STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205137	A. BUILDING _____ B. WING _____	C 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEDGEWOOD MANOR	**200 ROUTE 115 WINDHAM, ME 04062**

(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
F 000	INITIAL COMMENTS On 4/29/25, an unannounced, on-site visit was conducted at Ledgewood Manor to investigate complaints #ME00051256 and #ME00051229. It was determined that Ledgewood Manor was in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure professional standards of quality were met for controlled medication administration for 1 of 1 resident reviewed. Finding: Record review revealed Resident #1 was admitted in 2019 with diagnoses to include dementia. Resident #1 was admitted to Hospice services on 1/10/25. Review of Resident #1's active physician orders revealed the following: -Order with a start date of 4/9/25 for, "Morphine Sulfate (Concentrate) Solution 20 MG/ML [milligrams per milliliter] *Controlled Drug* Give 5	F 658	Past noncompliance: no plan of correction required.	

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

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 658	Continued From page 1	F 658		

mg by mouth every 30 minutes as needed for PAIN / DISCOMFORT ..."

- Order with a start date of 3/19/25 for, "LORazepam Intensol Concentrate 2 MG/ML (LORazepam) *Controlled Drug* Give 0.5 mg by mouth every 15 minutes as needed for ANXIETY ..."

Review of facility-reported incident, dated 4/12/25, states, " ... [Resident #1's] family members informed nursing staff that the night shift charge nurse ...informed the family that she did not have time to give [Resident #1] his/her PRN [as needed] medications as often as they were requesting them. She then drew up a dose of Morphine and a dose of Ativan (Lorazepam) into syringes and gave them to the family to administer themselves."

On 5/2/25 at 9:48 a.m., during a phone interview, the Registered Nurse (RN) stated that at 5:00 a.m. she gave Resident #1 a dose or lorazepam and morphine and then asked Resident #1's [family member] to give the next dose at 5:30 a.m. because the RN was too busy and proceeded to give Resident #1's [family member] a pre-drawn oral syringe of morphine and a pre-drawn oral syringe of lorazepam to administer at 5:30 a.m. At this time, the RN stated she knows she is not supposed to leave medications at the bedside table for family to administer.

On 4/29/25 at approximately 11:00 a.m., the Director of Nursing (DON) stated the RN was sent home as soon as the incident was reported to the DON, and the RN's employment was terminated once the facility determined the RN had given medications to the family to administer

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F 658	Continued From page 2 to Resident #1. As a result of the facility's investigation the following correction actions were immediately taken: -On 4/14/25 a report of the incident was submitted to the Department of Licensing and Certification ("DLC") -The Registered Nurse was terminated -The Maine State Board of Nursing was notified -On 4/24/25 a Licensed Nursing Meeting included the "Narcotic Incident Review" which instructed licensed staff that under no circumstances are they to give medications to family to administer.	F 658		