STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205003	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Nursing Care Center	630 Ocean Avenue Portland, ME 04112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44049 Based on observations and interviews, the facility failed to maintain adequate housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior for 3 of 3 residential units. Findings: On 4/3/2024 beginning at 9:00a.m., during a facility tour with the Maintenance Supervisor, the following findings were observed: [NAME] Unit: Stained ceiling tile in hallway just outside of restroom. Cobwebs attached to the light fixture and ceiling just outside of dining room. Black/[NAME] Unit: room [ROOM NUMBER] - Stained ceiling tile in the middle of the room room [ROOM NUMBER] - Debris stuck to floor from an area rug that was fixed to the floor Intravenous (IV) pole that is used for Tube feedings has stains and debris on base of IV pole room [ROOM NUMBER] - Stained ceiling tile in the middle of the room Unit exit door - has a buildup of sticky material on the door, staff member stated it was glue residue from a Velcro patch that was on the door. [NAME] Unit: Dining Room - Stained ceiling tiles in the middle of the room; 5-6 stained spots on the ceiling in front of the window Hallway in front of the Nutrition Kitchen - 2 stained ceiling tiles (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	205003	A. Building B. Wing	04/03/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conference Room on first floor - Stained ceiling tile above white board All of the above were confirmed with the Maintenance supervisor at 9:45 a.m., during the facility tour.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37648 Based on record review, observations and interview, the facility failed to implement a care plan in the area of nutrition for 1 of 1 sampled resident for tube feedings (#36). Finding: Review of Resident #36's nutrition care plan, revised 3/2/24, instructs nursing to, Verify that my tube placement is correct prior to administering any medications, tube feedings or flushing of the tube. On 4/1/24 at 12:01 p.m., during observation of a Registered Nurse (RN) administering medication and a feeding bolus via gastrostomy tube (GT); the RN failed to confirm placement of the G-Tube and check gastric residual volume (GRV) prior to administering medications and feeding bolus. In an interview with the RN, she stated she did not check placement or residual because, We don't have orders to. On 4/1/24 at 4:11 p.m., during an interview, the above was discussed with the [NAME] President of Nursing.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37015 Based on observation, record review and interview, the facility failed to revise the care plan to reflect a resident's current status for 1 of 3 residents reviewed for skin conditions (#21) and 1 of 1 resident reviewed for limited range of motion (#8). Findings: 1. On 4/1/24 at 9:43 a.m., observation of Resident #21 to have compression wraps with kerlix and coban, to both lower extremities. Review of Resident #21's medical record contained the following: a care plan initiated on 2/22/21 for Edema, interfering with functional abilities with an intervention of put ted hose on in am, off at hs. A Wound Assessment Report initiated on 2/21/24 stated, a new wound identified, Venous Ulcer to right top of foot and a Provider order dated 2/21/24 for wound care for bilateral lower edema (BLE) every Tuesday and Saturday. Cleanse BLE with soapy water / cover wounds with Ag (Silver) Alginate / compression wraps with kerlix followed by coban mid foot -knee. On 4/2/24 at 12:08 p.m., during an interview, the Registered Nurse confirmed the resident is no longer using ted hose and the care plan does not reflect the current needs/treatment of the resident in the area of edema. 2. On 4/01/24 at 10:55 a.m., in an interview with a surveyor, Resident #8 stated I do have splints for my arm and leg but I've lost weight and it doesn't fit. The fell ow who fit it no longer works here. A review of Provider Orders, signed on 1/4/24, noted the following order: Resident should wear resting left hand splint day and evening as much as possible. No order was found for use of a left leg splint. A review of the Minimum Data Set (MDS) 3.0, Quarterly Assessment, dated 12/13/23, Section O0500, Restorative Nursing Program, C. Splint or Brace Assistance, found no documentation for restorative nursing to provide assistance with splints or braces. A review of Resident #8's care plan, last revised 3/9/24, noted the following: I have an impaired ability to apply my left ankle AFO (Ankle Foot Orthosis) related to foot drop and I also want to prevent getting a contracture. Interventions included: Provide me with verbal cues for sequence of step by step instructions. Provide me with passive range of motion (PROM) to my left ankle for 5 minutes prior to donning my left ankle AFO 2 times per day following instructions from therapy. Apply my left ankle AFO first thing in the morning and worn the entire time I am up in my chair. And, I will wear a brace on my left leg and a resting splint on my left hand. I have a schedule in my room to follow. On 04/02/24 at 12:30 p.m., in an interview with a surveyor, RN #3 stated he/she had never known Resident #8 to wear splints. (continued on next page)

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	205003	A. Building B. Wing	04/03/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/24 at 3:10 p.m., in an interview with 3 Certified Nursing Assistants (CNA) on the [NAME] Unit, a surveyor asked if Resident #8 has a splint or leg brace applied, and if staff performs PROM. The CNA's stated PROM was not done because Resident #8 is usually in too much pain and is too sensitive. The staff stated Resident #8 refuses (care) a lot, and staff will position him/her with a pillow under his/her left elbow for support. Staff stated Resident #8 may agree to wearing the left wrist splint when he/she is up and out of bed in the morning, but usually for no more than an hour. Staff stated Resident #8 has not worn the leg brace for a long time and they are not performing PROM on the ankle. On 4/02/24 at 3:30 p.m., in an interview with a surveyor, the Rehabilitation Manager stated due to the scope and severity of Resident #8's contractures and his/her spasticity, performing PROM would be too painful. The Rehabilitation Manager stated Resident #8's condition was brought to his/her attention during rounds and was discussed with the team 2-3 weeks ago. The surveyor asked if staff should be applying the hand splint and/or AFO now. The Rehabilitation Manager stated applying them would cause more harm, such as pressure ulcers, due to them not fitting right. On 04/02/24 at 4:10 p.m., in an interview with the Director of Nursing (DON), a surveyor discussed that Resident #8's current care plan instructs staff to perform PROM and apply the wrist splint and AFO. However, therapy's recommendation is to avoid use until Resident #3 can be re-evaluated. The DON confirmed that Resident #8's care plan was not revised to reflect the current needs of the resident regarding limited range of motion. 37648

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 37648 Based on observation, interviews and record reviews, the facility failed to ensure that nursing obtained new orders for wound care and followed physician orders for 2 of 3 residents reviewed for skin conditions (Resident #21 [R21], R30) and the facility failed to follow physician orders to obtain a urine sample for 1 of 2 residents reviewed for falls (R3). Findings: 1. Review of R21's medical record contained a Provider order dated 2/21/24 for wound care for bilateral lower edema (BLE) every Tuesday and Saturday. Cleanse BLE with soapy water / cover wounds with Ag (Silver) Alginate / compression wraps with kerlix followed by coban mid foot -knee. Review of a Wound Assessment Report stated R21's venous ulcer to top of the right foot had resolved on 2/29/24. On 4/2/24 at approx. 11:34 a.m., during an interview, the wound nurse stated, R21 had an open area to his/her right lateral heel and legs were weepy due to edema, he/she did have an alginate dressing, but the wound healed, so now it's just kerlix and coban. During the observation of R21's BLE dressing change, the wound nurse did not apply alginate as per the MD order. The wound nurse stated she did not use the alginate because the opened area was closed, and she would normally update the orders for alginate as needed after treatments/assessment of wound. At this time, the wound nurse confirmed the wound was documented as healed on 2/29/24 and the order was not updated to reflect the current treatment. 2. On 4/1/24 at 10:25 a.m., R30 was observed to have extremely dry, scaly skin on bilateral arms. In a brief interview, the resident was asked if staff apply lotion to his/her arms, resident replied No, they don't do anything with it, they put lotion on my legs. Review of R30's medical record contained a Provider order dated 3/17/24, to apply moisturizer to arms twice daily. The Treatment Administration Record has documented administration of moisturizer to his/her arms twice daily. In addition, the documentation states on 4/1/24 that Registered Nurse (RN) #1 applied lotion on the day shift. On 4/2/24 at 2:29 p.m., during an interview, RN #1 stated she was not aware of R30 having any orders for lotion. Both the surveyor and RN #1 observed R30's extremely dry, scaly arms. In an additional interview with R30, he/she again stated, that he/she has not had any lotions applied to his/her arms, not yesterday or today. At this time, RN#1 stated, we will have to get an order for lotion. The surveyor informed the RN#1 that there was already an order in place, she signed it off that she applied lotion to the resident's arm yesterday. On 4/2/24 at 2:54 p.m., the above was discussed with the [NAME] President of Nursing. 35904 (continued on next page)

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	205003	A. Building B. Wing	04/03/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R3's Post-Incident Actions report states .resident found down at bedside on floor with head under the bed and updated provider of increased confusion and {R3) stated that he/she felt the need to void more often and that his/her back hurt. Received order from provider to do st cath (straight cathetor) for u/a (urinalysis) reflux and sediment due to staff and family observing behavior changes and urine frequency. Review of Resident #3's medical record contained a provider order dated 3/30/24 to obtain urine sample to rule out UTI (urinary tract infection), increased confusion and urinary frequency, and fall protocol/neuro (neurological) checks. On 4/3/24 at 11:00 a.m. in an interview with the [NAME] President of Nursing, a surveyor confirmed that a urine sample was not obtained, and neurological checks were not completed.

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	205003	A. Building B. Wing	04/03/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 37648 Based in record review, observation and interview, the facility failed to provide appropriate treatment to prevent the risk of complications related to enteral feeding, for 1 of 1 resident reviewed for tube feeding. (#36) Finding: Facilities Medication Administration via Gastrostomy Tube, with no initiation or revision dates available states, of this procedure is to provide guidelines for the safe administration of medications through an enteral tube, with the following procedures to be completed before administration of medication and/or feeding; confirm placement of feeding tube and check gastric residual volume (GRV) to assess for tolerance of enteral feeding. On 4/1/24 at 12:01 p.m., during observation of Registered Nurse (RN#1) administering a feeding bolus and medication via gastrostomy tube for resident #36, RN#1 failed to confirm placement of the G-Tube and check GRV prior to administering the medication and feeding bolus. In an interview with RN#1, she stated she did not check placement or residual because, We don't have orders to. On 4/2/24 at 10:42 a.m., during an interview, Resident #36 was asked if nursing ensures the G-tube is in the correct place prior to administering medications or feedings, resident stated No. He/she was asked if nursing checks residual prior to administering feeding, resident stated, No. On 4/1/24 at 4:11 p.m., during an interview, the above was discussed with the [NAME] President of Nursing

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37648 Based on observations and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to nebulizer and oxygen tubing for 2 of 2 residents reviewed for respiratory care. (#4, #82) Findings 1. On 4/1/24 at 9:48 a.m., Observation of Resident #21 to have a nebulizer pipe with tubing stored in a basin along with an exercise band and socks. At this time, during an interview, resident stated he/she has not used a nebulizer for, long time ago, only when I need it. On 4/2/24 at 2:29 p.m., both the Registered Nurse (RN#1) and surveyor observed the nebulizer pipe and tubing in the basin, the RN#1 removed/discarded the nebulizer pipe into the trash. On 4/2/24 at 3:50 p.m., during an interview, the [NAME] President of Nursing stated Resident #21's last nebulizer order was back in 3/24/20 and if a nebulizer is being used it should be rinsed out, dried and stored in a bag. 2. On 4/1/24 at 10:46 a.m., observation of Resident #170's oxygen concentrator with a nasal cannula tubing, unlabeled/dated and hanging off the knob of the concentrator. At this time, in an interview, Resident stated, he/she only uses oxygen at night. On 4/2/24 at 9:30 a.m., an additional observation of Resident #170's oxygen concentrator with a nasal cannula now dated with a date of 3/31 and hanging off the back of the concentrator. On 4/2/24 at 2:31 p.m., both the RN#1 and surveyor observed the oxygen nasal cannula hanging off the back of the concentrator. The surveyor questioned the validity of the dated nasal cannula tube due to the observation the day prior. The RN#1 did not have a reason for the discrepancy, and stated she has worked at the facility for 3 years and has never seen oxygen tubing stored in bags stating, it often looks like that, wrapped up. On 4/3/24 at 8:24 a.m., during an interview, the [NAME] President of Nursing confirmed the above stating nasal cannulas should be stored in plastic bags, when not in use. In addition, the facility was unable to provide a policy and procedure for storage of oxygen tubing and nebulizer supplies when used intermittently.

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	205003	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Nursing Care Center	630 Ocean Avenue Portland, ME 04112

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on record review, observations and interviews, facility failed to adequately date and properly dispose of open medications according to manufacturer specifications and failed to ensure expired medications were removed from the supply available for use on 3 of 3 neighborhoods observed ([NAME], [NAME], Black Wolf). Findings: The facilities Storage of Medication policy and Procedure effective January 2019 states, All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining, The facility should maintain a temperature log in the storage area to record temperatures at least once a day and The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC guidelines. 1. On 4/1/24 at 11:18 a.m., observation of medication storage on the [NAME] Neighborhood with the Certified Medication Technician the following was observed: The Certified Medication Cart contained an opened bottle of multivitamins with minerals with expiration date of 3/24 and the Medication room refrigerator contained one influenza vaccine, the refrigerator temperature log from 1/7/24 through 4/1/24 has recordings of temperatures once daily with 11 days without monitoring. 2. On 4/2/24 at 8:45 a.m., observation of medication storage on the [NAME] Neighborhood with the RN#2 the refrigerator contained an opened bottle of Tuberculin Purified Protein unlabeled without an opened date with manufactures instructions, once entered vial should be discarded after 30 days. On 4/2/24 at 10:02 a.m., during an interview, the above was discussed with the [NAME] President of Nursing 48648 3. On 4/1/24 at 12:21 p.m. a surveyor observed the following on top of Resident #47's nightstand; 1 Spiriva inhaler, 2 Combivent inhalers, 1 Flonase inhaler. When Resident #47 was asked about the medications, they confirmed that is where the nurses leave them. On 4/1/24 at 12:40 p.m. a surveyor interviewed the unit manager and learned that Resident #47 had not been assessed to safely keep medications at the bedside nor were those medications being stored safely.

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	205003	A. Building B. Wing	04/03/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44049 Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner due to the Dietitian walking through the kitchen with hair not contained or covered. Additionally, the walk-in refrigerator contained a pan of green beans that was not labeled or dated. Findings: 1- 0n 4/1/2024, at 9:10 a.m., during the initial tour of the kitchen with the Dietary Director a surveyor observed a pan of green beans in the refrigerator unlabeled and undated. The Dietician was observed walking through the kitchen with hair uncontained and uncovered. The Food Service Director was present and aware of the findings at that time. 2- On 4/2/2024 @ 8:00 a.m. - Observation of serving breakfast on [NAME] Unit a surveyor observed food server with long hair not contained but wearing a hair net over the top of her head. Staff member stated that she is not a kitchen staff member, she works in Medical Records, and we train them to be able to serve the meals. 3- On 4/2/2024 @ 2:20p.m. - Return observation to the Kitchen with Dietary Manager, a surveyor observed a light amount of dust on and hanging from approximately 1/4 of kitchen ceiling On 4/2/2-24. The above findings were confirmed with the Director of Nursing at approximately 3:30p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205003	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37015 Based on record review and interview, the facility failed to conduct an annual review of it's Infection Prevention and Control Program (IPCP). Finding: On 4/2/24, during a review of the facility's IPCP policy and procedures, a surveyor noted various policies within the program lacked dates indicating a review and/or revision was completed. Policies included: Infection Control, undated; Pneumococcal Immunization for Resident with Prevnar 13 and Prevnar 23, undated; Infection Control: Influenza Vaccination for Residents, Administration of Covid-19 Vaccine, with a revision date of 1/4/22; Coronavirus Pandemic Strategies to Mitigate Healthcare Personnel Staffing Shortages, with a revision date of 3/11/22; Influenza Protocol, undated; Transmission Based Precautions, undated. On 4/2/24 at 11:00 a.m., in an interview with a surveyor, the Director of Nursing stated the facility reviews its policies and procedures, but confirmed the policies were unsigned and there was no evidence to show the policies related to the IPCP were reviewed and revised on an annual basis.

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	205003	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37015 Based on record reviews and interview, the facility failed to ensure 1 of 5 residents (#51) reviewed for immunizations was reviewed and offered pneumococcal vaccination in accordance with the United States Centers for Disease Control and Prevention (CDC) recommendations. Finding: A review of the CDC's Vaccine Information Statement (Interim) Pneumococcal Conjugate Vaccine, dated 5/12/23, stated Pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease. There are three pneumococcal conjugate vaccines (PCV13, PCV15, and PCV20). The different vaccines are recommended for different people based on age and medical status. Adults [AGE] years or older who have not previously received pneumococcal conjugate vaccine should receive pneumococcal conjugate vaccine. During a review of Resident #51's immunization record, the surveyor could not locate evidence that Resident #51 was reviewed, offered, or received a pneumococcal conjugate vaccination. The Resident is over [AGE] years of age. On 4/2/24, during an interview with a surveyor at approximately 11:00 a.m., the Director of Nursing confirmed the record lacked evidence that Resident #51 was reviewed and offered a pneumococcal vaccination.