

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>205137                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                        | (X3) DATE SURVEY<br>COMPLETED<br><br>05/28/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Ledgewood Manor                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>200 Route 115<br>Windham, ME 04062 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                 |                                                 |
| F 0851<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on record review and interviews related to mandatory submission of staffing information, the facility failed to ensure complete and accurate direct care staffing information based on payroll data was submitted to CMS (Centers for Medicare and Medicaid Services) for fiscal year quarter 1 2026 (October 1, 2025 - December 31, 2025). This has the potential to affect all residents (47 Residents). Findings: Review of the facility's payroll based journal report, titled PBJ Staffing Data Report CASPER (Certification and Survey Provider Enhanced Report) 1705D FY (Fiscal Year) Quarter 1, 2026 (October 1 - December 31) stated that the facility Failed to Submit Data for the Quarter was triggered. Triggered' was defined as no data submitted for quarter. A facility document titled Daily Census, printed 5/26/26, documented there were 47 residents living in the facility. On 5/26/26 at 9:30 a.m., in an interview with a surveyor, the Administrator stated there were 47 residents living in the facility. The Administrator revealed that the facility had not submitted the PBJ data for the 1st quarter (10/1/25 - 12/31/25) due to staff's inability to log in to the CMS website. The most recent quarter had been submitted. On 5/27/26 at 1:00 p.m., in an interview with a surveyor, the Human Resources/Nursing Scheduler and MDS Support staff, stated at the time of submission, she had difficulty with accessing the CMS website. She contacted the CMS IT (information technology) site and was given a ticket number. The staff stated the period to submit information is up to 45 days after the end of the quarter (2/14/26). She had not tried to submit the data earlier during this time and waited until the last day it was due, then was unable to gain access. The staff stated she did not have a copy of any communications with the CMS IT department or other information addressing her efforts to submit the data when it was due.</p> |                                                                                 |                                                 |

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 0584<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview, the facility failed to adequately provide maintenance and housekeeping services necessary to maintain the physical environment in good repair and in a clean, sanitary condition. This was evidenced by the widespread use of heavy adhesive tape (duct tape) to patch and repair damaged floors, sinks, and handrails across multiple resident rooms and common areas, creating un-cleanable surfaces. In addition, the facility failed to maintain floors and ceiling tiles in good structural repair, and failed to clean patient care equipment. An environmental tour conducted by two (2) surveyors on May 28, 2026, starting at 9:37 AM, revealed the following environmental deficiencies throughout the facility: Surveyors observed widespread use of heavy adhesive tape used as a permanent repair method and as a room-dividing barrier, creating sticky, frayed, and un-cleanable surfaces in the following locations: 1. Tape was observed on the floors or room entries of Rooms 101, 102, 104, 105, 106, 109, 111, 112, 113, 114, 115, 116, 119, 121, and 129.- Tape was affixed to the floor at the entry to Wing 2, the area between rooms [ROOM NUMBERS], the floor outside room [ROOM NUMBER], and the entry area/floor around the Nurses' Station, including the Nurses' Station restroom entryway.- The floor at the end of the corridor outside room [ROOM NUMBER] had two white X marks made of tape that was heavily soiled and fraying upward.- Tape was used to repair the end caps and surfaces of handrails outside Rooms 103, 105, 109, and 113.- room [ROOM NUMBER]'s bathroom and bedroom floors contained tape, and tape was utilized on a broken sink fixture.- Dining Room-the rear door had tape affixed to the floor 2. The corridor floor outside rooms [ROOM NUMBERS] was chipped down to the bare, exposed concrete.- The hallway area outside rooms [ROOM NUMBERS] exhibited large areas of entirely missing flooring.- The rear door in the Dining Room had chipped paint.- Two (2) water-stained, wet ceiling tiles were sagging outside of the Laundry area. 3. Whirlpool Room-the shower area exhibited accumulated black grout and a heavily soiled floor surface.- A sit-to-stand mechanical lift parked in the corridor outside room [ROOM NUMBER] was covered in visible dirt and debris. On May 29, 2026, the entire list of the environmental findings was compiled and emailed directly to the Administrator at his request.</p> |                                                                                 |                                                 |

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| F 0868<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and review of the facility's Quality Assurance and Performance Improvement (QAPI) Program, the facility failed to present evidence that the required members attended 3 of 5 quarterly committee meetings provided from April 2025 through April 2026. Finding: On 5/28/26, a surveyor reviewed the facility's QAPI program and attendance sheets for the previous year. The attendance sheets lacked evidence that the facility's Medical Director attended quarterly committee meetings held on 10/15/25, 1/14/26, and 4/9/26. On 5/28/26 at 1:45 p.m., in an interview with a surveyor, the Administrator and Director of Nursing confirmed the finding and stated that future meetings have been rescheduled to allow for the Medical Director's attendance. Review of the facility's Nursing Quality Assurance &amp; Performance Improvement Policy and Procedure, with an effective date of 3/10/26, stated Policy 9.1: QAPI Program Structure and Oversight . QAPI Committee Structure, 1. The facility shall maintain a QAPI Committee chaired by the Administrator or designee. 2. Membership shall include, at a minimum: Administrator, Director of Nursing, Medical Director (as applicable), Infection Preventionist, Department Leadership (e.g., dietary, therapy, environmental services).</p> |                                                                                 |                                                 |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, record reviews, and policy review, the facility failed to develop and implement an Infection Control Program designed to prevent the transmission of infection related to linen handling for 1 of 3 days of survey, and Enhanced Barrier Precautions (EBP) for 5 of 8 residents reviewed for indwelling foley catheters (R2, R8, R17, R44, and R45). Findings:</p> <p>1. On 5/26/26 at 10:55 a.m. a surveyor observed a rack in the hallway with clothing items hanging on it and not covered.</p> <p>On 5/26/26 at 10:56 in an interview with a surveyor, the Director of Housekeeping and Laundry confirmed that the rack had clean, unidentified items on it for staff and residents to identify any items that might be a resident's missing clothing item, confirming it was not covered, and that they would cover it.</p> <p>2. On 5/27/26 at 12:18, two surveyors interviewed the Director of Nursing (DON) expressing concerns with no EBP signage for residents with catheters. The DON stated that the Infection Preventionist (IP) and herself had looked into EBP stating, this is a newer thing, we have been doing a lot of research and consulted with the medical director. The DON stated the medical director had told them to continue doing what they were doing and only do EBP with active infections. The DON stated that they had tried to educate staff, but they do not like change, and that they planned on doing an in-service for EBP in June. They also stated they had drafted a policy in February. The DON stated that the facility only had 5 cases of influenza when asked if there had been any widespread infections in the facility.</p> <p>On 5/28/26 at 11:00 a.m. a surveyor reviewed the facilities Infection and Prevention policy which was last reviewed 7/9/25 and did not include EBP policies or procedures.</p> <p>3. On 5/26/26 at 9:55 a.m., a surveyor observed R17's catheter drainage bag sitting on the floor. Further observation shows no Personal Protective Equipment (PPE) or Enhanced Barrier Precaution (EBP) signage upon entering the R17's room.</p> <p>On 5/6/26 at 10:05 a.m., the above information was observed and confirmed with RN1 (Registered Nurse).</p> <p>4. On 5/27/26 at 7:20 a.m., during an interview with CNA1 (Certified Nursing Assistant), who stated that when he/she provides catheter care to residents, he/she only wears gloves.</p> <p>5. On 5/27/26 at 7:23 a.m., during an interview with CNA2, who stated that when he/she provides catheter care, he/she just wears gloves.</p> <p>6. On 5/27/26 at 7:27 a.m., during an interview with CNA3, who stated that CNA's are the ones who typically provide catheter care. When asked what kind of PPE he/she wears when providing catheter care, CNA3 stated that he/she only wears gloves. However, he/she will wear a gown, goggles, and (continued on next page)</p> |                                                                                 |                                                 |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>gloves when there is a precaution sign up or if the resident has anything in his/her urine.</p> <p>7. On 5/27/26 at 7:30 a.m., during an interview with CNA-M1, who stated that when he/she provides catheter care, he/she will only wear gloves. However, if the resident is colonized with something, he/she will wear PPE as directed by signage.</p> <p>8. On 5/27/26 at 7:52 a.m., during an interview with CNA4 regarding precaution types, he/she is unsure what EBP are.</p> <p>9. On 5/27/26 at 7:54 a.m., during an interview with CNA3 regarding precaution types, he/she is unsure what EBP is and what it is used for.</p> <p>10. On 5/27/26 at 8:00 a.m., during an interview with LPN1 regarding precautions, specifically EBP he/she stated, I have never heard of that.</p> <p>11. On 5/27/26 at 8:05 a.m., in an interview with CNA6, who stated he/she has never heard of EBP before and has been a CNA for a long time.</p> <p>12. On 5/27/26 at 8:08 a.m., during an interview with RN1, who stated he/she just heard about EBP yesterday from another surveyor but never knew about it before then.</p> <p>13. On 5/26/26 at 10:36 a.m. during an interview with R45, it was observed that he/she had a catheter and stated that he/she has had it for about 6 months. When ask how the staff clean it, R45 stated that staff put on gloves and then clean it.</p> <p>Surveyor observation that there was no sign on the door for EBP, nor was there any PPE available outside of resident's room.</p> <p>14. On 5/26/26 at 1:05p.m during an interview with R44, it was observed that he/she had a catheter. R44 stated he/she had just returned from the hospital. When asked about the catheter R44 stated that he/she had it prior to going to the hospital and that the staff take good care of it and clean it well. When asked what staff wear when they clean the catheter, R44 stated that staff wear gloves.</p> <p>Surveyor observation that there was no sign on the door for EBP nor was there any PPE available outside of resident's room.</p> <p>15. On 5/26/2026 at approximately 11:00 a.m., in an interview with a surveyor, R2 confirmed he/she had an indwelling urinary catheter. The surveyor asked if staff wear any special precautions when providing care for the catheter, and R2 stated staff only use gloves, no gown or other PPE.</p> <p>On 5/26/26 at approximately 11:30 a.m., surveyor noted no signage outside of R2's room indicating the need for special precautions and no PPE station was present.</p> <p>16. On 5/26/25 at 11:35 a.m., surveyor interviewed CNA4 and asked if R2 required any special (continued on next page)</p> |                                                                                 |                                                 |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>precautions when receiving care. CNA4 stated not that he/she was aware of. Surveyor asked how CNA would know if the resident required special precautions, and CNA4 stated a sign would be posted outside the room and a PPE station would be set up.</p> <p>17. On 5/26/2026 at 1:16 p.m., in an interview with a surveyor, R8 stated he/she has an indwelling urinary catheter and was being treated for a urinary tract infection. Surveyor asked what type of PPE staff use when providing catheter care. R8 stated staff only wear gloves. Surveyor noted no signage was posted outside of R8's room indicating the need for special precautions and no PPE station was present.</p> <p>A review of R8's clinical record noted a history of urinary tract infections with multidrug resistant organisms (MDRO's). A urine culture dated 2/27/26, noted an infection with E. Coli/ESBL (extended spectrum beta lactamase), an MDRO. Most recently, a hospital Discharge summary, dated [DATE], stated R8 was treated for polymicrobial UTI (urinary tract infection). A urine culture dated 4/26/26 resulted in E. Coli resistant to tetracycline (an antibiotic).</p> <p>On 5/28/26 at 10:30 a.m., a surveyor discussed the findings with the Director of Nursing.</p> |                                                                                 |                                                 |

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| F 0656<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interviews, the facility failed to develop and implement a resident's care plan in the area of Enhanced Barrier Precautions (EBP) for Multi-drug Resistant Organisms (MDRO's) for 1 of 8 residents reviewed with indwelling urinary catheters (R8). Findings: A review of the clinical record revealed Resident #8 was admitted in June, 2023, and had diagnoses which included neurogenic bladder and a history of urinary calculi (stones) and multi-drug resistant urinary tract infections. Resident #8 required an indwelling (Foley) catheter for urinary elimination. In February, 2026, a urine culture revealed ESBL (extended spectrum beta lactamase) - a drug resistant organism, for which R8 was treated. In April, 2026, R8 was hospitalized for urosepsis. The hospital Discharge summary, dated [DATE], noted R8 was admitted for polymicrobial urinary tract infection, with the organisms <i>Proteus mirabilis</i>, <i>Citrobacter freundii</i>, ESBL <i>Escherichia coli</i> requiring a 7-day course of intravenous antibiotics. Upon discharge, a urine culture obtained on 4/26/26, noted the presence of <i>Enterococcus faecalis</i>, resistant to tetracycline (an antibiotic) and R8 was discharged with an antibiotic the organism was sensitive to. A review of Resident #8's care plan included a problem area of Indwelling Catheter. Interventions included: Catheter bag changed weekly on Sundays for infection prevention. Monitor and document intake and output as per facility policy. Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Position catheter bag and tubing below the level of the bladder and away from entrance room door. (R8) frequently puts head lower than foley - remind to keep head higher so foley can drain. On 5/28/26 at 10:30 a.m., in an interview with the Director of Nursing, the surveyor discussed R8's history of recurrent MDRO's associated with the urinary catheter was not included in the resident's care plan, which should include the need for staff to use Enhanced Barrier Precautions whenever providing direct care to avoid transmission of resistant organisms.</p> |                                                                                 |                                                 |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interviews, the facility failed to ensure a valid physician's order was obtained before administering an antibiotic to 1 of 1 residents reviewed for dialysis care (R2). Findings: On 5/26/26 at approximately 11:00 a.m., during an interview with a surveyor, R2 stated he/she goes to the local Veterans Administration (VA) every month for catheter changes. R2 stated recently the VA prescribed an antibiotic for a urinary tract infection (UTI). A review of the clinical record for R2 noted admission in September, 2025. Diagnoses included Chronic Kidney Disease, stage 5, with dependence on hemodialysis, and chronic urinary retention requiring an indwelling foley catheter. The electronic medical record noted an order dated 5/26/26 for the antibiotic Sulfamethoxazole-Trimethoprim 400-80 mg. (milligrams), give 1 tablet by mouth at bedtime for UTI for 6 days. This order was unsigned by a licensed medical provider. Further review of the electronic and hard copy medical record lacked evidence that a provider's evaluation had been completed or an authorized and signed prescription had been obtained. A nursing progress note, dated 5/25/26, stated R2 noted what he/she described as intense pain and burning around the catheter and into his/her bladder. He/she expressed desire for immediate relief. Discussed with [family] about if the VA or dialysis could help. The [family] decided to take R2 to urgent care where they diagnosed him/her with a UTI and provided new orders. R2 is currently at dialysis but will return with new orders and the medication. On 5/26/26, the facility's physician evaluated R2 and noted the presence of urinary retention but did not refer to a new urinary tract infection or treatment with an antibiotic. The physician did not sign the electronic order for the antibiotic. There was no evidence that a urine culture had been obtained prior to initiating an antibiotic. A review of R2's medication and treatment administration record noted staff had administered the antibiotic on 5/26/26 and 5/27/26. On 5/28/26 at 9:30 a.m., in an interview with a surveyor, RN1 stated on 5/25/26, R2's family had transported him/her to dialysis and took R2 to an urgent care clinic. R2 stated the clinic diagnosed R2 with a UTI and ordered an antibiotic. RN1 stated he/she did not think the clinic had examined the resident or obtained a urine culture. RN1 stated he/she did not know if a written order was obtained and stated the family did not bring back an after-care summary from the clinic. On 5/28/26 at 10:30 a.m., the surveyor discussed the above concerns with the Director of Nursing (DON), who stated the family frequently takes R2 to appointments but does not communicate with the facility. The DON stated she has discussed this with the family. The DON stated she did not think R2 was receiving an antibiotic at this time. On 5/28/26 at 11:00 a.m., the surveyor met with RN1, R2 and his/her daughter. The surveyor asked if R2 was receiving an antibiotic right now. RN1 confirmed R2 was receiving the medication at this time and confirmed no order had been received from the prescriber at the urgent care clinic. The [family member] confirmed that [he/she] had filled the prescription at a local pharmacy and brought the bottle of pills in when [he/she] returned R2 to the facility. The surveyor discussed that when the resident is taken to an outside provider, paperwork including doctor's signed orders must be given to the facility if staff are going to be administering medications/treatments. The [family member] asked if the instructions which stated what was done and ordered (after care summary) were enough, and the surveyor explained these were not signed physician orders. The [family member] stated [he/she] would go to the pharmacy and obtain a copy of the prescription and bring it back. On 5/28/2026 at 12:45 p.m., the DON and facility's Infection Preventionist (IP) provided a copy of the final report from the 5/25/26 visit to the urgent care clinic with a copy of the antibiotic prescription attached. The IP stated R2's daughter brought the clinic paperwork to staff on the morning of 5/26/26 and the first dose of the antibiotic was administered by dialysis. On 5/28/26 at (continued on next page)</p> |                                                                                 |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

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| F 0684<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | 1:00 p.m. in an interview with a surveyor, RN1 stated R2's [family member] brought in a copy of the<br>prescription after speaking with the surveyor earlier that morning. |                                                                                 |                                                 |

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| F 0757<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>Based on record review and interview, the facility failed to monitor side effects of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (R6). Findings: On 5/27/26 review of Resident #6's (R6) active orders revealed an order for risperidone oral tablet 0.25 mg, give 0.25 mg by mouth two times a day for anxiety/agitation with start date of 9/19/25. On 5/27/26 review of R6's care plan states, (R6) is/has potential to be verbally aggressive (threatening, agitation, anxiety, anger/frustration) r/t Severe Dementia with Agitation & Behaviors, Ineffective coping skills, PTSD, defensive behavior d/t childhood physical & sexual abuse. Interventions/Tasks: Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of R6's Medication Administration Record and Treatment Administration Record dated May 2026 lacked evidence they were being monitored for side effects of the medication listed above. On 5/27/26 at 1:57 p.m. in an interview with a surveyor the Director of Nursing confirmed there is no documentation for assessment of the psychotropic side effects for this resident. |                                                                                 |                                                 |

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| F 0761<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>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.</p> <p>Based on observation and interview, the facility failed to ensure that medications were stored properly as evidenced by unattended medication left at a resident's bedside, allowing residents and unauthorized persons access to the medication on 1 of 2 units (Wing 2). Finding: On 5/26/26 at approximately 11:00 a.m., during an interview with Resident #26, a surveyor observed a cup containing medication on the resident's overbed table. After the interview, at approximately 11:30 a.m., the surveyor asked RN#2 if he/she was aware of the meds left at the bedside. RN#2 observed the medication and stated he/she thought the resident had taken them. On 5/26/26 at 4:00 p.m., the finding was discussed with the Director of Nursing.</p> |                                                                                 |                                                 |

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| F 0842<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 6 residents whose Medication Administration Records (MAR) and Treatment Administration Records (TAR) were reviewed. (R17)Findings:On 5/28/26 a surveyor reviewed R17's clinical record which showed an active physician order for Trazodone HCL with instructions to give 50 milligrams by mouth at bedtime. A review of his/her MAR/TAR for the month of May lacked evidence that the medication was given on 5/4/26, 5/15/26, 5/21/26, 5/22/26, 5/25/26. Additionally, the clinical record showed active physician orders to remove TED stockings every night, apply Miconazole powder to the groin/peri area for redness two times a day for skin integrity, and apply Biofreeze Cool the Pain External Gel 4% to both shoulders and neck three times a day. A review of his/her MAR/TAR for the month of May lacked evidence that the treatments were given on 5/10/26.On 5/28/26 at 10:10 a.m., the above information was reviewed and confirmed with the Director of Nursing.</p> |                                                                                 |                                                 |

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| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                 |                                                 |
| F 0636<br><br>Level of Harm - Potential for<br>minimal harm<br><br>Residents Affected - Some                                       | <p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>Based on record reviews and interviews, the facility failed to complete a Minimum Data Set (MDS) upon a resident's discharge (R40). Additionally, the facility failed to adequately capture the presence of a resident's wounds on the MDS for 1 of 2 residents reviewed for pressure ulcers (R8). Findings:</p> <p>1. Review of R40's clinical record revealed he/she discharged from the facility in April of 2026. Review of R40's Minimum Data Set (MDS) lacked evidence that a MDS was completed upon his/her discharge.</p> <p>During an interview on 5/28/26 at 12:38p.m., the Director of Nursing reviewed R40's clinical record and confirmed that an MDS was not completed after the resident was discharged .</p> <p>2. A review of R8's clinical record revealed diagnoses which included stroke and paraplegia. Physician orders indicated R8 was receiving treatment for deep tissue injuries (DTI's) of the toes. A review of the quarterly MDS assessment, dated 4/6/26, section M: Skin Conditions, noted no pressure ulcers or other skin conditions.</p> <p>On 5/28/2026 at 10:30 a.m., in an interview with the Director of Nursing, a surveyor discussed that R8's quarterly MDS did not include DTI's for which he/she was receiving treatment.</p> |                                                                                 |                                                 |