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	01/15/2025

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 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51669 Based on interviews, record review, and facility policy, 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 care for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Finding: Review of policy, OPS416 Person-Centered Care Plan, dated 10/24/22, states .The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care .1. A baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including, but not limited to: initial goals based on admission orders; physician orders; dietary orders; therapy services; social services; PASRR recommendation, if applicable . Review of policy, NSG236 Skin Integrity and Wound Management, dated 10/15/24, states, .The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation . Resident #1 was admitted on [DATE] with diagnoses to include Deep Tissue Injury. Review of Resident #1's Wound Evaluation, dated 12/11/24, revealed Resident #1 had a Deep Tissue Injury located on his/her coccyx that was present on admission. Review of Resident #1's care plan, initiated 12/12/24, lacked evidence that goals and interventions were put into place for the wound. On 1/15/25 at 3:17 p.m., the interim Director of Nursing (DON) reviewed Resident #1's care plan and confirmed it did not contain goals and interventions for the above concern.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51669 Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for wounds (Resident #1). Finding: Review of facility policy, Skin Integrity and Wound Management, dated 10/15/24, states, Practice Standards . 6. The licensed nurse will .6.2 Document any newly identified skin/wound impairments .6.7 Notify interdisciplinary team members for a comprehensive approach to care including prevention and wound treatments .9. Notify physician/APP to obtain orders . Resident #1 was admitted on [DATE] with diagnoses to include Deep Tissue Injury on coccyx. Review of Resident #1's Wound Evaluation, dated 12/11/24, revealed Resident #1 had a Deep Tissue Injury located on his/her coccyx that was present on admission. Further review of the Wound Evaluation revealed, Treatment .Cleansing solution: soap & water .Primary dressing: no dressing applied . Review of Resident #1's Wound Evaluation, dated 12/18/24, revealed the coccyx wound was Deteriorating and Treatment . Dressing Appearance: Intact .Cleansing solution: Generic wound cleanser .Primary Dressing: zinc oxide covered with optifoam . Further review of Resident #1's clinical record lacked evidence of a provider order for the treatments indicated on Resident #1's Wound Evaluations, dated 12/11/24 and 12/18/24. During an interview on 1/16/25 at 9:45 a.m., Registered Nurse (RN) #1 stated that on admission, residents are assessed for wounds, and if a wound is present, the nurse takes a picture and documents and then notifies the doctor, and the treatment orders are obtained. During an interview on 1/15/25 at 1:48 p.m., Physician Assistant-Certified (PA-C) #1 stated it was her expectation that there would be a provider order to match what is listed in the Treatment section of a resident's weekly Wound Evaluation assessment. During an interview on 1/15/25 at 3:15 p.m., the interim Director of Nursing (DON) reviewed Resident #1's entire clinical record and confirmed it did not contain a provider order for the for the treatments indicated in Resident #1's Wound Evaluations.