STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205060	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Center	23 Cedar Ridge Drive Skowhegan, ME 04976

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37440 Based on observations and interviews the facility failed to promote care for resident in a manner that maintains the resident's dignity by allowing an uncovered urine filled Foley catheter bag to be seen by passersby for 1 of 3 residents (Resident #9) observed for dignity related to urinary collection bags during 1 of 2 days of survey (5/7/24). Findings: On 5/7/24 at 9:20 a.m., a surveyor observed Resident #9's Foley catheter bag hanging on the side of the bed, containing yellow urine, visible from the hallway/dining room. At this time, Resident #9 indicated he/she would like to have it covered and would be embarrassed if people could see it from the hallway/dining area. On 5/7/24 at 9:30 a.m., in an interview, Registered Nurse (RN)3 confirmed that Resident #9's Foley catheter bag with urine was visible to passersby in the hallway/dining room. On 5/8/24 at 8:15 a.m., in an interview, the surveyor discussed the finding with the Administrator.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50218 Based on observations, interview, record review, and facility policy the facility failed to complete a Self-Administration of Medication Assessment for 1 of 4 resident reviewed for medication administration. (Resident #1) Findings: Review of facility policy titled NSG309 Medications: Self Administration last reviewed 3/1/22 states Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self-administer: A physician/advanced practice provider (APP) order is required. Self-administration and medication self-storage must be care planned. Resident#1 was initially admitted [DATE] with diagnoses including hypertension, peripheral vascular disease, renal disease, and arthritis. Review of annual Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status (BIMS) of 11 of 15, indicating he/she has mild/moderately impaired cognition. During an observation Resident#1 on 5/7/24 at 9:15 a.m. a surveyor observed a plastic jar of A&D ointment on his/her bedside table. At this time Resident#1 indicated he/she received his/her eczema cream today and opened up the plastic jar of A&D ointment which contained a small plastic med cup which containing a small amount of white cream. Record review of Resident#1's Care Plan dated 4/5/24 lacks evidence of ability to self-administer medications. Record review of Resident#1's Electronic Medical Record (EMR) active orders for May 2024 revealed order with start date of 9/9/23: Resident MAY NOT administer own meds. During an interview on 5/7/24 at 10:47 a.m. with 2 surveyors and Certified Nursing Assistant (CNA)#2 he/she indicated that Resident#1 self-administers her eczema cream. During an interview on 5/7/24 at 10:50 a.m., Registered Nurse (RN)#2 confirmed Resident#1 was given Triamcinolone Acetonide External Cream this morning for self-administration. At this time RN#2 reviewed Resident #1's clinical record and confirmed with 2 surveyors that Resident#1 does not have an order for self-administration.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews and interviews, the facility failed to update/implement goals and interventions for 3 of 9 care plans reviewed (Resident #1, #4 and #6). Findings: Review of facility policy Person-Centered Care Plan dated 10/24/22 states A comprehensive person-centered care plan must be developed for each patient .Included measurable objectives and timetables to meet a patient's medical, nursing, and mental and psychosocial needs . 1. Review of Resident#1's active medication orders dated May 2024 revealed order with start date of 11/6/23 for Venlafaxine HCl ER Tablet Extended Release 24 Hour 75 MG Give 1 tablet by mouth one time a day for depression, Review of Resident#1's entire clinical record lacked evidence for monitoring side effects. Review of Resident#1's Care Plan dated 4/5/24 states [Resident #] is at risk for complications related to the use of psychotropic drugs for depression. [Resident #] will have the smallest most effective dose without side effects by next review . Monitor for side effects On 5/8/24 at 10:59 Registered Nurse (RN)#2 and RN#1 confirmed with 2 surveyors that Resident#1's clinical record lacks evidence of side effect monitoring. 2. Resident #4 was admitted on [DATE] with recent history of liver transplant. Review of Resident #4's clinical record revealed order with start date of 8/15/23 for Tacrolimus oral capsule 1 mg. Give 1 capsule by mouth every morning and at bedtime for prevent organ rejection. Review of Resident #4's care plan initiated 7/1/21 lacked evidence of goals and interventions for above medication. 3.Resident #6 was originally admitted on [DATE] with diagnoses to include congestive heart failure, dementia, depression, anxiety and delrium. Review of Resident #6's care plan initiated 4/2/21 states [Resident #6] exhibits physical and verbal behaviors .Ineffective coping skills, i. e., poor anger management, Poor impulse control. removes [his/ her] colostomy appliance and throws it at times.will not harm others by next review (became agitated . and struck other resident . pulled another residents hair) .will exhibit decreased episodes of anger, scratching staff, hitting and agitation Observe for signs of delirium, including delusions/hallucinations . exhibits distressed/fluctuating mood symptoms related to: Psychiatric Disorder Anxiety disorder, vascular dementia with behaviors . scratches and pinches staff when they are providing care. Observe for signs of delirium, including delusions/hallucinations- Observe worsening signs/symptoms of existing psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.) .Refocus to something positive when hitting and scratching .at risk for complications related to the use of psychotropic drugs for depression, Insomnia, Delerium, and Anxiety. Observe for changes in mental status and functional level .Observe for continued need of medication as related to behavior and mood. -Observe for side effects. Review of Resident #6's entire clinical record lacked evidence he/she was being monitored for these behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's medication orders active March 2024 revealed: -Order with start date of 9/5/23 for Furosemide tablet 20 mg. Give 1 tablet by mouth one time a day for CHF [chronic heart failure]. Review of Resident #6's Care plan initiated 2/23/23 lacked evidence that goals and interventions were in place for use of diuretic medication. During an interview on 5/8/24 at 10:53 a.m., Registered Nurse #2 confirmed the above findings. During an interview on 5/8/24 at 11:15 a.m., the above concerns were discussed with the Director of Nursing. 50218

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42531 Based on interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) that included, to the extent possible, participation of the resident and/or his/her representative after each assessment for 1 of 2 sampled residents (Resident #6). Findings: Review of facility policy Person-Centered Care Plan dated 10/24/22 states . a comprehensive, individualized care plan will be developed after each assessment .and review and revise the care plan after each assessment. After each assessment means after each .Minimum Data Set (MDS). The care plan will be prepared by the interdisciplinary teams . In conjunction with the patient/and or patient representative During review of Resident 6's medical record, the surveyor noted quarterly Minimum Data Set (MDS) Assessments dated 1/23/24. The clinical record lacked evidence that a care plan meeting was held by the Interdisciplinary Team (IDT), resident and/or representative for this assessment. In addition, the last documented IDT meeting was held on 10/23/23. During an interview on 5/8/24 at 11:05 a.m., Social Worker (SW) indicated that an IDT meeting should be held within 7 days of the MDS. At this time SW reviewed Resident #6's entire clinical record and confirmed a care plan meeting was not held with interdisciplinary team/Resident and/or representative.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 42531 Based on record review and interviews, the facility failed to monitor and document targeted behaviors to support the use of an antipsychotic and antianxiety medication for 1 of 2 residents reviewed for unnecessary medications (Resident #6). Findings: Review of facility policy Psychotropic Medication Use dated 10/24/22 states .Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication with agitated or psychotic behavior(s). Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions . Review of Resident #6's care plan initiated 4/2/21 states [Resident #6] exhibits physical and verbal behaviors .Ineffective coping skills, i. e., poor anger management, Poor impulse control. removes [his/ her] colostomy appliance and throws it at times.will not harm others by next review (became agitated . and struck other resident . pulled another residents hair) .will exhibit decreased episodes of anger, scratching staff, hitting and agitation Observe for signs of delirium, including delusions/hallucinations . exhibits distressed/fluctuating mood symptoms related to: Psychiatric Disorder Anxiety disorder, vascular dementia with behaviors . scratches and pinches staff when they are providing care. Observe for signs of delirium, including delusions/hallucinations- Observe worsening signs/symptoms of existing psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.) .Refocus to something positive when hitting and scratching .at risk for complications related to the use of psychotropic drugs for depression, Insomnia, Delerium, and Anxiety. Observe for changes in mental status and functional level .Observe for continued need of medication as related to behavior and mood. -Observe for side effects. Review of Resident #6's entire clinical record lacked evidence he/she was being monitored for these behaviors. Review of Resident #6's medication orders effective March 2024 revealed: -Order with start date of 8/24/23 for Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 75 MG (Venlafaxine HCl). Give 2 capsule by mouth one time a day for anxiety. Review of Residents clinical record lacked evidence he/she was monitored for behaviors, or side effects. -Order with start date of 8/24/23 Haloperidol oral tablet 0.5 mg (Haloperidol.) Give 1 tablet my mouth one time a day for delusions. Review of Residents entire clinical record lacked evidence that he/she was monitored for side effects of this medication/ behaviors for this medication. During an interview on 5/8/24 at 1:30 p.m., with 3 surveyors, Administrator and Director of Nursing (DON). DON was asked: - How behaviors are being monitored for psychotropic medications use? DON indicated the facility documents by exception and Certified Nursing Assistants (CNA) document behaviors, and the CNA would tell the charge nurse, and the charge nurse should put it in a progress note (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Why aren't the nurses assessing and documenting if there are behaviors/interventions in the Medication Administration Record (MAR)/Treatment Administration Record (TAR)? DON indicated it was because the CNA does the behavior monitoring. -How do you know staff is actually monitoring behaviors if it's not documented? DON stated, Because I trust my staff. -How is a provider supposed to know if the medications are effective if the nurse isn't documenting on a regular basis? How can they justify whether they should or shouldn't do a Gradual Dose Reduction if there's nothing being documents? DON indicated that they can ask the staff. At this time DON confirmed above findings.