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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205060 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/16/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR RIDGE CENTER | 23 CEDAR RIDGE DRIVE DR MANN RD, SKOWHEGAN, Maine, 04976 |

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| F0000 | INITIAL COMMENTS<br><br>On 4/13/26 through 4/16/26, unannounced on-site visits were conducted at Cedar Ridge Center for the purpose completing the annual Long Term Care Survey Process for Federal Recertification; investigate facility reported intakes 2693327, and 217915; and complaints 2677637, and 2564024. It was determined that Cedar Ridge Center is not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. | F0000 | 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 law. | |
| F0584<br>SS = E | Safe/Clean/Comfortable/Homelike Environment<br><br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br><br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br><br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition; | F0584 | The air gap on the ice machine on the Blue Spruce unit was corrected. The bottom of the cabinet was replaced. The drain tube on the ice machine on Balsam unit was replaced and all items were stored appropriately. The area behind the ice machine on Scotch Pine was cleaned and made serviceable.<br><br>A house audit was conducted to ensure all air gaps were appropriate, items under cabinets were removed and stored appropriately, and all countertops around ice machines were clean and serviceable to maintain a safe, functional, and sanitary environment.<br><br>The resident has a right to a safe, clean, comfortable and homelike environment , including but not limited to receiving treatment and support for daily living safely. The Administrator, Maintenance staff, Nursing staff and Housekeeping staff were re-educated to this process<br><br>The Administrator/Designee will conduct weekly audits x4, then monthly audits x 2. Results of these audits will be brought to the monthly QAPI committee for further review and recommendations. | 5/27/26 |

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 reverse for further 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 |
|---|---|---|
| [signature] | Administrator | 5/7/26 |

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| F0584 SS = E | Continued from page 1<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, and sanitary environment for 2 of 4 days of survey (4/13/26 and 4/14/26).<br><br>Findings:<br><br>1.On 4/13/26 at 12:15 p.m., during an observation of the Blue Spruce unit (C unit) the surveyor observed the ice machine on the counter in the kitchenette area. The air gap was not visible; the Maintenance Director stated the air gap was in the secured doors of the cabinet. The Maintenance Director removed the screws from the doors, and it was noted that the air gap was improper (see F812) at this time an observation of the interior of the cabinet was made and it was noted that the bottom of the cabinet was warped exposing the edges of the wood panel and an area on the back left corner of the cabinet was caved in. This area was noted to have a dark substance on the edges of the exposed panel.<br><br>At the time of this observation the above finding was confirmed by the surveyor with the Maintenance Director.<br><br>2.On 4/13/25 at 12:25 p.m., during an observation of the Balsam unit (D unit) the surveyor observed the ice machine on the counter in the dining/common area. In the cabinet under the ice machine the air gap was observed to be correct, it was noted that the drain tube from the ice machine had a large buildup of a black substance hanging off the end of the drain tube. In the cabinet there were 2 urinals, 1 incontinence brief and an opened box of gloves along with several loose garbage bags. | F0584 | | |

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| F0584 SS = E | Continued from page 2<br>The above findings were confirmed by the surveyor with the Director of Nursing and the Market Clinical Advisor in training (MCAT).<br><br>3.On 4/13/26 at 12:40 p.m., during an observation of the Scotch Pine Unit (B unit) the surveyor observed the ice machine on the counter in a small kitchenette area, the area around the ice machine was observed to be heavily soiled with dark unknown substances. A staff member in the kitchenette stated that it was from when the coffee pot overflowed last week. The area behind the ice machine was observed, the counter behind the ice machine had been cut to allow for the piping for the ice machine leaving cut edges of the countertop that were exposed and was discolored from the spilled coffee.<br><br>The above finding was confirmed by the surveyor with the staff at the time of the observation. | F0584 | | |
| F0711 SS = E | Physician Visits - Review Care/Notes/Order<br><br>CFR(s): 483.30(b)(1)-(3)<br><br>§483.30(b) Physician Visits<br><br>The physician must-<br><br>§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;<br><br>§483.30(b)(2) Write, sign, and date progress notes at each visit; and<br><br>§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record reviews and interviews, the facility failed to ensure that during the regulatory visit, the Provider reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the physician block orders for 5 of 5 residents reviewed for unnecessary medications (Residents #7 [R7]), R59, R5, R14, R33).<br><br>Findings: | F0711 | The findings regarding R7, R59, R5, R14, and R33 all happened in the past and cannot be corrected.<br><br>A house audit was conducted to ensure Physician visits include validation and signing of all orders.<br><br>The facility ensures that during the regulatory visit, the Provider reviews the residents' total program of care, which includes signing orders for medications and treatments listed. The Administrator, DON, Unit Clerk, and Providers were re-educated to this process.<br><br>The DON/ Designee will conduct weekly x4, then monthly x2 audits to ensure medications and treatments listed on the physician's block orders were completed at the time of the regulatory visits. Results of these audits will be brought to the monthly QAPI committee for further review and recommendations. | 5/27/2026 |

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| F0711 SS = E | Continued from page 3<br><br>1. On 4/16/26, a review of R7's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 2/24/26 a provider progress note was completed on 2/24/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 2/24/26 required regulatory visit.<br><br>2. On 4/16/26, a review of R59's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 2/26/26. A provider progress note was completed on 2/26/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 2/26/26 required regulatory visits.<br><br>3. On 4/16/26, a review of R5's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 3/3/26. A provider progress note was completed on 3/3/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 3/3/26 required regulatory visit.<br><br>4. On 4/16/26, a review of R14's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 3/3/26. A provider progress note was completed on 3/3/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 3/3/26 required regulatory visit.<br><br>5. On 4/16/26, a review of R33's clinical record was completed. Documentation indicated a required regulatory visit was conducted on 3/17/26 a provider progress note was completed on 3/17/26, but there was no evidence that the physician block order was signed. The facility was unable to provide evidence that the physician block order was signed on the day of the 3/17/26 required regulatory visit.<br><br>On 4/16/26 at 11:31 a.m., in an interview with the surveyors, the Market Clinical Advisor confirmed the findings. | F0711 | | |

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| F0812 SS = E | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation and interviews, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 1 of 4 days of survey (4/13/26). In addition, the facility failed to prepare food under sanitary conditions for 1 of 4 days of survey (4/14/26).<br><br>Findings:<br><br>1.On 4/13/26 at 12:15 p.m. during a unit observation tour on the Blue Spruce unit (C unit) the kitchenette had an ice machine on the counter, the air gap was not visible. The Maintenance Director was asked to show the air gap to the ice machine, which was located under the sink, the cupboard doors were secured shut with screws. When the Maintenance Director unscrewed the doors, it was observed that the air gap to the ice machine was less than the 1 inch required.<br><br>This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which | F0812 | The air gap on Blue Spruce was corrected. The finding regarding the food preparation occurred in the past and cannot be corrected.<br><br>A house audit was conducted to ensure air gaps were in accordance with the Maine State plumbing code. A house audit of the kitchen was completed to validate the cans were free of dust and debris prior to opening.<br><br>The facility ensures the plumbing fixtures are properly installed to prevent back flow as required by Maine State plumbing code. The Administrator and Maintenance staff were re-educated to this process. The facility ensures food is stored, prepared, distributed and served in accordance with professional standards for food service safety. The Dietary Staff were re-educated to this process.<br><br>The Maintenance Director/Designee will conduct audits of the air gaps weekly x4, then monthly x2 to ensure the air gaps are clean and in accordance with Maine State plumbing code.<br><br>The Dietary Director/Designee will conduct audits 3x weekly for 4 weeks, then weekly x4, then monthly x2 to ensure food is prepared under sanitary conditions. Results of these audits will be brought to the monthly QAPI committee for further review and recommendations | 5/27/2026 |

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| F0812 SS = E | Continued from page 5<br>defines an "Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one-inch (2.54 cm)" and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states "all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils."<br><br>The above finding was confirmed by the surveyor at the time of the observation with the Maintenance Director.<br><br>2.On 4/14/26 at 11:40 a.m. a surveyor observed the Food Service Director (FSD) preparing lunch desserts. He brought a can of peaches from the supply room, the can was observed to have a dirty/dusty top, the FSD opened the can of peaches contaminating the peaches with the soiled lid. The FSD brought in a second can and wiped the top of the can with the sanitizing cloth and did not rinse the top leaving the sanitizing agent on the top lid, the can was brought over to the can opener, a surveyor intervened, the can top was rinsed then opened by the Dietary Aide. She then brought the can to the counter and placed it down near the dessert dishes. She put on gloves and with a gloved hand reached into the opened can grabbing some peach slices, she then began cutting them up in her hand with a knife and placed the cubed pieces into the small dessert dishes. She then reached into the open can with the same gloved hand and cut up the peach slices and filled dessert dishes an additional 2 times before the surveyor intervened.<br><br>This finding was confirmed by the surveyor at this time with the Dietary Aide and with the Corporate Dietary Supervisor. | F0812 | | |
| F0880 SS = E | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>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. | F0880 | The finding regarding R55 occurred in the past and cannot be corrected.<br><br>All residents have the potential to be affected by the deficient practice.<br><br>The facility maintains 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 disease and infections, highlighting hand hygiene, cleaning of multi-use equipment, and the adherence to EBP. Licensed nursing will be re-educated to this process. | 5/27/2026 |

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| F0880 SS = E | Continued from page 6<br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. | F0880 | -cont-<br><br>The DON/Designee will conduct observations of licensed staff performing hand hygiene, dressing changes, and care provided to residents requiring EBP. These observations will be weekly x4, then monthly x2 to ensure the infection prevention and control program is maintained. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. | |

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| F0880 SS = E | Continued from page 7<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, observation, and interview, the facility failed to maintain an infection control program to help prevent the spread of infection related to pressure ulcer treatment for 1 of 2 residents observed for a pressure ulcer dressing change (Resident #55 [R55].<br><br>On 4/13/26, a review of R55's clinical record was completed. Documentation indicated R55 has a Stage 3 pressure ulcer on the left heel. Documentation in the physician orders indicated that the pressure ulcer treatment is to cleanse the wound with wound cleanser, apply a medihoney dressing to the wound bed and cover with a foam border once a day and as needed. On 4/14/26 at 6:50 a.m., a pressure ulcer dressing change observation was completed with RN1 performing the dressing change.Initially RN1 donned clean gloves, and set up a clean work field at the foot of the bed. RN1 placed the wound cleanser bottle on the soiled linen and medihoney dressing and foam cover on clean work field. RN1 went back to treatment cart and with the same clean gloves touched the cart with both gloved hands, took the keys from the cart, and put the keys in her pocket. She then picked up a camera (used for taking pictures of wounds) without cleaning it and went to bedside and placed camera on clean work field (contaminating the area). With the same gloves on; removed soiled dressing. RN1 changed gloves and cleansed wound. She then handled the camera and was unable to get a good picture. She lifts resident's leg and places it in a different position, moves the left leg again and takes a picture. With the now soiled gloves, she applied the medihoney dressing and foam. On 4/14/26 at 7:05 a.m., in an interview with RN1, the surveyor discussed the use of soiled gloves when applying a sterile dressing and working in contaminating a clean work field with a soiled camera. In addition, the surveyor discussed with RN1 the Enhanced Barrier Precaution (EBP) sign outside the residents | F0880 | | |

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| F0880<br>SS = E | Continued from page 8<br>room. RN1 did not follow the instructions for the EBP by not wearing a protective gown while performing a wound dressing change. | F0880 | | |
| F0585<br>SS = D | Grievances<br><br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br><br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; | F0585 | R44 grievances have been addressed by the facility.<br><br>A review of current grievances was conducted to ensure the concerns were addressed in accordance with the policy.<br><br>The resident has the right to and the facility must make prompt efforts to resolve grievances the resident may have. The facility ensures the grievance/concern policies andprocedures are followed. The Administrator and managerial staff were re-educated to this process.<br><br>The Administrator/ Designee will conduct weekly audits x4, then monthly audits x2 to ensure grievance/concern policies and procedures are followed. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. | 5/27/2026 |

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| F0585 SS = D | Continued from page 9<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br><br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br><br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br><br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interviews, review of the facility's filed grievances, and record review, the facility failed to implement parts of its Grievance/Concern policy and procedure for 1 of 2 residents that filed grievances (Resident #44 [R44]). | F0585 | | |

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| F0585 SS = D | Continued from page 10<br>Finding: On 4/13/26 at 10:50 a.m., in an interview with a surveyor, R44 voiced concern that they had filed a few grievances in the past couple of months and no one from management has talked to them about the outcome of their grievances. R44 stated that they do attend resident council meetings most of the time and they did discuss one of the grievances regarding snacks, but no one saw the resident in person to discuss it. On 4/15/26, a review of the facility's Grievance Binder was completed. In the Grievance Binder were four grievance forms filed by R44. The grievances are as follows:A. On 1/15/26, the scalloped potatoes were hard on the evening of 1/14/26.Documentation indicated that the corrective action was the Administrator stated quality control is done prior to meals leaving kitchen.B. On 1/16/26, did not receive evening medications until 11 p.m.Documentation indicated the corrective action was that the Administrator did a face to face visit with R44 and explained the medication nurse was a new staff and was a bit behind that evening.C. On 2/16/26, R44 is not receiving snacks in the afternoon.Documentation indicated the corrective action was that the dietary staff and nursing staff were spoken to about their responsibilities to provide snacks. D. On 2/16/26, there are no Purell hand wipes provided to residents prior to meals.Documentation indicated the corrective action was to speak to staff about offering hand wipes prior to meals and ensure they are in stock. Other than the grievance regarding a medication pass, there is no documentation on the grievance forms indicating the resident was spoken to directly about the concerns.On 1/15/26, R44's clinical record was reviewed and there was no evidence that the resident had been directly spoken to regarding his/her grievances. On 1/15/26, the facility's Grievance Policy and Procedure was reviewed. Documentation in the facility policy 'Grievance and Concerns Policy and Procedure" under section 6. The department manager will:6.1 contact the person filing the grievance to acknowledge receipt6.5 notify the person filing the grievance of resolution in a timely manner On 4/15/26 at 11:10 a.m., in an interview with a surveyor, the Administrator stated he remembered discussing some grievance resolutions with R44, but was unsure which ones other than the grievance form that indicated a face to face regarding the late medication pass. He stated the facility is going to improve the follow up process. | F0585 | | |
| F0605 SS = D | Right to be Free from Chemical Restraints<br><br>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) | F0605 | The R59 was seen by the provider on 5/7/2026. The provider documented the rationale to continue the prn medication past 14 days.<br><br>A house audit was conducted to identify any | 5/27/2026 |

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| F0605 SS = D | Continued from page 11<br>§483.10(e) Respect and Dignity.<br><br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any . . . chemical restraints<br><br>imposed for purposes of discipline or convenience, and not required to treat the<br><br>resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br><br>The resident has the right to be free from abuse, neglect, misappropriation of<br><br>resident property, and exploitation as defined in this subpart. This includes but is<br><br>not limited to freedom from corporal punishment, involuntary seclusion and any<br><br>physical or chemical restraint not required to treat the resident's medical<br><br>symptoms.<br><br>§483.12(a) The facility must-. . .<br><br>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints<br><br>imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.<br><br>. . . .<br><br>§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:<br><br>(i) Anti-psychotic;<br><br>(ii) Anti-depressant;<br><br>(iii) Anti-anxiety; and<br><br>(iv) Hypnotic. | F0605 | -cont-<br><br>residents with PRN psychotropic medications to ensure PRN orders did not extend beyond 14 days unless there was a provider's rationale and indication for the duration of the PRN order.<br><br>The facility ensures PRN psychotropic drugs are limited to 14 days. Except as provided in, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The DON, Licensed nurses, and providers were re-educated to this process.<br><br>The DON/Designee will conduct weekly audits x4, then monthly x2 to ensure PRN orders did not extend beyond 14 days without a practitioner's rationale and duration. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. | |

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| F0605 SS = D | Continued from page 12<br><br>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>§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;<br><br>§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;<br><br>§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<br><br>§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 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. | F0605 | | |

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| F0605 SS = D | Continued from page 13<br><br>§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.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record reviews and interviews, the facility failed to ensure an as needed (PRN) psychotropic medication was ordered for 14-days or less unless there is a practitioner's rationale for PRN use beyond 14-days for 1 of 5 residents reviewed for unnecessary medications (Resident #59 [R59]).<br><br>Findings:<br><br>Review of R59's clinical record, on the "physician order summary" for medications states, "Lorazepam (used to treat anxiety) give 0.5 mg (milligrams) by mouth every 8 hours as needed for anxiety for 6 months", with an order start date 11/24/25 and order end date 5/24/26. There was no evidence in the clinical record of a practitioner rationale for the extended use of the psychotropic PRN order beyond 14-days.<br><br>On 4/16/26 at 11:28 a.m. in an interview with the Director of Nursing (DON), a surveyor confirmed that R59's clinical record lacked evidence of practitioner's rationale for extended use of 6 months for the PRN Lorazepam order. The DON stated upon her review of R59's clinical record she couldn't find a practitioner rationale for the extended use either. | F0605 | | |
| F0644 SS = D | Coordination of PASARR and Assessments<br><br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br><br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. | F0644 | R1 was referred for a Level II pre-admission screening and resident reviews on 4/15/2026.<br><br>A house audit was conducted to identify any resident with a newly diagnosed mental disorder to ensure a level II review was conducted by PASARR.<br><br>The facility ensures all residents with newly identified serious mental disorder, intellectual disability, or a related condition are referred for Level II pre-admission screening and resident reviews. The Administrator, DON, MDS nurse, and Social Services Director were re-educated to this process.<br><br>The Social Services Director/Designee will conduct weekly audits x4, then monthly x2 to ensure that residents with newly evident or possible serious mental disorder are referred for Level II pre-admission screening and resident reviewsResults of these audits will be brought to the monthly QAPI committee for further review and recommendations. | 5/27/2026 |

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| F0644 SS = D | Continued from page 14<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 2 sampled residents reviewed for PASRR (Resident #1 [R1]).<br><br>Finding:<br><br>On 4/14/26, R1's clinical record was reviewed. R1's PASRR, completed on 12/24/25, did not require a level II determination due to his/her clinical record did not show that he/she had a serious mental illness. On 9/2/25, R1 was diagnosed with bipolar disorder, but the clinical record lacked evidence that the resident was referred to the State mental health authority for a new PASRR determination.<br><br>On 4/14/26 at 1:35 p.m., during an interview with a surveyor, the Licensed Social Worker stated a new PASRR was not submitted for R1 with the diagnosis of bipolar disorder. At this time a surveyor confirmed the facility failed to refer R1 for a PASRR after a new diagnosis and/or experienced symptoms related to a mental disorder. | F0644 | | |
| F0684 SS = D | Quality of Care<br><br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br><br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0684 | The findings regarding R7 and R59 occurred in the past and cannot be corrected.<br><br>A house audit was conducted to identify residents with blood pressure parameters to ensure physician orders are followed prior to administering medications and to ensure the physician orders were followed.<br><br>The facility ensures that residents receive treatment and care in accordance with professional standards of practice. The licensed nursing staff as well as CNA-M's were re-educated to this process.<br><br>The DON/Designee will conduct weekly audits x4, then monthly x2 to ensure physician orders including parameters are being followed. Results of these audits will be brought to the monthly QAPI committee for further review and recommendations. | 5/27/2026 |

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| F0684 SS = D | Continued from page 15<br>Based on clinical record reviews and interviews, the facility failed to ensure physician orders were followed for blood pressure parameters prior to administering a medication for 1 of 5 resident's reviewed for unnecessary medications (Resident #7 [R7]) and failed to follow physician's orders by holding a medication that was ordered for 1 of 5 resident's reviewed for unnecessary medications (R59).<br><br>Findings:<br><br>1.On 4/15/26 during a clinical record review the surveyor noted R7 had an order dated 9/9/25 for Carvedilol (medication that works by relaxing blood vessels and slowing the heart rate) 3.125 milligrams (mg) by mouth every morning and at bedtime for hypertension (high blood pressure) with directions to take with food and to hold Carvedilol for systolic blood pressure (SBP) below 100 and to hold Carvedilol for diastolic blood pressure (DBP) below 60. Upon review of R7's electronic medical administration record (EMAR) there is no evidence that R7's SBP or DBP was monitored prior to receiving his/her scheduled Carvedilol for the months of March 2026 and April 2026. During a review of the electronic clinical record Point Click Care (PCC) there is no evidence of his/her SBP or DBP being taken twice a day.<br><br>On 4/15/26 at 3:39 p.m. during interviews and record review for R7 with the Director of Nursing (DON), Market Clinical Advisor and Market Clinical Advisor trainee, a surveyor confirmed the above finding.<br><br>2. On 4/16/26 R59's clinical record was reviewed and the EMAR dated 4/1/2026-4/30/2026 states, "Metoprolol (blood pressure medication) Succinate ER (Extended Release) Oral Tablet ... 50 MG ... Give 2 tablet by mouth one time a day for hypertension". Documentation on the EMAR states that the Metoprolol doses were held (not given) on 4/10/26, and 4/13/26. There is no evidence in R59's clinical record why the medication was held or that the provider was contacted pertaining to holding the Metoprolol.<br><br>On 4/16/26 at 11:28 a.m., in an interview with the DON, a surveyor confirmed that R59's medication for Metoprolol was not given as ordered on 4/10/26, and 4/13/26. | F0684 | | |