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	09/03/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37440 Based on the facility's Falls Management policy, interviews and record review the facility failed to ensure that a resident's physician and/or representative were notified immediately of an unwitnessed fall and failed to follow its own policy and procedure for unwitnessed falls for 1 of 9 residents reviewed for falls. (#1) Findings: Cedar Ridge's Falls Management Policy and Procedure, revised 3/15/24 states under, 5. Post-Fall Management: 5.1 Evaluate the patient for injury. 5.1.1 First aid will be provided for minor cuts and abrasions. 5.2 Notify the physician / advanced practice provider (APP) of the fall, report physical findings and extent of injuries, and obtain orders if indicated. 5.2.1 If the injury is of an emergent nature, the patient will be transported to the hospital. 5.2.2 If the extent of injuries cannot be determined, the nurse will notify emergency medical services (EMS) for evaluation and transport to the hospital. 5.4 The patients representative will be notified of the fall and any follow up treatment needed. On 9/3/24 at 3:35 p.m., in an interview, Resident #1's [representative] stated that on 8/30/24, [Resident #1] had a fall and they did not notify [representative]. When [representative] came in the next day at approximately 1:30 p.m. which was 8/31/24, a Certified Nurses Aide (CNA) told [representative] about [representative][Residnet #1] falling the day before. The [representative]wanted [Resident #1] shipped to the hospital immediately. The facility shipped him/her and found out from the hospital he/she had a fractured leg. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's medical record indicated a nurses note dated 8/31/24 at 4:16 p.m. stated, CNA and [Resident #1's] [family member] came to this nurse stating res had fallen out of bed last night, and CNA reported to charge nurse on duty . Left knee is slightly swollen, painful to touch. Resident unable to use pain scale appropriately. Facial grimacing and protective body movements observed. Light range of motion (ROM) was completed on left ankle, no pain noted. Pain appears to be on left knee radiating to left hip only. Neurological assessment completed, no abnormal findings. Scheduled and PRN pain medication given prior to [family member] coming in. [family member] requested resident be transported to [hospital] for x-ray/evaluation of left knee and hip. This nurse called 911, res was transported to [hospital] via [ambulance]. His/her [family member]went with him/her. On call provider notified of situation, received order for transport . On call nurse manager notified of situation . Additionally, Resident #1's medical record lacked evidence that the physician and/or resident representative were notified on 8/30/24 of the resident fall. On 9/3/24 at 3:55 p.m., in an interview, the Director of Nursing (DON) told a surveyor that her understanding was that the resident fell out of bed on 8/30/24 sometime in the late afternoon or early evening and the [resident representative], who is the Power of Attorney (POA), was not notified until 8/31/24 when he/she was told by a CNA about the fall. The DON stated a CNA did not tell the nurse on 8/30/24 until about 9:00 p. m. or 10:00 p.m. in the evening about the resident fall. The DON stated she is not sure why a nurse did not call and notify the physician and the resident's POA. The [resident representative] stated [Resident #1] was obviously in pain and [resident representative] wanted him/her shipped out to the hospital. It was found out at the hospital he/she had a fracture of his/her lower left leg. At this time, the DON confirmed that the resident's physician and [resident representative] were not notified of the fall on 8/30/24 and that the [resident representative] had to find out from a staff member on 8/31/24 and that is when an order from an on call physician was received to transport the resident to a hospital for evaluation.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 37648 Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 9 residents reviewed. (#7) Finding: 1. Resident #7 was admitted to the facility 8/5/24 with diagnosis of cardiovascular accident with left side hemiparesis requiring anticoagulant treatment, dysarthria with modified diet texture, thrombocytopenia, depression, anxiety with ordered antianxiety medications and neurogenic bladder with indwelling supra-pubic catheter. On 9/3/24 resident #7's clinical record was reviewed and revealed that it lacked evidence of a base line care plan that included the instructions necessary to properly care for Resident #7's immediate health and safety needs for the use of an anticoagulant and antianxiety. In addition, a care plan for Activities of Daily Living, impaired swallowing, cognitive loss, chronic pain, indwelling supra- pubic catheter and risk of falls were not initiated until 8/13/24, eight days after admission. On 9/3/24 at 2:25 p.m., during interview with interim Director of Nursing the above was confirmed.

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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** 37648 Based on record review and interviews, the facility failed to ensure that a care plan was followed for a 2 assist transfer for 1 of 4 sampled residents requiring a mechanical device use for a transfer and failed to ensure the care plan was accurate to reflect the residents advanced directive code status. (Resident #7) Findings: 1. On 8/30/24 at 9:24 a.m. during an interview with Resident #7's representative, [he/she] stated Resident #7 fell on [DATE] due to only one staff assisting (him/her) during a transfer when there should have been 2 staff. Review of Resident #7's medical record contained an e-Interact note dated 8/7/24 stating, The resident in [room] had a fall today. The CNA (Certified Nurses Aide) was helping the resident to transfer to the commode. While standing pivoting to the commode, (he/she) lost (his/her) balance. And The CNA tried to catch the resident but the resident was moving too fast and ended up on the floor. The Nurse went to [room] and saw the resident was on the floor and the CNA tried to help and comfort at that moment. Resident #7's care plan dated 8/5/24 states, [Resident] requires assistance for mobility related to: deconditioning r/t recent hospitalization .Intervention: Provide [Resident] with sit to stand Med size total assist two assistance transfer . 2. Review of Resident #7's medical record contained the hospital history and physical dated 7/31/24 stating, [Resident] is a Do not resuscitate (DNR). The hospital discharge summary dated 8/5/24 states, Code Status: Allow Natural Death, DNR and the Treatment Directives signed by the physician on 8/5/24 states the resident is a Do not resuscitate (DNR). Review Resident #7's care plan initiated on 8/6/24 states, [Resident] has an established advanced directive code status: Full Code. On 9/3/24 at 2:25 p.m., during interview, the interim Director of Nursing confirmed the CNA did not follow the plan of care which resulted in the residents fall and confirmed the plan of care was not accurate in the area of advanced directives.

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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. 37440 Based on interview, observation and record review, the facility failed to revise the care plan to reflect a resident's current status for 1 of 2 residents reviewed for infection prevention and control (#1). Findings: On 9/3/24, review of Resident #1's electronic medical record, on the front page stated, Infection Prevention and Control Covid 19(Coronavirus) Onset Date 8/24/2024 Infection Status Confirmed (D) Isolation Precautions Airborne, Contact Isolation Start Date 8/24/2024 - Expected End Date 9/4/2024 PPE Requirements - Gloves, Gown, N95 Respirator, Eye Protection (Face Shield or Goggles) On 9/3/24 at 9:00 a.m., a surveyor observed signage on the Resident #1's room door which stated Airborne and contact precautions N95 mask, a gown, a face shield, and gloves. There was a wheeled cart outside the residence door with personal protective equipment in it. Review of Resident #1's current care plan lacked evidence of updating and revised to reflect the current status of the resident. On 9/3/24 at 10:20 a.m., in an interview, the Director of Nursing confirmed that Resident #1's current care plan lacked evidence of updating and revision to include COVID to reflect the current status of the resident.

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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. 51331 Based on facility policy, observations, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer use for 2 of 2 residents reviewed for respiratory care. (Resident #4 and #6) Findings: The facilities procedure on Nebulizer: Small Volume last revised on 11/1/2023, section 21 states to rinse small volume nebulizer, mouthpiece, and T piece with sterile water and dry. In subsection 21.1 the procedure states to place in treatment bag labeled with patient name and date. Subsection 21.2 the procedure then states to replace and date the setup daily, if used. The facilities Oxygen Nasal Cannula procedure dated 8/7/23 instructs nursing to, replace disposable set-up every seven days. Date and store cannula in treatment bag when not in use. 1. On 9/4/2024 at 9:00 a.m., observation of Resident #4's unlabeled nebulizer tubing and mouthpiece stored on bedside table with other personal belongings. No treatment bag was observed in the resident's room. Review of Resident #4's medical record, the last documented nebulizer treatment was administered on 8/30/24. In addition, the medical record lacked evidence of a provider's order to change nebulizer tubing or when the nebulizer tubing was last changed. 37648 2. On 9/3/24 at 9:08 a.m. and 11:06 a.m., observation of Resident #6 with Oxygen (O2) nasal cannula tubing labeled with a date of 8/25/24, the oxygen concentrator filter was coated with thick layer of dust. On 9/3/24 at 12:07 p.m., both the surveyor and Registered Nurse (RN) #2 observed Resident #6's O2 tubing dated 8/25/24 with the filter coated with dust. At this time, the RN stated the tubing should have been changed and the filter cleaned weekly on Sunday nights. On 9/3/24 at 12:45 p.m., during an interview, the Director of Nursing confirmed the above.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on facility policy review, interview and record review the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs by administering excessive doses of Ativan in less than 7 hours and failed to monitor of psychotropic medication side effects for 1 of 9 sampled residents (#7). Findings: The facility's policy, Behaviors: Management of Symptoms, revised on 7/1/24 states, Staff will use non-pharmacological interventions as the first line of approach to managing challenging behaviors. The facility's policy, Medication Monitoring dated 1/24 under Guidelines For Psychotropic Medication Monitoring states, When monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences and under section Chemical Restraints states, When any medication restricts the resident's movement or cognition, or sedates or subdues the resident, and is not an accepted standard of practices for a resident's medical or psychiatric condition, the medication may be a chemical restraint. On 8/30/24 at 9:24 a.m., during a telephone interview, Resident #7's [representative] stated when [he/she] had visited [Resident #7] on 8/13/24, [he/she] had concerns about [his/her] parent status, and noticed [his/her] parent was out of it, [Resident #7] was not making any sense and [Resident #7] couldn't open his/her eyes. Resident #7s respresentative then stated [he/she] was told by the nurse they were giving (Resident #7) Ativan overnight, but they gave (him/her) too much, stating they snowed (him/her) and they gave (him/her) 3 mg Ativan overnight to basically make (him/her) sleep. Resident #7 was admitted to the facility on [DATE] with diagnosis of cardiovascular accident (CVA) with left side hemiparesis (L Hemi), depression and anxiety. Review of resident #7's medical record contained a Providers Admission History and Physical dated 8/6/24 under Assessment Plan stated, Hx CVA: w/L Hemi, dysarthria, spastic bladder. Continue with ASA, Plavix and Statin therapy. Supportive care and monitor, and Anxiety: (He/she) admitted with Ativan TID (three times daily) PRN (as Necessary). Physician order dated 8/5/24 for Lorazepam (Ativan) oral tablet 1 milligram (mg), give 1mg by mouth as needed for anxiety x3 daily PRN. The Medication Administration Record for August 2024 showed, Resident #7 received 3 mg of Ativan within 7 hours. On 8/12/24 he/she received Ativan 1mg at 8:00 p.m. another 1mg at 10:27 p.m., then the 3rd mg at 3:00 a.m., on 8/13/24. The medical record lacked evidence of behavioral symptoms warranting the PRN or non-pharmacological interventions attempted prior to the 8:00 p.m., dose. The medical record also lacked documentation of non-pharmacological interventions attempted prior to the resident receiving the second dose at 10:27 p.m., or the third dose at 3:00 a.m. Further review of Resident #7's clinical record, the medical record lacked evidence of monitoring for potential adverse consequences for the use of Ativan. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A providers note dated 8/13/24 under Assessment Plan stated, Anxiety: Patient currently with Ativan 1 milligram three times daily as needed. Nursing notes that they used all three doses in a short time. Family left concerns with nursing staff about decreasing overall dosing of Ativan. In discussion with nursing on day shift will change Ativan to 1 milligram scheduled at bedtime and half a milligram every eight hours as needed for severe anxiety. On 9/3/24 at 2:25 p.m., during an interview, the Interim Director of Nursing (DON) reviewed the Ativan administration times and documentation stating, nursing expectation for an order for 3x daily should be every 8 hours. On 9/5/24 at 1:25 p.m., during an interview, the PharMerica pharmacists (pharmacy utilized at the facility) stated if an order is written to administer a medication 3x daily or TID (three times daily), it's the expectation or standard of every 8 hours, it's the expected practice.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37648 Based on record review and observation, the facility failed to ensure the Treatment Administration Record (TAR) was accurately documented for changing of oxygen tubing for 1 of 2 residents reviewed for oxygen use (#6). Finding: On 9/3/24 at 9:08 a.m., and at 11:06 a.m., a surveyor observed Resident #6 using Oxygen (O2), via nasal cannula with the tubing dated for Sunday 8/25/24 and the filter located on the back of the concentrator coated with a layer of dust. Review of the residents TAR, nursing documented the oxygen tubing was changed and the filter was cleaned on 9/1/24. On 9/3/24 at 12:07 p.m., both the surveyor and the registered Nurse (RN) #2 observed resident #6's O2 tubing dated 8/25/24 and the filter coated with dust. RN #2 stated the tubing should be changed on Sunday nights. On 9/3/24 at 12:12 p.m., during an interview, the above was discussed with the Director of Nursing

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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. 37440 Based on record review, interviews and observations the facility failed maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 day of survey. Findings: On 9/3/24 at 9:00 a.m., two surveyors observed signage on Resident #1's bedroom door which stated, contact and airborne precautions. N95 mask, a gown, a face shield, and gloves needed when entering room. There was a wheeled cart outside the resident's door with personal protective equipment in it. On 9/3/24 at 9:10 a.m., in an interview, when asked by a surveyor what precautions were needed to enter Resident #1's room, the Registered Nurse (RN #1) stated that resident #1 is on contact and airborne precautions and a N95 mask, a gown, a face shield, and gloves were needed. On 9/3/24 at 9:13 a.m., two surveyors observed two Certified Nursing Assistants (CNA #2 and CNA #3) go in to Resident #1's room, without donning a N95 mask, a gown, a face shield and gloves. When exiting the room, both CNA #2 and CNA #3 confirmed they did not use required personal protective equipment for Resident #1's room. They stated that they thought the resident was off precautions. At this time, RN #1 confirmed that the two CNAs did not use required personal protective equipment when entering the resident's room and stated the resident was on precautions until 9/4/24. On 9/3/24 at 1:00 p.m., in an interview, a surveyor discussed the infection control findings with the Director of Nursing and the Administrator.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observation and interviews, the facility failed to ensure that a resident's bed was maintained in good repair and safe operating condition for 2 of 2 observations for 1 of 1 day of survey. (9/3/24) Findings: On 9/3/24 at 3:35 p.m., in an interview with Resident #1's representative [RR], [he/she] stated that the bed rail had been broken for a long time and it was stuck in the up position. Resident #1s representative demonstrated to the surveyor that the side rail would not function properly on the right side of the bed as you're looking at it from the foot of the bed. The surveyor observed [RR] trying to put the railing down and it would not go down as it was stuck in the up position. The [RR] then went around to the other side of the bed and easily put down the left side rail. [RR] stated [RR] had reported this to the nursing staff many times over the past few weeks and no one had done anything about it. On 9/3/24 at 4:20 p.m., in an interview, Certified Nursing Assistant/Medication Tech(CNA/M) told the surveyor that when the ambulance brought Resident #1 back to the facility on [DATE] from an evaluation at a hospital emergency room for a fall the resident had on 8/30/24, she nor the ambulance crew could make the right siderail (facing the bed from the foot of the bed) work or function. She stated she does not know how long the side rail had not been working and stuck in the up position. On 9/3/24 at 4:25 p.m., a surveyor observed two maintenance men in Resident #1's room working on his/her bed side rail for approximately 5 minutes without fixing it. They went around and tried the left side rail and found it to be working properly. They then exited the room and spoke with a surveyor. The surveyor asked if the right side railing was broken and if either maintenance personnel knew how long the railing had been broken. They both stated that it was broken, they did not have a work order on the bed rail and they did not know how long it had been broken. On 9/3/24 at 4:10 p.m., in an interview, the surveyor discussed the finding of the broken bed rail on Resident #1's bed with the Administrator.