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	01/30/2025

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

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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 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. 51669 Based on observation, record review, and interviews, the facility failed to provide care to residents in a manner that maintains each resident's dignity by failing to serve all residents seated at the same table at the same time for 1 of 2 dining observations on 1 of 1 days of survey. Finding: Review of the facility's Resident Council Meeting Minutes, dated 12/31/24, revealed resident concerns that residents are concerned that trays are being served in rooms on units before the dining room service . Resident Council Meeting Minutes , dated 11/27/24 states, Dining Services .Trays in order of room on carts . Nursing: Tray served in dinning [dining] room first by table before room trays . Resident Council Meeting Minutes, dated 10/30/24 states, CNA's [Certified Nursing Assistants] are not serving residents at the table in the dining room first . On 1/28/25 between 12:23 p.m. and 12:40 p.m., during a dining observation on the Hickory Unit, a surveyor observed a table seating 3 residents. At 12:29 p.m., Resident #60 received his/her meal. Staff then proceeded to deliver meals to other tables in the dining room and to residents who were eating in their rooms. At 12:34 p.m., Resident #55 received his/her meal. Staff again delivered to adjacent tables and residents in their rooms. Resident #12, seated at the same table, did not receive his/her meal until 12:39 p. m. At this time, Certified Nursing Assistant-Medication Tech (CNA-MT) #1 and Certified Nursing Assistant (CNA) #3 stated residents typically sit at the same table each day and that the meal truck is typically ordered by room number; staff serves residents in the dining room before serving residents in their rooms and should serve a complete table before serving residents at another table. On 1/28/25 at 1: 05 p.m., during an interview the Food Services Account Manager, stated the trays in the meal delivery trucks are organized by room number and that there has been talk about changing the order of stacking in the trucks to coordinate with how the residents are seated in the dining room, but nothing has been implemented. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at approximately 1:10 p.m., during an interview, the above finding was discussed with the Director of Nursing (DNS), who stated the concern has been brought to Quality Assurance and Performance Improvement (QAPI) meeting for review. As of 1/30/25 upon the surveyors exit, the DNS was unable to provide evidence that a performance improvement process was in place.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 51331 Based on record review and interviews the facility failed to appropriately notify a resident and or resident representative in a timely manor, prior to changing a residents room, for 1 of 1 residents reviewed for room change. On 1/21/25 the Division of Licensing and Certification received a complaint in regards to a resident's room being changed without proper notification. On 1/27/25 at 8:00 p.m., during an interview Resident #57 and his/her family member both stated that they had not received any notification of a room change prior to it occurring. Review of Resident #57's clinical record indicates that the resident was moved from Elm Unit to Hickory Unit on 1/15/25. Further review of the clinical record lacked evidence that any notification of the room change occurred. On 1/30/25 at 2:31 p.m., during an interview with the Market Clinical Advisor the above information was confirmed.

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on facility policy review, record reviews, and interviews, the facility failed to ensure that the resident and/or resident representative was provided with written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, was completed for 8 of 16 residents reviewed for advanced directives. (Resident #5, #61, #27, #51, #26, #31, #474 and #325). Findings: Review of facility policy Health Care Decision Making revision date 1/8/24 states It is the right of all patients/residents to participate in their own health care decision making, including the right to decide whether they wish to request, accept, refuse, or discontinued treatment, and to formulate or not formulate an advance directive. Centers Must: inform and provide written information to all patients concerning their right to refuse medical or surgical treatment and, at the patient's option, formulate an advance directive. Provide a written description of the facility's policies to implement advanced directives and applicable state laws. Approach a capable patient who does not have an advanced directive upon admission; the patient will be approached by the social worker or other designated staff person admission, quarterly, and with changing condition to discuss whether to consider developing an advanced directive. Inquire with the individuals patient representative if the patient is incapacitated at the time of admission as to whether and advance directive has been completed/executed in accordance with state law. 1. Resident #5 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 2. Resident #61 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 51331 3. Resident #27 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 4. Resident #51 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. (continued on next page)

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	51669 5. Resident #26 was admitted on [DATE]. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 6. Resident #31 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative or that the resident and/or representatives were provided with written information concerning the right to formulate an advanced directive. 7. Resident #474 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative or that the resident and/or representatives were provided with written information concerning the right to formulate an advanced directive. 37015 8. Resident #325 was admitted on [DATE]. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative or that the resident and/or representatives were provided with written information concerning the right to formulate an advanced directive. On 1/29/25 at 3:17 p.m., in an interview with 4 surveyors, the Market Clinical Advisor confirmed the residents' medical records lacked Advance Directives or evidence that the resident or representative had been offered assistance to formulate an Advanced Directive.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37440 Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of Post-Traumatic Stress Disorder(PTSD)/trauma for 3 of 4 sampled residents reviewed for PTSD. (#1, #5, #51) Findings: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses to include PTSD. Review of Resident #1's clinical record on 1/28/25 revealed it lacked documented evidence that the current care plan had been developed and implemented in the area of PTSD to include goals, interventions and triggers. 2. Resident #5 was admitted to the facility on [DATE] with diagnoses to include PTSD. Review of Resident #5's clinical record on 1/28/25 revealed it lacked documented evidence that the current care plan had been developed and implemented in the area of PTSD to include goals, interventions and triggers. 51331 3. Resident #51 was admitted to the facility on [DATE]. Review of the residents medical record indicates he/she has a diagnosis of Post-Traumatic Stress Disorder (PTSD). Further review of the his/her medical record lacks evidence of a care plan for PTSD . On 1/28/25 at 3:37 p.m., in an interview, the Market Clinical Advisor confirmed that the residents' current care plans did not include Goals, Interventions or triggers to address PTSD.

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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 and record review, the facility failed to review, revise and update a care plan in the area of Post-Traumatic Stress Disorder (PTSD) for 1 of 4 residents whose care plans were reviewed for PTSD. (#18) Finding: Resident #18 was admitted the facility on 12/23/21. On 4/14/23, the resident was identified/diagnosed with Post-Traumatic Stress Disorder (PTSD). Review of Resident #18's clinical record revealed the current care plan was not reviewed, revised and updated to include goals, interventions or triggers for PTSD. On 1/30/25 at 12:47 p.m. in an interview, the Market Clinical Advisor confirmed that the Resident 18's care plan was not reviewed, revised and updated to include goals, interventions or triggers for PTSD.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observations and interviews, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 4 days of survey. (1/27/25, 1/28/25 and 1/29/25) Findings: 1. On 1/27/25 at 6:15 p.m. a surveyor observed on the Blue Spruce Unit a portable oxygen machine and nasal canula and tubing on the floor next to the exit door. On 1/27/25 at 6:15 p.m., in an interview, Licensed Practical Nurse (LPN #1) confirmed that the portable oxygen machine, the nasal canula and the tubing should not be on the floor and that it should be bagged and stored off the floor. On 1/27/25 at 6:30 p.m., in an interview, Registered Nurse (RN#1) confirmed that the portable oxygen machine, the nasal canula and the tubing was and should not have be on the floor and went on to say that no resident was using it at that point. 2. On 1/27/25 at 6:20 p.m., a surveyor observed oxygen tubing and a nasal canula hanging on the left wheelchair handle and not stored in a bag which was hanging on the back of a wheelchair. On 1/27/25 at 6:17 p.m., in an interview, LPN #1 stated that it should be stored in a bag when not in use. On 1/27/25 at 6:30 p.m., in an interview, RN#1 stated that this oxygen tubing and nasal canula hadn't been used by a resident for 2 to 3 days and that it should be stored in a bag when not in use. 51669 3. On 1/28/25 at 9:14 a.m., during an observation of room [ROOM NUMBER], Resident #474's unbagged and undated nasal cannula tubing was draped over the top corner of the light fixture located above the resident's bed, with the nasal cannula prongs in direct contact with the surface of the light fixture. 4. On 1/27/25 at 6:32 p.m. and on 1/28/25 at 2:45 p.m., during observations of room [ROOM NUMBER], Resident #31's unbagged nasal cannula was lying at the head of the bed. The oxygen concentrator next to the bed had an empty plastic storage bag, dated 1/26/25. During a follow-up observation on 01/29/25 at 9:30 a.m., the unbagged nasal cannula tubing was tucked between the resident's sheets. On 1/29/25 at 3:06 p.m., during an interview both the surveyor and Registered Nurse (RN) #1 observed that Resident #31 was sleeping on top of his/her nasal cannula. At this time, RN #1 confirmed that nasal cannulas should be stored in a plastic bag when not in use and that tubing and bags are changed weekly.

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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. 37440 Based on record review and interviews, 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 Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the fourth quarter of 2024 (July 1 - September 30). On 1/28/25 at 3:30 p.m., in an interview with a surveyor and review of weekend staffing for July 1, 2024, through September 30, 2024, the Administrator confirmed the facility did not have enough staff to meet resident needs on the weekends. On 1/28/25 at 10:58 a.m., in an interview with a surveyor, Resident #327 stated on one day during the previous weekend, I had to pee myself, had to wait 30 minutes after using the call bell, due to lack of staff. When in bed Resident #327 stated compression devices are applied to both legs and he/she can't stand up without assistance due to dizziness. Resident #327 stated they need more help around here. On 1/28/25 at 2:35 p.m., in an interview with 4 surveyors, a family member stated one night between 1/17/25 to 1/19/25, he/she had received a call from the resident stating that he/she needed to use the bathroom and no one had answered the call bell. The family member stated he/she she tried to call numerous times, but no staff answered the phone. The family member came to the facility and found the call light for room still on. On 1/28/25 at 4:12 p.m., in an interview with a surveyor, Resident #16 stated he/she had a diagnosis of PTSD (post traumatic stress disorder), and I've been stuck in the bathroom and had to wait 20 minutes for someone to come. I panic if someone leaves me more than 20 minutes. It's hard, they can say they're sorry all they want but it doesn't take away that fear. They never have floats anymore. They try to make do with what they have. Resident #16 stated he/she requires a sit to stand lift for transfers and there is usually only 1 staff on the unit most of the time. This causes an extended wait due to staff needing to find assistance to complete the transfer. On 1/28/25 at 5:03 p.m., in an interview with a surveyor, Resident #9 stated I rang to go out in the dining room at 4:00 p.m., and I just got out there (4:45 pm). There's only 1 staff and she was giving a shower and had 4-5 (call) bells on. Resident #9 stated there had been one night where was he/she had been left wet all night when his/her catheter was leaking and no staff answered the call bell.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on record review, observations and interviews the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts, on 4 of 4 units reviewed (Hickory, Elm, Blue Spruce and Scotch Pine) and failed to maintain adequate pharmaceutical services to ensure the receipt and administration of physician ordered medication was available to meet the needs of a resident requiring intravenous antibiotics (Resident #329). Findings: A review of the facility's Controlled Medication Storage policy and procedure dated: 1/24, under #6 states: At each shift change or when keys are surrendered, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses or approved individuals per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. On 1/29/25 during medication storage the following was reviewed: 1. Blue Spruce unit Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 9/29/24, 10/8/24, 10/9/24, 10/17/24, 10/21/24, 10/22/24, 10/30/24, 11/27/24, 11/28/24, 11/29/24, 12/4/24, 12/7/24, 12/21/24, 12/22/24, 1/8/25, 1/9/25, 1/17/25 and 1/18/25. 2. Hickory unit Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates:8/12/24, 8/21/24, 8/15/24, 10/16/24, 11/4/24, 11/14/24, 11/18/24, 1/4/25, 1/19/25 and 1/20/25. 3. Elm unit Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 9/27/24, 10/16/24, 10/21/24, 10/24/24, 12/6/24, 12/7/24, 12/8/24, 12/17/24, 12/21/24, 12/25/24, 1/13/25 and 1/14/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Scotch Pine unit Controlled Substance Book and Shift Counts were reviewed, which indicated the facility counts at the change of each shift, approx. 3 times a day. The person authorized to administer medications coming on duty and/or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 11/14/24, 11/19/24, 11/27/24, 1/8/25, 1/28/25 and 1/29/25. On 1/29/25 at 9:45 a.m., during an interview, the above was discussed with the Director of Nursing. 37015 5. On 1/28/25 at 1:18 p.m., in an interview with a surveyor, Resident #329 stated he/she had been admitted last Friday (1/24/25), and was supposed to receive an IV (intravenous) antibiotic but it was not available until Monday (1/27/25). A review of the clinical record confirmed Resident #329 was admitted on [DATE] with diagnoses including acute osteomyelitis of the left foot and underwent a below the knee amputation on 1/8/24. Resident #329 was readmitted to the hospital with vasculitis, viral pneumonia, urinary tract infection and pyelonephritis. A review of the physician orders noted the following, Aztreonam Injection Solution Reconstituted 1 GM (gram) - Use 1 gram intravenously three times a day for infection. A review of the medication and treatment administration record indicated the dose was to be given at 7:00 a.m., 1:00 p.m., and 7:00 p.m. each day. The record revealed that doses were not administered on 1/25/25, 1/26/25, and 1/27/25 7:00 a.m. This resulted in a total of 7 missed doses. A progress note, dated 1/25/25, at 1:10 p.m., stated The antibiotic is not available at this time due to the pharmacy's supply. Called on call-provider and we have to wait until the medication is available. The on-call provider note, dated 1/25/25 at 1:32 p.m., stated Awaiting IV antibiotics. Plan: IV antibiotics to commence Monday when received. No alternative antibiotics available at present. Follow-up scheduled for Monday. On 1/30/25 at 2:00 p.m., a surveyor discussed the finding with the Market Clinical Advisor, who stated the facility's pharmacy contracts with another pharmacy for all IV medications. The Market Clinical Advisor was unaware of local pharmacies which could handle an emergency order. On 1/30/25 at 3:38 p.m., the Market Clinical Advisor stated the facility's pharmacist had informed her its emergency pharmacy was Walgreen's, which does not provide IV medications. The Market Clinical Advisor did not have the pharmacy's policy or procedure for obtaining IV medications when unavailable.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51669 Based on record review, interview, and facility policy, the facility failed to demonstrate evidence of behavior monitoring and monitoring for side effects of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (#26). Finding: Facility policy, Medication Management, dated 1/2024, states, Policy . Evaluation of a resident's physical, behavioral, mental, psychosocial signs and symptoms .including adverse consequences of medications . The need for and response to therapy are monitored and documented in the resident's medical record . Guidelines for Psychotropic Medication Monitoring .Potential Adverse Consequences: The facility assures residents are being adequately monitored for adverse consequences . Resident #36 was admitted on [DATE] with diagnoses to include anxiety and depression. Resident #36's care plan, initiated 12/17/24, states, .at risk for complications related to the use of psychotropic drugs . complete behavior monitoring flow sheet .monitor for side effects . Review of Resident #36's clinical record revealed the following active physician orders: -Order with a start date of 1/7/25 for Clonazepam 0.5 mg (milligram) tablet, give 0.5 tablet by mouth one time a day for anxiety for 28 days AND 0.5 tablet by mouth one time a day for anxiety at 0600, 1000, 1400, 1800. -Order with a start date of 12/17/24 for Mirtazapine 15 mg oral tablet, one tablet by mouth at bedtime for depression. -Order with a start date of 12/18/24 for Escitalopram Oxalate 10 mg tablet, 1.5 tablet by mouth one time a day for depression. -Order with a start date of 1/28/25 for Hydroxyzine HCl 25 mg oral tablet, 1 tablet by mouth as need for anxiety for 14 days, BID [two times daily] prn [as needed]. Further review of the clinical record lacked evidence of a provider order/and or monitoring for behaviors and side effects of the psychotropic medication use. During an interview on 1/29/25 at 3:45 p.m., the Market Clinical Advisor reviewed Resident #36's entire clinical record and confirmed it lacked evidence of behavior monitoring and monitoring for side effects.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation and interview, the facility failed to adequately date and properly dispose of open biologicals according to manufacturer specifications in 1 of 4 units observed for medication storage. (Scotch Pine House) Findings: 1. On [DATE] at 9:51 a.m., observation of Scotch Pine House treatment cart with the Registered Nurse (RN) the following was observed; one opened Aspart Insulin Flex Pen dated ,d+[DATE] and one opened and undated Insulin Glargine-yfgn Solution Pen with both with the manufacture's instructions of, after first use . discard after 28 days. At this time, the RN removed both of the insulin pens and confirmed they were either expired or undated.

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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. 51669 Based on observations, interviews, and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. Additionally, the facility failed to ensure foods were sealed, labeled, and dated in a dry storage room, a walk-in freezer and a walk-in refrigerator, as well as failed to ensure the emergency food supply was not stored with unsecured chemicals for 1 of 3 days of survey (1/27/25). Furthermore, the facility failed to ensure that the Dish Machine temperatures, Refrigerator temperatures, and Freezer temperatures were monitored for 3 of 3 months reviewed. Findings: Review of policy, Food Storage: Cold Foods, revised 4/2018, states, Procedures .5. All foods will be stored wrapped or in covered containers, labeled and dated . Review of policy, Food Storage: Dry Goods, revised 9/2017 states, Storage areas will be neat, arranged for easy identification, and date marked as appropriate .Toxic materials will not be stored with food . 1. On 1/27/25 between 6:10 p.m. and 6:40 p.m., a surveyor conducted a kitchen tour with Dietary Aide (DA) #1, during which the following findings were observed: -White ceramic bowls were stacked on a soiled, parchment-lined metal tray on a metal storage cart, located next to the reach-in refrigerator. The bottom surface of the cart was covered in food crumbs and debris, and there were clean kitchen linens and potholders touching the debris. -There were food crumbs and debris covering the top surface of the double-door oven. -Grease and food debris was built up on the burner plates on the stovetop. - Food debris was observed on the underside of the uncovered food slicer. - Food debris and crumbs were observed on top of the metal food prep table. - The wall mount air conditioner unit above the reach-in refrigerator was covered in dust and debris. - Four wall mount oscillating fans covered in dust and debris were observed in the dish-washing area, above clean/dry stacked dishes. - A gray basin containing unknown liquid, was on top of a folded blanket under the three-bay sink. - Floors throughout the kitchen were covered with food crumbs and debris, and debris was observed throughout the kitchen underneath equipment and shelving. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The reach-in refrigerator contained a tray containing 5 cups of sliced fruit that were unlabeled and undated. Observation of the walk-in refrigerator revealed the following available for use: -14-ounce container of Sysco Reliance Beef Flavored Base, opened and undated - large metal bowl containing a partial head of iceberg lettuce with obvious pink discoloration, uncovered, unlabeled, and undated -metal bowl on a wire shelf in the back of the refrigerator, containing a partial head of iceberg lettuce, 1/2 onion, a green bell pepper, and a tomato, unlabeled and undated. - ring-shaped, sponge-type cake was unlabeled and undated. - The walk-in freezer contained an open zip-loc bag of cooked potato wedges, dated 1/25/24, unsealed and open to air and a plastic bag containing a deep-dish pie shell, unsealed and open to air and available for use. - The Dry Storage room had a plastic bag of a white, flour-appearing substance, rolled and secured with a binder clip, that was unlabeled and undated and an open, undated 16-ounce bag of mini marshmallows. Observation of the food preparation area revealed the following: - open, undated, 3.2 ounce packet of ranch seasoning, a large metal bowl of wheat rolls, located on the top shelf of the steam table, undated and uncovered, open to air. -A piece of sponge-type cake in ceramic bowl, located next to the food slicer, was undated and unlabeled. On 1/28/25 at 6:40 p.m. the above findings were reviewed with Dietary Aide (DA) #1. On 1/28/25 at 9:00 a.m. the above findings were reviewed with the Food Services Account Manager and the Dietary District Manager. 2. On 1/27/25, between approximately 6:50 and 7:10 p.m., two surveyors observed the facility's Emergency Food Supply, located in the Central Supply Room. The emergency food supply was stored on open shelving, next to and directly across from shelves of approximately 50 bottles of unsecured chemicals, including Ecolab Grease Strip Plus and No-Rinse Alkaline Floor Cleaner, Oasis Multi-Quat Sanitizer, Lime Away, and Ice Machine Cleaner, as well as nursing supplies. On 1/27/25 at 7:15 p.m., two surveyors reviewed this finding with the Administrator and interim Director of Nursing Services.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on interviews and record reviews, the facility failed to ensure the terms and conditions of a binding arbitration agreement were clearly communicated to the residents or their representatives for 4 of 5 residents reviewed for Arbitration (Resident #35, #46, #57, #331). Findings: On 1/27/25 at 7:28 p.m., a surveyor conducted an entrance conference with the Administrator and the Director of Nursing and was told, when asked, that no residents in the facility had signed an arbitration agreement. 1. Review of Resident #35's medical record shows he/she was admitted to the facility on [DATE]. Further review of the resident medical record indicates he/she had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she is cognitively intact. On 1/30/25 at 3:50 p.m., a surveyor met with Resident #35 and asked if he/she signed an arbitration agreement with the facility during admission. He/she stated that he/she did not know what that was and stated that his/her child signed admission paperwork for him/her. Resident #35 then stated that they received no education on what an arbitration agreement entailed or even what that meant. A surveyor let him/her know that they had signed an arbitration agreement and explained what that meant. Resident #35 stated that they would not have signed that paperwork if they knew what the arbitration agreement was. 2. Review of Resident #46's medical record shows he/she was admitted to the facility on [DATE]. Further review of the resident medical record indicates he/she had a Brief Interview for Mental Status (BIMS) of 13 of 15, indicating he/she is cognitively intact. On 1/30/25 at 3:53 p.m., a surveyor met with Resident #46 and asked if he/she signed an arbitration agreement with the facility during admission. He/she stated that he/she did not know what that was and stated that he/she thinks his/her child signed admission paperwork for him/her. Resident #46 then stated that they received no education on what an arbitration agreement entailed or even what that meant. A surveyor let him/her know that they had signed an arbitration agreement and explained what that meant. Resident #46 stated that they would not have signed that paperwork if they knew what the arbitration agreement was. 3. Review of Resident #57's medical record shows he/she was admitted to the facility on [DATE]. Further review of the resident medical record indicates on 1/9/25 he/she had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she is cognitively intact. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 2:50 p.m., a surveyor met with Resident #57 and asked if he/she signed an arbitration agreement with the facility during admission. He/she did not think they signed an arbitration, but said they are unable to recall signing any documents. Resident #57 then stated that they received no education on what an arbitration entailed. A surveyor let him/her know that they had signed an arbitration agreement and explained what that meant. Resident #57 stated that he/she would not have signed this now knowing what it means. 4. On 1/30/25 at 3:00 p.m., in an interview with a surveyor, the spouse of Resident #331 stated he/she thought he/she had signed the admission paperwork. He/she had no recollection if arbitration agreements were explained to him/her or what they were. A review of the clinical record for Resident #331 noted an admitted [DATE]. Diagnoses included hepatic encephalopathy. The admission MDS (Minimum Data Set 3.0) assessment, dated 11/27/24, noted in Section C, Cognitive Patterns, a BIMS (Brief Interview of Mental Status) score of 8, indicating moderate cognitive impairment. A review of Resident #331's admission agreement noted that the arbitration agreement is embedded within the document. Resident #331's signature was noted throughout the agreement, dated 11/25/24. On 1/30/25 at 4:00 p.m., in an interview with Resident #331's spouse, a surveyor showed the contract which Resident #331 had signed on 11/25/24. The spouse stated Resident #331 was not cognitively intact at that time and was not able to understand what he/she had signed. A review of the facility's Voluntary Binding Arbitration Agreement stated under #20, Entire agreement. This agreement contains the entire agreement between the Parties with respect to Arbitration and no prior, concurrent, or subsequent oral written representations or agreements shall be of any force or effect, unless made in writing and signed by the parties. This agreement shall survive the termination, cancellation or expiration of the admission agreement. On 1/30/25 at 2:43 p.m., during an interview with 5 surveyors present and the facilities Market Clinical Advisor, the Admissions Director confirmed an arbitration agreement is within the admission agreement stating, the admission agreements are completed on a tablet. She stated she will go through the admission agreement by section and when it gets to Arbitration she tells them, If there is a problem you work it out between you and the facility before lawyers or others are involved. A surveyor asked if she explains to the residents that they have 30 days to revoke the arbitration. She stated, no. A surveyor asked if the resident would receive a new agreement with every admission. She stated, if they are readmitted after 30 days then they will have a new one to fill out. A surveyor then asked if the second signed arbitration would replace the first signed arbitration. She stated she believed it did. At this time, a surveyor informed the Admission Director that after 30 days the agreement is binding for any future admission/readmissions. the Admissions Director stated she was unaware that it was binding for all future admissions, and she has provided a new arbitration agreement to residents who have been readmitted . The surveyor asked how she identifies if the resident or representative understands what she is saying. She stated, I don't just go in and have them sign, I talk to them, I won't wake them up. At this time, the surveyors asked for a list of residents who have entered into a binding arbitration, she stated, everyone has. A surveyor asked for confirmation. The Admissions Director confirmed all of the residents had signed, entering into a binding arbitration. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 3:16 p.m., during an additional interview with the Admissions Coordinator and Market Clinical Advisor, a surveyor asked if the admission agreement is sent by email to the resident representative. The Admission Director stated, Yes. She would generate the packet and send it by email, and they get a text, I tell them to go to the link and sign it and I let them know if they have any questions, let me know. The surveyor then asked if the admission agreement is emailed how does she explain the Arbitration agreement. She stated, I'm not, it's in the email if they have any questions let me know. She then explained when the admission agreement is signed the program will use the signature for the rest of the document. It will prompt the residents and/or representatives to go to the next page, where they can then hit the signature button to automatically put in their signature. At this time, another surveyor joined the interview and asked, if the resident's record is checked for advanced directives, such as a power of attorney or guardianship before asking them to sign. The Director of Marketing and Admissions stated not all the time. 37015 37440 51331

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37015 Based on observations, interviews, record reviews, and facility policy review, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases for residents requiring Enhanced Barrier Precautions (Residents #327 and #331) on 1 of 5 facility units. Findings: 1. On 1/28/25 at 10:40 a.m., in an observation on the Elm House unit, a surveyor briefly reviewed the electronic record for Resident #327 before entering the room. The record indicated Resident #327, admitted on [DATE], required Enhanced Barrier Precautions for CRE (Carbapenemase-producing carbapenem-resistant Enterobacteriaceae), a drug-resistant organism. The surveyor could find no signage at the entrance of the room, or within the resident's room indicating precautions were necessary. The surveyor asked the Registered Nurse on duty if Resident #327 required special precautions. The RN at first stated the resident did not require precautions, then remembered he/she did. The surveyor pointed out there was no sign at the entrance of the room. The RN confirmed the finding and stated a sign would be posted. On 1/28/25 at 10:49 a.m., a surveyor asked CNA #1 (Certified Nursing Assistant) if he/she uses any special PPE (personal protective equipment) when providing care for Resident #327. The CNA stated Resident #327 did not require any special PPE and staff use gloves. The surveyor showed CNA #1 that Resident #327's electronic record stated Enhanced Barrier Precautions were required for CRE. CNA #1 stated I did not know that. A review of the clinical record for Resident #327 noted a hospital discharge summary, dated 1/21/25, which stated Precaution Alert: CRE. The base line care plan, initiated on 1/21/25, stated Resident #327 had actual colonization/infection with Multidrug Resistant Organism: CRE. The goal stated: Signage for PPE will remain on doors for resident and staff safety to prevent possible transmission through next review. Interventions included: Enhanced Barrier Precautions: Use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator), wound care (any skin opening requiring a dressing). Enhanced Barrier Precautions: Educate patient/family and visitors regarding precautions. 2. On 1/28/25 at 12:15 p.m., in an observation on the Elm House unit, a surveyor briefly reviewed the electronic record for Resident #331 before entering the room. The record indicated Resident #331, admitted on [DATE], required Enhanced Barrier Precautions. The surveyor could find no signage at the entrance of the room, or within the resident's room indicating precautions were necessary. At this time, the surveyor interviewed Resident #331's spouse, and asked if staff wore any type of PPE when providing care. The spouse stated no, but they wore gowns, gloves and masks when (he/she) had Covid. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at approximately 12:20 p.m., a surveyor asked CNA #1 if Resident #331 required special precautions. CNA #1 stated he/she did not know. CNA #2 joined the conversation and stated he/she did not know if Resident #331 required special precautions when providing care. The surveyor showed both CNA's Resident #331's electronic record stated Enhanced Barrier Precautions were required for MRSA, VRE, and ESBL. A review of the clinical record for Resident #331 noted a hospital discharge summary, dated 11/22/24, which stated Precaution Alert: MRSA (Methicillin Resistant Staphylococcus Aureus), VRE (Vancomycin Resistant Enterococcus), and ESBL (Extended Spectrum Beta-Lactamase), all drug resistant organisms. A review of Resident #331's care plan, last revised 11/29/24, stated Resident #331 has actual colonization/ infection with MDRO: MRSA, VRE, ESBL and is on Enhanced Barrier Precautions. The goal stated, Signage for PPE will remain on doors for resident and staff safety to prevent possible infection transmission through next review. Interventions included: Enhanced Barrier Precautions: Use gown and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator), wound care (any skin opening requiring a dressing). Enhanced Barrier Precautions: Educate patient/family and visitors regarding precautions. The facility's policy regarding Enhanced Barrier Precautions, with a revision date of 12/16/24, stated In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact Precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms (MDROs). The Centers for Disease Control and Prevention (CDC) Targeted MDRO's are defined as: (included in the list) * Carbapenemase-producing carbapenem-resistant Enterobacteriaceae. Additional MDRO's that might be included based on local requirements: *Methicillin-Resistant Staphylococcus Aureus (MRSA), * ESBL-producing Enterobacterales, *Vancomycin-Resistant Enterococci (VRE). On 1/28/25 at approximately 12:30 p.m., the findings were discussed with the Director of Nursing and the Senior Administrator. The Director of Nursing stated the signs had been up last Friday (1/24/25) and had been taken down some time since then. The Senior Administrator stated Maine CDC had provided guidance allowing facilities to use discretion regarding EBP's for epidemiologically important MDRO's. A copy of the Maine CDC email, dated 10/10/24, was provided to the surveyor in which it stated We have been recommending the use of EBP for epidemiologically important MDRO's - all the time.