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 _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE CENTER	**23 CEDAR RIDGE DRIVE SKOWHEGAN, ME 04976**

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F 000	INITIAL COMMENTS On 1/15/25, an unannounced, on-site visit was conducted at Cedar Ridge Center to investigate complaint #ME00050177. It was determined that Cedar Ridge Center is not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		

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

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F 655	Continued From page 1 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to care for 1 of 3 residents reviewed during a complaint investigation (Resident #1). Finding: Review of policy, "OPS416 Person-Centered Care Plan," dated 10/24/22, states " ...The Center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care ...1. A baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including, but not limited to: initial goals based on admission orders; physician orders;	F 655		

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F 655	Continued From page 2 dietary orders; therapy services; social services; PASRR recommendation, if applicable ..." Review of policy, "NSG236 Skin Integrity and Wound Management," dated 10/15/24, states, "...The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation ..." Resident #1 was admitted on 12/11/24 with diagnoses to include Deep Tissue Injury. Review of Resident #1's Wound Evaluation, dated 12/11/24, revealed Resident #1 had a Deep Tissue Injury located on his/her coccyx that was present on admission. Review of Resident #1's care plan, initiated 12/12/24, lacked evidence that goals and interventions were put into place for the wound. On 1/15/25 at 3:17 p.m., the interim Director of Nursing (DON) reviewed Resident #1's care plan and confirmed it did not contain goals and interventions for the above concern.	F 655		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 3 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842		

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F 842	Continued From page 4 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for wounds (Resident #1). Finding: Review of facility policy, "Skin Integrity and Wound Management," dated 10/15/24, states, "Practice Standards ...6. The licensed nurse will ...6.2 Document any newly identified skin/wound impairments ...6.7 Notify interdisciplinary team members for a comprehensive approach to care including prevention and wound treatments...9. Notify physician/APP to obtain orders ..." Resident #1 was admitted on 12/11/24 with diagnoses to include Deep Tissue Injury on coccyx.	F 842		

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F 842	Continued From page 5	F 842		

Review of Resident #1's Wound Evaluation, dated 12/11/24, revealed Resident #1 had a Deep Tissue Injury located on his/her coccyx that was present on admission. Further review of the Wound Evaluation revealed, "Treatment ...Cleansing solution: soap & water ...Primary dressing: no dressing applied ..." Review of Resident #1's Wound Evaluation, dated 12/18/24, revealed the coccyx wound was "Deteriorating" and "Treatment ... Dressing Appearance: Intact ...Cleansing solution: Generic wound cleanser ...Primary Dressing: zinc oxide covered with optifoam ..."

Further review of Resident #1's clinical record lacked evidence of a provider order for the treatments indicated on Resident #1's Wound Evaluations, dated 12/11/24 and 12/18/24.

During an interview on 1/16/25 at 9:45 a.m., Registered Nurse (RN) #1 stated that on admission, residents are assessed for wounds, and if a wound is present, the nurse takes a picture and documents and then notifies the doctor, and the treatment orders are obtained.

During an interview on 1/15/25 at 1:48 p.m., Physician Assistant-Certified (PA-C) #1 stated it was her expectation that there would be a provider order to match what is listed in the "Treatment" section of a resident's weekly Wound Evaluation assessment.

During an interview on 1/15/25 at 3:15 p.m., the interim Director of Nursing (DON) reviewed Resident #1's entire clinical record and confirmed it did not contain a provider order for the for the treatments indicated in Resident #1's Wound Evaluations.

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