DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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CEDAR RIDGE CENTER	23 CEDAR RIDGE DRIVE SKOWHEGAN, ME 04976

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F 000	INITIAL COMMENTS From January 27, 2025 to January 30, 2025, on-site visits were conducted at Cedar Ridge Center for the purpose of conducting the annual Long Term Care Survey Process for Federal Recertification, and complaint investigations #ME00049802, #ME00050140, and #ME00050304. It was determined that Cedar Ridge Center is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000	Please note the filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550	The event happened in the past and cannot be corrected. A facility-wide interview and observation audit of tray service within the past 14 days was conducted to review resident satisfaction and ensure each resident's dignity is maintained during meal services. The facility ensures that each resident's dignity is maintained during meal service by serving all residents seated at the same table at the same time. Nursing staff will be re-educated to this process. NHA/Designee will conduct audits weekly x 4 weeks, then monthly x 2 to ensure dignity is maintained during meal service. Results of these audits will be	3/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Center Executive Director 2/26/2025

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.

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F 550	Continued From page 1	F 550	- cont -	

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
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

Plan of correction (F 550, cont.): brought to the monthly QAA Committee for further review and recommendations.

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F 550 Continued From page 2 F 550

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.

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

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F 550	Continued From page 3 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.	F 550		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: 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.	F 559	The event occurred in the past and cannot be corrected. A facility-wide audit was conducted to ensure that any resident with room changes has documentation included on their chart to include notification to potential roommates and resident representatives if applicable. The facility ensures that charts are reviewed to reflect notification of room changes. Licensed staff will be re-educated to this process. DON/Designee will conduct audits weekly x 4, then monthly x2 to ensure all room changes are inclusive of timely notification to potential roommates and resident representatives. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations.	3/14/25

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F 559	Continued From page 4 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.	F 559		
F 578 SS=B	Request/Refuse/Dscntnue Trmnt ;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i)These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii)This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii)Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578	Resident #31 D/C on 1/31/2025 and cannot be corrected. Resident #26 D/C on 2/15/2025 and cannot be corrected. Resident #474 D/C on 1/29/2025 and cannot be corrected. Resident # 325 D/C on 2/9/2025 and cannot be corrected. Resident or resident POA #61, #5, #51 and #27 were given written information on their right to formulate an advanced directive. The administrator or designee will conduct a facility wide audit to ensure all residents have been provided written information concerning the right to formulate an advanced directive. Additionally identifited residents will be provided written information concerning the right to formulate an advanced directive. The Administrator or designee will provide education to the social service department on policy OPS 117 Health Care Decision Making.	3/14/25

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F 578	Continued From page 5 requirements of this section are met. (iv)If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v)The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: 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.	F 578	- cont- The Administrator or Designee will audit social service assessments weekly x4 then monthly x2 to ensure residents are provided written information concerning the right to formulate an advanced directive and bring results to the monthly QAPI meeting for further review.	

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F 578	Continued From page 6 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 4/7/23. 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 7/11/24. 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. 3. Resident #27 was admitted on 3/8/24. 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.	F 578		

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F 578	Continued From page 7	F 578		

4. Resident #51 was admitted on 2/20/24. 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.

5. Resident #26 was admitted on 1/10/25. 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 11/5/24. 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 1/10/25. 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.

8. Resident #325 was admitted on 11/12/24. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident

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F 578	Continued From page 8 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.	F 578		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i)The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii)Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii)Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F656	A care plan for Post Traumatic Stress Disorder was developed and implemented for Resident's #1, #5, and #51 have had their care plans updated. A facility-wide audit was conducted to ensure all resident care plans with applicable Post-Traumatic Stress Disorder (PTSD)/Trauma status are corrected and updated. The facility ensures that resident care plans are developed in the area are PTSD/Trauma to include goals, interventions, and triggers where applicable. Licensed staff will be re-educated to this process.	3/14/25

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F 656 Continued From page 9

findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
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 10/11/19 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

F 656 - cont -

DON/Designee will conduct weekly audits x4, then monthly audits x2 to ensure care plan PTSD/Trauma status are accurate. Results of these audits will be brought to the monthly QAA Committee for review and further recommendations.

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F 656	Continued From page 10 4/7/23 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. 3. Resident #51 was admitted to the facility on 2/20/24. 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.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657	Resident #18's care plan was reviewed, and updated in the area of Post Traumatic Stress Disorder A facility-wide audit was conducted to ensure all residents with Post-Traumatic Stress Disorder (PTSD)/Trauma has this included in their care plan. The facility ensures that care plans are reviewed and reviewed by the interdisciplinary team after each assessment, and as needed to reflect the response to care and changing needs/goals of the resident, inclusive of changes to PTSD/Trauma. Licensed nurses will be re-educated to this	3/14/25

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F 657	Continued From page 11 and their resident representative is determined not practicable for the development of the resident's care plan. (F)Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: 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.	F 657	- cont - process. DON/Designee will conduct audits weekly x 4, then monthly x 2 to ensure PTSD/Trauma status is being updated in the care plan. Results of these audits will be brought to the monthly QAA meeting for review and further recommendations.	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) §483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695	Oxygen and nebulizer equipment and tubing were removed from residents' rooms where not utilized and equipment cleaned with tubing dates updated for	3/14/25

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F 695 Continued From page 12

The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

This REQUIREMENT is not met as evidenced by:

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

F 695 - cont -

residents utilizing respiratory treatment and care.

A facility-wide audit was conducted to validate that all residents utilizing oxygen and/or a nebulizer have a bag to place tubing/mouthpiece/nasal cannula equipment when not in use.

The facility ensures residents with oxygen and nebulizer tubing/mouthpiece/nasal cannula have bags to place them in when not in use. Nursing staff will be re-educated to this process.

DON/Designee will conduct audits weekly x 4, then monthly x 2 to ensure oxygen and nebulizer tubing, mouth pieces, and nasal cannulas are placed in a bag when not in use. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations.

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F 695	Continued From page 13 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. 3.On 1/28/25 at 9:14 a.m., during an observation of Room 202, 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 201, 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.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725	The event occurred in the past and cannot be corrected. The facility will continue to schedule direct care staff to meet the care needs of the residents to include meeting federal and state	3/14/25

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practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
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

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guidelines for staffing ratio minimums (Day 1:5, Evening 1:10, Night 1:15 for direct care staff).

The facility ensures sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care when considering the number, acuity, and diagnoses of the facility's resident population. Facility staff responsible for the scheduling of direct care staff will be re-educated to this process.

DON/Designee will audit staffing sheets daily to validate sufficient direct care staff are scheduled to meet the needs of the residents and federal/state guidelines of minimum nursing staff-to-resident ratios. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.

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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.

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F 725	Continued From page 16 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.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services . The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	The Consultant Pharmacist was notified on 1/29/25 and provided an In-Service on 2/11/25 to CMAs and Licensed Staff on the "Narcotic Blue Book Documentation". Resident #329 received IV antibiotics by Licensed Nurses per provider orders following discussions between the provider and the pharmacist. A facility-wide audit was conducted to ensure all persons authorized to administer narcotic medications sign the Shift Count page of the Blue Controlled Substances Book by on duty oncoming/off going staff.	3/14/25

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§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
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

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An audit of residents current medication orders was conducted to validate medications are available to provide to residents as ordered.

Emergency pharmacutical services are available on a 24-hour basis from Pharmerica. Emergency needs for medication are met by using the nursing care centers approved emergency medication supply or by special order from the provider pharmacy. Emergency medications and supplies are provided by the pharmacy in compliance with applicapble state and federal regulations. The pharmacy employs a backup pharmacy to meet the biologic needs of the facility, including IVs. The consulting pharmacist and Licensed staff will be reeducated to this process.

The facility performs a complete count of all Schedule II to IV controlled substances at the change of shifts or at any time in which narcotic keys are surrendered from one Licesned nursing staff to another (one staff can be a CNA-M and one person must be a Licensed nurse). The two nursing staff sign the shift count page in the "Controlled Substances Book" to acknowledge a correctly reconciled count. Licensed nurses and CNA-M will be reeducated to this process.

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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

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DON or designee will audit substance book weekly x4 then monthly x2 or until resolved to ensure shift count is conducted per the controlled medication storage policy and bring results to monthly QAPI meetings for further review and recommendation

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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.

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.

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 1/24/25 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

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F 755	Continued From page 20 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.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758	Resident #36's clinical record	3/14/25

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CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is

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was clarified and updated during resident's stay in facility. An order to monitor for behaviors and side effects of psychotropics medication use was added to the plan of care.

A facility-wide audit was conducted to ensure that residents with psychotropic medications have orders for monitoring behaviors and side effects.

The facility ensures that residents on psychotropic medications are monitored for behaviors and side effects. Licensed staff will be re-educated to this process.

DON/Designee will conduct weekly audits x 4, then monthly audits x 2, to ensure all residents with psychotropic medications have orders to monitor for behaviors and side effects. Results of these audits will be brought to the QAA Committee for further review and recommendations.

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appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
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 12/17/24 with diagnoses to include anxiety and depression.

Resident #36's care plan, initiated 12/17/24, states, "...at risk for complications related to the

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F 758	Continued From page 23 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.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761	On 1/29/25 a Registered Nurse removed an out of date and an undated insulin pen from the treatment cart. A facility-wide audit was conducted to ensure all	3/14/25

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F 761	Continued From page 24 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 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 1/29/25 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 12/22 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".	F 761	- cont - medications/biologicals are dated and properly disposed of according to manufacturer specifications. The facility ensures that medications/biologicals are dated when opened and properly disposed of according to manufacturer specifications. Licensed staff will be re-educated to this process. DON/Designee will conduct weekly audits x 4, then monthly audits x 2, to ensure medications/biologicals are dated when opened and properly disposed of according to manufacturer specifications. Results of these audits will be brought to the QAA Committee for further review and recommendations.	

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F 761	Continued From page 25 At this time, the RN removed both of the insulin pens and confirmed they were either expired or undated.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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	F 812	The event occurred in the past and cannot be corrected. An audit of the kitchen was conducted to ensure the area is maintained in a cleaned and sanitary manner. All foods were sealed, labeled, and dated in the dry storage, walk-in freezer, and walk-in refrigerator. Additionally, chemicals were secured in a metal cabinet, away from the emergency food supply. The facility ensures the kitchen will be maintained in a clean and sanitary manner; all foods within the dry storage, walk-in freezer, and walk-in refrigerator are sealed, labeled, and dated; and chemicals are stored in a metal cabinet. Kitchen staff will be re-educated to this process. NHA/Designee will conduct weekly audits x 4, then monthly audits x 2, to the kitchen is maintained in a clean and sanitary manner.	3/14/25

F 812 Continued From page 26

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.

F 812 - cont -

Results of these audits will be brought to the QAA Committee for further review and recommendations.

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- 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.
- 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, ½ 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:

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F 812	Continued From page 28 - 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.	F 812		
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.	F 847	The event occurred in the past; residents #35, 46, 57, and 331 and/or their resident representatives signed and voiced understanding of the facility Binding Arbitration Agreement on admission.	3/14/25

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F 847	Continued From page 29 §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees,	F 847	- cont - The facility will continue to communicate and provide the terms and conditions of the binding arbitration agreement to residents and/or their representatives at admission. The facility will ensure that the terms and conditions of the binding arbitration Agreement are clearly communicated to the residents and/or their representatives to include that they can decline the agreement during the admission process. NHA/Designee will conduct weekly audits x 4, then monthly audits x 2, to ensure all new admissions have received the terms and conditions of the binding arbitration Agreement. Results of these audits will be brought to the QAA Committee for further review and recommendations.	

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and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:
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 and not required as a condition of admission due to the agreement lacking an area of where the resident and/or representative can decline the agreement with it being a part of the admission paperwork 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 3/27/24. 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

F 847 Continued From page 31 F 847

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 5/21/23. 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 10/12/24. 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.

On 1/30/25 at 2:50 p.m., a surveyor met with Resident #57 and asked if he/she signed an

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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 admission date of 11/22/24. 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

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F 847	Continued From page 33 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." A review of #24, "Acknowledgement of Understanding Agreement" revealed the agreement lacks an area where the resident and/or resident representative can decline entering into the arbitration 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	F 847		

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F 847	Continued From page 34 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. 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."	F 847		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	The Enhanced Barrier Precautions signage for residents #327 and #331 was replaced on 1/28/25.	3/14/25

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§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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A facility-wide audit was conducted to ensure that any resident that needs to be on precautions has the correct signage and PPE set-up available.

The facility ensures the prevention of development and transmission of communicable diseases for residents requiring Enhanced Barrier Precautions by maintaining the correct signage and PPE. Nursing staff will be re-educated to this process.

DON/Designee will conduct weekly audits x 4, then monthly audits x 2, to ensure maintenance of the infection prevention and control program by providing the correct signage and PPE set-up to prevent the development and transmission communicable diseases for resident requiring Enhanced Barrier Precautions. Results of these audits will be brought to the QAA Committee for further review and recommendations.

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
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:

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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 1/21/25, 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

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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 11/22/24, 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."

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

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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

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(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."