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	06/03/2025

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 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treat residents equally regarding transfer, discharge, and provision of services for all residents, regardless of payment source Based on record review and interviews, the facility failed to ensure equal access to services, including assistance with alternative placement, when the payor source changed from Medicare Part A to private pay for 1 of 1 residents reviewed for discharge. Findings: A review of the clinical record for R9 reveals he/she was admitted to skilled nursing services in May, 2023. On 9/24/24, the facility provided notice of Medicare non-coverage (NOMNC) to R9's health care power of attorney (POA) informing that skilled services would be ending on 9/26/24. On 11/12/24, a Medical Eligibility Determination Assessment was completed which found R9 was not medically eligible for nursing home level of care. Section Y of the assessment indicated R9 would be entering residential care. A review of the quarterly Minimum Data Set (MDS) 3.0, dated 11/29/24 revealed a BIMS (brief interview for mental status) score of 13, indicating R9 was cognitively intact. Section Q of the MDS - Participation in Assessment and Goal Setting, revealed R9 and the family participated and that no active discharge plan was in place for R9 to return to the community. A review of the facility's policy, Discharge and Transfer, dated 3/24/25, Section 4. Voluntary Discharge, stated 4.1 If patient is discharging to home, an assisted living center, or other community based/home alternative setting: 4.1.1. The Discharge Transition Plan is given to the patient, family member, or legal representative; 4.1.2., a copy of the Discharge Transition Plan will be placed in the patient's medical record; 4.2, A patient must not be forced, pressured or intimidated into leaving the center voluntarily. For patients who are admitted for short term, skilled rehabilitation under Medicare, in anticipation of completion of the rehabilitation program, the Center must assist the patient to evaluate their need for care and pursue payment options in the manner required by applicable laws/regulations. Unlawful discrimination based on payment source is prohibited. A review of a progress note, dated 11/21/24, stated staff met with R9 and the POA to discuss that he/she did not qualify for nursing home level of care and that it was necessary to move to a lower level of care to save money. The record indicated a bed was available at an assisted living facility in Farmington. Documentation in the record indicated R9 refused to move from the facility. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25, the annual MDS was completed, which revealed a BIMS score of 3, indicating severely impaired cognition. Section Q stated no active discharge plan to return to the community was in place. Section GG, Functional Abilities, indicated R9 required set up/clean up assistance for ADLs, supervision/touch assistance for transfers to shower/tub, partial/moderate assistance with upper body dressing, and was independent with wheelchair mobility. The assessment indicated R9 required a lower level of care than nursing home. On 5/30/25, the quarterly MDS was completed, which revealed a BIMS score of 3, indicating severely impaired cognition. Section Q stated an active discharge plan to return to the community was in place and the discharge date was 3 or fewer months away. Section GG, Functional Abilities, indicated R9 required set up/clean up assistance for all ADLs, and was independent with transfers and wheelchair mobility. The assessment indicated R9 had improved in functional abilities and required a lower level of care than nursing home. No discharge plan was located within R9's clinical record. On 6/2/25, at 11:35 a.m., in an interview with a surveyor, R9's POA stated he/she had been paying privately for R9's care at the facility, and within 2 months, R9's money would be gone. The POA stated R9 did not belong at the facility but had chosen to remain there and the facility staff had indicated R9 was capable of making his/her own decisions. The POA stated facility staff threatened me with APS (Adult Protective Services) if I have attempted to move R9. On 6/3/25 at 2:00 p.m., two surveyors interviewed the Market Clinical Advisor, Administrator, Long-Term Care Unit Manager, Business Office Manager, and Social Worker. A surveyor discussed the POA's concerns that R9's savings were almost depleted, that the BIMS was only 3, and that R9 was not competent to make the decision to remain at the facility. The Administrator stated R9 was very sure he/she wanted to stay at the facility and under no circumstances wanted to go anywhere else. A surveyor discussed that when the POA had arranged to transport R9 to an assisted living facility (ALF), staff had threatened him/her with calling APS, and as POA, did he/she have the right to take R9 out of the facility? The nurse manager stated We did call APS. (R9) gets very psychotic and threatens to kill him/herself, whenever the discussion is held regarding transfer. The nurse manager stated the POA had never had any contact with staff about discharge. A surveyor asked what will happen if R9 is reassessed and does not qualify at nursing home level of care. The Administrator stated the resident would be involuntarily discharged and would qualify for days awaiting placement. A surveyor asked why had the facility not taken steps towards preparing for discharge since R9 had qualified at assisted living level of care since November, 2024. The Administrator stated The conversations we've had with R9 were not just recently, before the change in his/her BIMS. We need to re-engage in the conversation. We have had no contact with the (POA). The surveyor asked what will the facility's plan be when R9's money runs out in approximately 2 months and can no longer pay privately. The Business Office Manager stated R9 would be days awaiting placement pending Mainecare. He/she would have to take an ALF when available within 60 miles. We will need to reach out to (the POA).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 10. On 6/3/25 at 10:00 a.m., in an interview with a surveyor, Resident #10 stated that he/she had asked to use the bedpan at approximately 2:10 am this morning. They came and put me on it and I rang again when I was finished. No one came until 7 or 8 o'clock this morning. I ended up taking it out and it fell off the bed when I moved. The nurse was the one who found it. On 6/3/25 at 1:20 p.m., in an interview with a surveyor, the RN confirmed that he/she had found Resident #10's bedpan spilled on the floor and had to clean it up. He/she stated there had been no CNA from 6 a.m. to 8 a.m. on the unit and he/she was doing both jobs as the CNA and the nurse on the Blue Spruce unit. On 6/3/25 at 1:30 p.m., the finding was discussed with the Director of Nursing. Based on record reviews, interviews, and facility staffing schedules review, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Findings: Review of the facility's staffing schedules and the resident census of those days, showed the facility failed to assure staffing minimums were met for 23 of 31 days reviewed for staffing.(3/14/25 to 3/23/25 and 5/14/25 to 6/3/25) 1. On 6/3/25 at 9:15 a.m., in an interview with a surveyor, Resident #3 stated, I have had to wait a very long time on the evening shift because there is not enough staff to do my care. I have had accidents and wet myself because no one has come for over an hour when I ring the call bell. Then, I have to sit in wetness for over an hour before I am changed. The staff tell me they are short staffed and will get to me when they can. 2. On 6/3/25 at 9:30 a.m., in an interview with a surveyor, Resident #4 stated, When I put my call bell on, it takes a very long time for them to come answer it. Sometimes over half an hour. I get the are busy but they say they are short staffed and they will get to me when they can. I have to wait a long time for my care. 3. On 6/3/25 at 9:55 a.m., in an interview with a surveyor, Resident #1 stated, I have been told by the CNA[Certified Nursing Aide] staff to stop ringing my call bell so much. I have had a few of the CNAs say to me to stop asking for assistance so much because they are short staffed and are doing the best they can. I used to walk but I am too weak to now because they stopped walking me. I don't ask anymore because the staff tell me they don't have time to walk me. 4. On 6/3/25 at 10:00 a.m., in an interview with a surveyor, Resident #5 stated, They take half an hour to an hour to answer my call bell. I have to wait so long to get my care. The CNA staff tell me it is because they are short staffed. My roommate and I have both yelled for assistance because no one comes for the call bells for a long time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 6/3/25 at 10:10 a.m., in an interview with a surveyor, Resident #7 stated, I have to wait a very long time to get my care. I have had accidents because they haven't assisted me to the toilet when I needed to go. They made me wait too long. The tell me that they are short staffed and I have to wait. Ask my roommate. We both have yelled for someone to come help us. 6. On 6/3/25 at 10:20 a.m., in an interview with a surveyor, a staff member wishing to stay anonymous stated, We are so short staffed that care for the residents isn't being done sometimes and a lot not done timely. Residents have to wait so long for us to answer their call bells that some have accidents, as in soiling themselves. I have come in and found resident left in soiled beds and I don't know for how long. We tell the administration and they say we are staffed to correct ratios. The evening shift is so short that they don't get their baths done and days have to try to pick them up. Some nights there is only one CNA here with a nurse for the whole facility. 7. On 6/3/25 at 10:30 a.m., in an interview with a surveyor, a staff member wishing to stay anonymous stated, We work short all the time here. Baths and positioning and ADL[Activities of daily living] care is not getting done as it should. Especially on the evening shift. 8. On 6/3/25 at 13:00 p.m., in an interview with a surveyor, Resident #6 stated, I have put my call bell on and have had to wait longer than half an hour for staff and have had an accident because no one came to help me. It was very embarrassing. The CNA staff have told me they are short staffed and for me not to use my call bell so much. 9. On 6/3/25 at 3:45 p.m., in an interview with a surveyor, Resident #8 stated, The staffing is terrible at this facility. On the evening shift, there is 1 CNA to cover the D and C units. The CNA will start out here and then go to the other unit and we are left here all alone. I have put my call bell on and no one comes for over an hour and I shit myself. Then I have to wait to be cleaned up. It's just not right. I had my bell on for over an hour this morning before anyone came to help me. My family was here with me a few days ago and I had to go to the bathroom and they had to go to another unit to find someone to help me because no one came to answer my call bell for over half an hour. I have had accidents more than once because they aren't staffing with enough staff. On 6/3/25 at 4:30 p.m., 2 surveyors discussed the findings with the Administrator.