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	04/16/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, and sanitary environment for 2 of 4 days of survey (4/13/26 and 4/14/26). Findings: 1.On 4/13/26 at 12:15 p.m., during an observation of the Blue Spruce unit (C unit) the surveyor observed the ice machine on the counter in the kitchenette area. The air gap was not visible; the Maintenance Director stated the air gap was in the secured doors of the cabinet. The Maintenance Director removed the screws from the doors, and it was noted that the air gap was improper (see F812) at this time an observation of the interior of the cabinet was made and it was noted that the bottom of the cabinet was warped exposing the edges of the wood panel and an area on the back left corner of the cabinet was caved in. This area was noted to have a dark substance on the edges of the exposed panel. At the time of this observation the above finding was confirmed by the surveyor with the Maintenance Director. 2.On 4/13/25 at 12:25 p.m., during an observation of the [NAME] unit (D unit) the surveyor observed the ice machine on the counter in the dining/common area. In the cabinet under the ice machine the air gap was observed to be correct, it was noted that the drain tube from the ice machine had a large buildup of a black substance hanging off the end of the drain tube. In the cabinet there were 2 urinals, 1 incontinence brief and an opened box of gloves along with several loose garbage bags. The above findings were confirmed by the surveyor with the Director of Nursing and the Market Clinical Advisor in training (MCAT). 3.On 4/13/26 at 12:40 p.m., during an observation of the Scotch Pine Unit (B unit) the surveyor observed the ice machine on the counter in a small kitchenette area, the area around the ice machine was observed to be heavily soiled with dark unknown substances. A staff member in the kitchenette stated that it was from when the coffee pot overflowed last week. The area behind the ice machine was observed, the counter behind the ice machine had been cut to allow for the piping for the ice machine leaving cut edges of the countertop that were exposed and was discolored from the spilled coffee. The above finding was confirmed by the surveyor with the staff at the time of the observation.

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record reviews and interviews, the facility failed to ensure that during the regulatory visit, the Provider reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the physician block orders for 5 of 5 residents reviewed for unnecessary medications (Residents #7 [R7]), R59, R5, R14, R33). Findings: 1. On 4/16/26, a review of R7's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 2/24/26 a provider progress note was completed on 2/24/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 2/24/26 required regulatory visit. 2. On 4/16/26, a review of R59's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 2/26/26. A provider progress note was completed on 2/26/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 2/26/26 required regulatory visits. 3. On 4/16/26, a review of R5's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 3/3/26. A provider progress note was completed on 3/3/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 3/3/26 required regulatory visit. 4. On 4/16/26, a review of R14's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 3/3/26. A provider progress note was completed on 3/3/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 3/3/26 required regulatory visit. 5. On 4/16/26, a review of R33's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 3/17/26 a provider progress note was completed on 3/17/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 3/17/26 required regulatory visit. On 4/16/26 at 11:31 a.m., in an interview with the surveyors, the Market Clinical Advisor confirmed the findings.

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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. Based on observation and interviews, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 1 of 4 days of survey (4/13/26). In addition, the facility failed to prepare food under sanitary conditions for 1 of 4 days of survey (4/14/26).Findings: 1.On 4/13/26 at 12:15 p.m. during a unit observation tour on the Blue Spruce unit (C unit) the kitchenette had an ice machine on the counter, the air gap was not visible. The Maintenance Director was asked to show the air gap to the ice machine, which was located under the sink, the cupboard doors were secured shut with screws. When the Maintenance Director unscrewed the doors, it was observed that the air gap to the ice machine was less than the 1 inch required.This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one-inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils.The above finding was confirmed by the surveyor at the time of the observation with the Maintenance Director. 2.On 4/14/26 at 11:40 a.m. a surveyor observed the Food Service Director (FSD) preparing lunch desserts. He brought a can of peaches from the supply room, the can was observed to have a dirty/dusty top, the FSD opened the can of peaches contaminating the peaches with the soiled lid. The FSD brought in a second can and wiped the top of the can with the sanitizing cloth and did not rinse the top leaving the sanitizing agent on the top lid, the can was brought over to the can opener, a surveyor intervened, the can top was rinsed then opened by the Dietary Aide. She then brought the can to the counter and placed it down near the dessert dishes. She put on gloves and with a gloved hand reached into the opened can grabbing some peach slices, she then began cutting them up in her hand with a knife and placed the cubed pieces into the small dessert dishes. She then reached into the open can with the same gloved hand and cut up the peach slices and filled dessert dishes an additional 2 times before the surveyor intervened. This finding was confirmed by the surveyor at this time with the Dietary Aide and with the Corporate Dietary Supervisor.

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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. Based on record review, observation, and interview, the facility failed to maintain an infection control program to help prevent the spread of infection related to pressure ulcer treatment for 1 of 2 residents observed for a pressure ulcer dressing change (Resident #55 [R55].On 4/13/26, a review of R55's clinical record was completed. Documentation indicated R55 has a Stage 3 pressure ulcer on the left heel. Documentation in the physician orders indicated that the pressure ulcer treatment is to cleanse the wound with wound cleanser, apply a medihoney dressing to the wound bed and cover with a foam border once a day and as needed. On 4/14/26 at 6:50 a.m., a pressure ulcer dressing change observation was completed with RN1 performing the dressing change.Initially RN1 donned clean gloves, and set up a clean work field at the foot of the bed. RN1 placed the wound cleanser bottle on the soiled linen and medihoney dressing and foam cover on clean work field. RN1 went back to treatment cart and with the same clean gloves touched the cart with both gloved hands, took the keys from the cart, and put the keys in her pocket. She then picked up a camera (used for taking pictures of wounds) without cleaning it and went to bedside and placed camera on clean work field (contaminating the area). With the same gloves on; removed soiled dressing. RN1 changed gloves and cleansed wound. She then handled the camera and was unable to get a good picture. She lifts resident's leg and places it in a different position, moves the left leg again and takes a picture. With the now soiled gloves, she applied the medihoney dressing and foam. On 4/14/26 at 7:05 a.m., in an interview with RN1, the surveyor discussed the use of soiled gloves when applying a sterile dressing and working in contaminating a clean work field with a soiled camera. In addition, the surveyor discussed with RN1 the Enhanced Barrier Precaution (EBP) sign outside the residents room. RN1 did not follow the instructions for the EBP by not wearing a protective gown while performing a wound dressing change.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews, review of the facility's filed grievances, and record review, the facility failed to implement parts of its Grievance/Concern policy and procedure for 1 of 2 residents that filed grievances (Resident #44 [R44]).Finding: On 4/13/26 at 10:50 a.m., in an interview with a surveyor, R44 voiced concern that they had filed a few grievances in the past couple of months and no one from management has talked to them about the outcome of their grievances. R44 stated that they do attend resident council meetings most of the time and they did discuss one of the grievances regarding snacks, but no one saw the resident in person to discuss it. On 4/15/26, a review of the facility's Grievance Binder was completed. In the Grievance Binder were four grievance forms filed by R44. The grievances are as follows:A. On 1/15/26, the scalloped potatoes were hard on the evening of 1/14/26.Documentation indicated that the corrective action was the Administrator stated quality control is done prior to meals leaving kitchen.B. On 1/16/26, did not receive evening medications until 11 p.m.Documentation indicated the corrective action was that the Administrator did a face to face visit with R44 and explained the medication nurse was a new staff and was a bit behind that evening.C. On 2/16/26, R44 is not receiving snacks in the afternoon.Documentation indicated the corrective action was that the dietary staff and nursing staff were spoken to about their responsibilities to provide snacks. D. On 2/16/26, there are no Purell hand wipes provided to residents prior to meals.Documentation indicated the corrective action was to speak to staff about offering hand wipes prior to meals and ensure they are in stock. Other than the grievance regarding a medication pass, there is no documentation on the grievance forms indicating the resident was spoken to directly about the concerns.On 1/15/26, R44's clinical record was reviewed and there was no evidence that the resident had been directly spoken to regarding his/her grievances. On 1/15/26, the facility's Grievance Policy and Procedure was reviewed. Documentation in the facility policy 'Grievance and Concerns Policy and Procedure under section 6. The department manager will:6.1 contact the person filing the grievance to acknowledge receipt6.5 notify the person filing the grievance of resolution in a timely manner On 4/15/26 at 11:10 a.m., in an interview with a surveyor, the Administrator stated he remembered discussing some grievance resolutions with R44, but was unsure which ones other than the grievance form that indicated a face to face regarding the late medication pass. He stated the facility is going to improve the follow up process.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, the facility failed to ensure an as needed (PRN) psychotropic medication was ordered for 14-days or less unless there is a practitioner's rationale for PRN use beyond 14-days for 1 of 5 residents reviewed for unnecessary medications (Resident #59 [R59]).Findings: Review of R59's clinical record, on the physician order summary for medications states, Lorazepam (used to treat anxiety) give 0.5 mg (milligrams) by mouth every 8 hours as needed for anxiety for 6 months, with an order start date 11/24/25 and order end date 5/24/26. There was no evidence in the clinical record of a practitioner rationale for the extended use of the psychotropic PRN order beyond 14-days. On 4/16/26 at 11:28 a.m. in an interview with the Director of Nursing (DON), a surveyor confirmed that R59's clinical record lacked evidence of practitioner's rationale for extended use of 6 months for the PRN Lorazepam order. The DON stated upon her review of R59's clinical record she couldn't find a practitioner rationale for the extended use either.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 2 sampled residents reviewed for PASRR (Resident #1 [R1]).Finding:On 4/14/26, R1's clinical record was reviewed. R1's PASRR, completed on 12/24/25, did not require a level II determination due to his/her clinical record did not show that he/she had a serious mental illness. On 9/2/25, R1 was diagnosed with bipolar disorder, but the clinical record lacked evidence that the resident was referred to the State mental health authority for a new PASRR determination.On 4/14/26 at 1:35 p.m., during an interview with a surveyor, the Licensed Social Worker stated a new PASRR was not submitted for R1 with the diagnosis of bipolar disorder. At this time a surveyor confirmed the facility failed to refer R1 for a PASRR after a new diagnosis and/or experienced symptoms related to a mental disorder.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record reviews and interviews, the facility failed to ensure physician orders were followed for blood pressure parameters prior to administering a medication for 1 of 5 resident's reviewed for unnecessary medications (Resident #7 [R7]) and failed to follow physician's orders by holding a medication that was ordered for 1 of 5 resident's reviewed for unnecessary medications (R59). Findings: 1.On 4/15/26 during a clinical record review the surveyor noted R7 had an order dated 9/9/25 for Carvedilol (medication that works by relaxing blood vessels and slowing the heart rate) 3.125 milligrams (mg) by mouth every morning and at bedtime for hypertension (high blood pressure) with directions to take with food and to hold Carvedilol for systolic blood pressure (SBP) below 100 and to hold Carvedilol for diastolic blood pressure (DBP) below 60. Upon review of R7's electronic medical administration record (EMAR) there is no evidence that R7's SBP or DBP was monitored prior to receiving his/her scheduled Carvedilol for the months of March 2026 and April 2026. During a review of the electronic clinical record Point Click Care (PCC) there is no evidence of his/her SBP or DBP being taken twice a day. On 4/15/26 at 3:39 p.m. during interviews and record review for R7 with the Director of Nursing (DON), Market Clinical Advisor and Market Clinical Advisor trainee, a surveyor confirmed the above finding. 2. On 4/16/26 R59's clinical record was reviewed and the EMAR dated 4/1/2026-4/30/2026 states, Metoprolol (blood pressure medication) Succinate ER (Extended Release) Oral Tablet . 50 MG . Give 2 tablet by mouth one time a day for hypertension. Documentation on the EMAR states that the Metoprolol doses were held (not given) on 4/10/26, and 4/13/26. There is no evidence in R59's clinical record why the medication was held or that the provider was contacted pertaining to holding the Metoprolol. On 4/16/26 at 11:28 a.m., in an interview with the DON, a surveyor confirmed that R59's medication for Metoprolol was not given as ordered on 4/10/26, and 4/13/26.