continued From page 3 Based on record review and interview, the facility failed to ensure a transfer/discharge report was kept in the resident's clinical record for 1 of 1 resident sampled that was transferred to the emergency department (ED) (Resident #2 [R2]). Finding: A review of R2's clinical record indicated that on 8/25/25 the resident had a fall with injury and was transferred to the ED for evaluation. There was no evidence that the transfer/discharge report was placed in the resident's record. On 10/28/25 at 1:00 p.m., in an interview with the surveyor, the Residential Care Director confirmed that a transfer form was completed but was not added to R2's clinical record. This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 8(9.a.).	P 468		
P 494	12.3 Standards for Resident Care 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	P 494		

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P 494	Continued From page 4 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 STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that service plans were updated to indicate residents current status and that a resident/resident representative's participation in developing a service plan was documented in the clinical record for 2 of 3 residents sampled for review (Resident #1 [R1}, R2). Findings: 1. On 10/28/25, R1's clinical record was reviewed. R2 had a physician order for a regular diet not to exceed 1800 calories a day. A review of the service plan indicated the resident was on a regular diet, but did not indicate R1's daily caloric intake was limited to 1800 calories.	P 494		

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P 494	Continued From page 5 On 10/28/25 at 10:30 a.m., in an interview with the surveyor, the Residential Care Director (RCD) confirmed this finding. 2. On 10/28/25, R2's clinical record was reviewed. Documentation indicated that a service plan was developed after admission on 4/30/25. There was no evidence in the clinical record of the resident or resident representative participating in the development of the service plan. On 10/29/25 at 11:24 a.m., the RCD stated the family did participate but she did not document it in the record and she confirmed this finding. In addition, documentation indicated that on 9/4/25, R2 was started on Hospice. A review of the service plan did not indicate the resident was on Hospice and receiving Hospice services. On 10/28/25 at 12:10 p.m., in an interview with the surveyor, the RCD confirmed that the service plan had not been updated to reflect Hospice services. This provision has changed in the rule effective 9/18/25. See new provisions of the rule Section 13.(C.5.a.) and Section 13 (C.5.a.).	P 494		