STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205137	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgewood Manor	200 Route 115 Windham, ME 04062

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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 0578 Level of Harm - Minimal harm or potential for actual 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. 37015 Based on record review and interview, the facility failed to ensure that the resident and/or resident representative was provided with written information concerning the right to formulate an advanced directive for 2 of 5 residents (Residents #24, #38), and failed to ensure a physician's order included the resident's preference for resuscitation (Resident #17). Findings: 1. Resident #24 was admitted in August of 2023. A review of the entire electronic medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 2. Resident #38 was admitted in September of 2024. A review of the entire electronic medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 3. Resident # 17 was admitted in December of 2024. A review of the electronic medical record revealed that provider orders did not designate the resident's preferred code status, meaning to resuscitate or do not resuscitate. On 2/25/25 at 12:30 p.m., in an interview with a surveyor, the Business Office Manager stated the facility's admission process includes requesting copies of an advanced directive but staff do not document if a resident is offered the opportunity to form an advanced directive or if the resident declines the offer, and stated it has not been routine practice to offer or provide assistance with formulating advanced directives. The Business Office Manager reviewed the records and confirmed that there was no advanced directive in the records of Residents #24 and #38. On 2/25/25, at approximately 3:30 p.m., the Business Office Manager reviewed Resident #17's record and confirmed the provider did not write an order indicating Resident #17's code status was to be designated as do not resuscitate.

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 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition 48648 Based on interview and record review, the facility failed to conduct a comprehensive Minimum Data Set 3.0 (MDS 3.0) assessment within 14 calendar days after a resident experienced a significant change of condition and hospice services were initiated for 3 of 16 sampled residents (Resident #23, Resident #29, and Resident #31). Finding: The Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 2, page 2-23 reads that a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Assessment Reference date (ARD) must be within 14 calendar days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. Resident #23's clinical record contained documentation that indicated the resident was admitted into Hospice care in mid December of 2024. An SCSA was not completed. Resident #29's clinical record contained documentation that indicated the resident was admitted into Hospice care in mid July of 2024. An SCSA was not completed. Resident #31's clinical record contained documentation that indicated the resident was admitted into Hospice care in mid October of 2024. An SCSA was not completed. On 2/25/25 at 9:45 a.m., during an interview with the Director of Nursing, the surveyor confirmed the SCSA was not completed for the residents listed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48648 Based on interviews and record review, the facility failed to complete a baseline care plan, as required, within 48 hours of admission to the facility for 5 of 16 residents sampled. (Resident #38, Resident #39, Resident #242, Resident #243 and Resident #244). Finding: Resident #38 was admitted to the facility in mid September of 2024. The care plan for Resident #38, located in the Electronic Medical Record (EMR), was initiated on 10/2/24. Resident #39 was admitted to the facility in early December of 2024. The care plan for Resident #39, located in the EMR, was initiated on 12/11/24. Resident #243 was admitted to the facility in mid February of 2025. The care plan for Resident #243 located in the EMR, was initiated on 2/20/25. Resident #242 was admitted to the facility in mid February of 2025. The care plan for Resident #242, located in the EMR, was initiated on 2/24/25. Resident #244 was admitted to the facility in mid February of 2025. On 2/25/25 a surveyor was unable to locate a care plan in the EMR for Resident #244. On 2/25/25 at 12:50 p.m. a surveyor met with the charge nurse about Resident #249's missing care plan. The charge nurse confirmed that a baseline care plan should be in the resident's EMR and completed within 48 hours. She/he was also unable to locate a care plan for Resident #249. On 2/26/25 at 9:50 a.m. a surveyor met with the Director of Nursing to discuss the above findings.

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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** 33639 Based on record review and interview, the facility failed to develop a comprehensive care plan that addressed the use of psychotropic drug use and nutrition for 1 of 5 residents reviewed for unnecessary medications. (#21). Finding: Resident #21's February 2025 Medication Administration Record (MAR) indicated that the resident had received the antidepressants Fluoxetine 40 milligrams (mg) once daily since 10/8/24 and Trazodone 100 mg once daily at bedtime since 5/8/24. Resident #21's Minimum Data Set (MDS) 3.0 Annual assessment dated [DATE], under Care Area Assessment Summary, noted Resident #21 would be care planned for Psychotropic Drug use and Nutrition. As of 2/26/25, Resident #21's medical record lacked evidence of a comprehensive care plan in the area of psychotropic drug use and Nutrition. The surveyor confirmed this lack of care plan for psychotropic drug use and in the care area of nutrition in an interview with the Director of Nursing, on 2/26/25 at 11:15 a.m.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48648 Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals and over-the-counter medications for 1 of 3 survey days. (2/24/25) Findings: On 2/24/25 at 9:08 a.m. a surveyor observed a storage room door propped open, cupboards in the room were unlocked and contained the facility's of supply of over-the-counter medications. The administrator was immediately made aware. On 2/24/25 at 9:14 a.m. a surveyor observed a whirlpool #1 room with a door propped open that had a closet door inside with a key in the door. The closet contained a supply of G2-2100 bottles used for surface cleaning and Simoniz hospital disinfecting deodorant. CNA #1 was immediately made aware. On 2/25/25 at 10:00 a.m. a surveyor observed Whirlpool #2 room with a door propped open and found a bottle of G2-2100 on a shelf unsecured next to the sink. A closet door inside Whirlpool #2 was observed with a key in the lock. The closet contained a supply of G2-2100 and Simoniz hospital disinfecting deodorant. CNA #2 was immediately made aware. She/he stated that shouldn't be there and locked the door and removed the key. On 2/24/25 at 9:00 a.m. a surveyor observed Resident #11 wandering in and out of accessible areas. MDS review of Resident #11 revealed a diagnosis of Dementia with a Brief Interview for Mental Status (BIMS) score of 0 indicting severe cognitive impairment. A review of the SDS for GC-2100 with a revision date of 3/24/27 showed a GHS US classification -Serious eye damage/eye irritation Category 2B A review of the SDS for Simoniz hospital disinfectant deoderant with a revision date of 3/3/2015 showed a classification for eye irritant as Category 2A. Hazardous ingredients include Propane/n-Butane and ethyl Alcohol. On 2/24/25 at 3:12 p.m. the Director of Nursing was made aware of the above findings.

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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. 37015 Based on observation, interview, clinical record and policy review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 1 of 2 residents (Resident's #24). Finding: On 2/24/25 at 11:18 a.m., a surveyor observed a nebulizer machine on a stand next to Resident #24's bed. The face mask and attached tubing was noted to be dated 10/27, and was placed exposed on a shelf of the stand. On 2/24/25 at 11:28 a.m., a surveyor asked the treatment nurse how staff care for nebulizer equipment. The nurse stated tubing is changed weekly and other items are washed every night. The nurse stated I don't have anyone with a nebulizer right now. At this time, the surveyor showed the nurse Resident #24's nebulizer machine and face mask with tubing dated 10/27. The nurse stated he/she did not know why that was there and should have been removed as there is no order for a nebulizer. The nurse then removed the equipment. A review of Resident #24's provider orders noted an active order, dated 10/22/24, for DuoNeb Solution (Ipratropium-Albuterol) 0.5-2.5 mg/3 ml (milligrams per milliliter) - 3 ml inhale orally every 4 hours as needed for shortness of breath, wheezing related to chronic respiratory failure with hypoxia; panlobular emphysema. On 2/24/25 at 4:00 p.m., a surveyor discussed the finding with the Director of Nursing who confirmed Resident #24 had an active order for nebulizer treatments and that the tubing should be changed weekly. The facility's policy, Equipment Change Out, revised 10/4/24, stated Small volume nebulizers will be dated and changed out weekly.

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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. 37015 Based on facility policy and clinical record reviews, 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 by failing 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 2 of 2 units reviewed. Findings: A review of the facility's policy, Controlled Drug Policy and Procedure, dated 10/4/24, stated Controlled drugs, as determined by the facility, are counted every shift by the nurse/med tech reporting on duty with the nurse/med tech reporting off-duty. The inventory of the controlled drugs must be recorded on the narcotic records and signed for accuracy of count. On 2/24/25 at 11:45 a.m., a surveyor reviewed the Controlled Substance Books and Shift Counts which indicated the facility counts at the change of each shift, approximately 3 times a day. The person authorized to administer medications coming on duty or the person authorized to administer medications going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on multiple days. Multiple days on both units were missing staff signatures for verification and completion of the controlled medication count on the following dates: 9/28/24, 11/28/24, 12/19/24, 1/21/25, 1/23/25, 2/3/25, 2/15/25, 2/23/25, and 2/24/25. On 2/24/25 at 4:00 p.m., the surveyor confirmed the findings with the Director of Nursing and the Administrator.

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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. 33639 Based on observations, interviews and record review, the facility failed to ensure the facility was maintained in a clean and sanitary manner for the kitchen counter, fans, ceiling vents and floors. In addition, the facility failed to ensure the kitchen ice machine and food preparation sink were plumbed in accordance with code requirements to prevent food contamination. Further, the facility lacked evidence that the sanitizing bucket and sanitizing sink solutions, dishwashing temperatures were documented and within the appropriate range for 3 of 3 days of survey. Findings: Initial Kitchen Tour: 1. On 2/24/25 from 9:23 a.m. to 9:45 a.m. a surveyor completed a tour of the kitchen with the Food Service Director [FSD] in which the following findings were observed: -The countertop near the food preperation sink had several gauged areas on the surface creating an uncleanable surface. -Two floor fans in the dish room had chipped paint on the front grille and base of fan. -The ceiling vent in the dishwashing room had dust/debris. -The floor in the dishwashing room was soiled and had missing pieces of tile. -The ceiling and walls in the dishwashing room were stained and had areas of chipped loose paint creating an uncleanable surface. The kitchen ice machine and the food preparation sink were not plumbed in accordance with the code requirement and did not have the required proper air gaps. 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. On 2/25/25 a.m. during an interview with the FSD. She indicated that the dishwashing final rinse temperature is not always accurate on the temperature gauge and that the facility is currently waiting for a part to repair the dishwasher. A surveyor asked if there was an alternate method of checking the final rinse temperature. The FSD confirmed that the staff had no alternative method of checking the final rinse temperature while using the dishwashing machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facilities monthly Dish Machine Temperatures log for October, November 2024 and February 2025 revealed that the staff recorded using the High-Temp dish washer at temperatures below the recommended range (Wash 150 F-165 F, Rinse 180 F) on various shifts and on five days including but not limited to: On the morning shift of 10/14/24 the rinse was recorded at 178 F; on the evening shift of 10/16/24, the rinse was recorded as 179 F; on the evening shift of 11/25/24, the rinse was recorded at 179 F; on the evening shift of 11/27/24, the rinse was recorded at 178 F; on the evening shift of 2/25/25, the rinse was recorded at 179 F. A review of the monthly Dish Machine Temperatures log for November 2024 and January 2025, revealed that the staff did not record dish machine temperatures for the Wash and Rinse cycles on various shifts on three days including but not limited to: Evening shift on 11/29/24 and 11/30/24; and Evening shift on 1/31/25. A review of the Dish Machine Temperature/Sanitizer Records Policy & Procedure indicates Dish machine temperatures and/or sanitizer strengths (as indicated) shall be monitored prior to each meal and recorded to prevent foodborne illness by ensuring all food contact surfaces are properly cleaned and sanitized. Special attention is required to determine if a high temperature or low temperature dish machine is being used. 1. The Dietary Manager shall train all dietary employees regarding the type of dish machine (high temperature/low temperature) and sanitation methods specific to the type being used. 2. Dish machines use either heat or chemical sanitation methods. The following are specifications according to the US Department of Health and Human Services , 7. If there is concern about the sanitizing quality due to inadequate wash or rinse temperature, inadequate sanitizer strength, or inappropriate flow pressure that cannot be resolved by the dietary employee, the ware washing shall be stopped and reported to the Dietary Manager or a designee for corrective action. 9. The Dietary Manager shall be responsible for assuring that the record of dish machine temperatures is maintained at all times. The facilities Sanitizer Bucket Strength Record Policy and Procedure revised 5/2011 indicates When sanitizing buckets are utilized as a system to sanitize food contact surfaces, the strength of the sanitizer in the buckets shall be monitored. Procedure: 1. The Dietary Manager shall train all dietary employees regarding the use of sanitizer test strips, acceptable sanitizer concentration, and the required procedure for documenting sanitizer strength in the sanitizer bucket(s). 3. Sanitizer strength in sanitizing bucket(s) shall be monitored following each meal and recorded by the dietary staff. The Sanitizer Bucket Strength Log may be utilized as a reference as needed. 5. The Dietary Manager or designee shall be responsible for posting the log in the Dietary Department to record sanitizer strength in sanitizer bucket(s). 6. The Dietary Manager shall be responsible for assuring that the record of sanitizer bucket(s) is maintained at all times. The Sanitization Buckets in the Kitchen: The facility lacked evidence that the sanitizer checks for appropriate parts per million (ppm) were monitored and documented for the following dates and times: 11/16/24 6 a.m., 9 a.m., 11 a.m., and 1 p.m., 11/20/24 and 11/21/24 3 p.m., 6 p.m., 11/23/24 and 11/24/24 6 a.m., 9, a.m., 11 a.m., 1 p.m., 3 p.m., 6 p.m., 11/25/24, 11/26/24 and 11/27/24 3 p.m., 6 p.m., 1/28/25 3 p.m., 6 p.m., 2/8/25 11 a.m. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 at 10:38 a.m. during an interview with a surveyor, the FSD stated that the facility started using paper and plastic during the evening meal on 2/25/25 and that the dishwasher is not currently being used. On 2/26/25 at 12:37 p.m., a surveyor discussed the above findings with the Administrator and the Director of Nursing.