

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Cedars Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 630 Ocean Avenue Portland, ME 04112	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observations and interviews, the facility failed to promote care for residents in a manner that maintained the residents' dignity when staff failed to groom a resident on 1 of 3 days of survey (6/23/25) (Resident #34).</p> <p>Finding:</p> <p>On 6/23/25 at 11:09 a.m., observation of Resident #34 with long facial hair on the chin and upper lip. During an interview, Resident #34 stated he/she usually shaves every other day but hasn't since admission because he/she does not have a shaver. The surveyor asked if he/she would like staff to assist him/her with shaving, he/she stated, That would be nice, I noticed it was getting long. The Surveyor asked if staff has offered or asked him/her if he/she would like to be shaved, he/she stated No.</p> <p>On 6/24/25 at 3:22 p.m., After surveyor intervention, observation of Resident #34 with a clean shaven face. At this time, he/she confirmed it bothered him/her to have facial hair stating, Oh yeah, I had a really long one on my neck and I don't feel so subconscious.</p> <p>Review of the care plan initiated on 6/5/25 for ADL self-care performance deficit relating to limited mobility had a nursing intervention for Personal Hygiene: The resident requires assistance with personal hygiene and oral care.</p> <p>On 6/25/25 at 12:22 p.m., the above was discussed with the Director of Nursing who stated he/she should've been offered and assisted to shave.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 3 Wings ([NAME], Black Wolf and [NAME]) and the common area/hallway for 3 of 3 days of survey.</p> <p>Findings:</p> <p>1. On 6/23/25 at 9:40 a.m., [NAME] wing had 3 fans in the hallways, all of which were coated with a thick layer of dust.</p> <p>On 6/24/25 at 7:17 a.m., the surveyor discussed the observation of the dust covered fans observed in the hallways on 6/23/25. The Director of Nursing stated, they were filthy and were removed from the hallways.</p> <p>2. On 6/24/25 at 1:34 p.m., an environmental tour was conducted with the Chief Operating Officer and the Director of Nursing for which the following was observed:</p> <p>[NAME] wing:</p> <p>room [ROOM NUMBER] next to the resident bed was a large area with exposed joint compound/sheetrock, creating an uncleanable surface.</p> <p>room [ROOM NUMBER]A had a fan coated with a thick layer of dust and the bathroom wall had a large area with exposed joint compound/sheetrock creating an uncleanable surface.</p> <p>room [ROOM NUMBER] the wall to the left side of window has large gouge with exposed sheetrock and edge of corner chipped paint exposing metal flashing.</p> <p>room [ROOM NUMBER] the corner of the wall has a plastic protector applied using medical tape and in the center of the floor there is a plank were the laminate is gouged out creating a hole in the floor.</p> <p>room [ROOM NUMBER]B had several areas of gouged wall with exposed sheetrock above the bed.</p> <p>Black Wolf Wing:</p> <p>room [ROOM NUMBER]B beside the bed was a very large area of gouged/scraped wall exposing sheet rock and the tile floor near the bathroom was stained white.</p> <p>[NAME] Wing:</p> <p>room [ROOM NUMBER]A had a broken lamp hanging on the wall</p> <p>3. The carpet in the common area/hallways near the elevators were torn and stained throughout.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/25/25 at 1:30 p.m., during an interview the above was discussed with the Director of Nursing.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on record review and interview, 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 properly care for 1 of 4 sampled residents reviewed for new admissions (Resident #281).</p> <p>Finding:</p> <p>Resident #281 was admitted in June of 2025 with a primary diagnosis of closed fracture of upper and lower end of left fibula, requiring a Enoxaparin (anticoagulant) injection daily. As of 6/25/25 Resident #281's medical record lacked evidence of a baseline care plan that included the instructions necessary to properly care for him/her, in the area above.</p> <p>On 6/25/25 at 11:15 a.m., the above was discussed with the Director of Nursing.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident for 1 of 25 reviewed for care planning. (Resident #65)</p> <p>On 6/23/25 at 9:26 a.m., during an interview, Resident #65 stated he/she has never heard of care plan meetings.</p> <p>Review of Resident #65's IDT care plan meeting notes showed IDTs occurring on 10/25/24, 1/28/25, 4/24/25, and 5/8/25. The medical record lacked evidence that he/she was invited and/or participated in his/her IDT meetings.</p> <p>On 6/25/25 at 1:00 p.m., the above was discussed with the Director of Nursing.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on performance evaluation reviews and interviews, the facility failed to complete annual performance evaluations at least every 12 months for 5 of 5 sampled employees. (Certified Nursing Assistant (CNA) #2, #3, #4, #5, and #6)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. CNA#2 was hired in April of 2023. The facility was unable to provide evidence of completed annual performance evaluations for 2024. 2. CNA#3 was hired in June of 2005. The facility was unable to provide evidence of completed annual performance evaluations for 2024. 3. CNA#4 was hired in March of 2017. The facility was unable to provide evidence of completed annual performance evaluations for 2024. 4. CNA#5 was hired in November of 2003. The facility was unable to provide evidence of completed annual performance evaluations for 2024. 5. CNA#6 was hired in October of 2020. The facility was unable to provide evidence of completed annual performance evaluations for 2024. <p>On 6/24/25 at 2:07 p.m., the above information was confirmed with the Director of Nursing.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 2 of 2 kitchen observations, and in 1 of 3 Kitchenette observations.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 6/23/25 at 8:50 a.m. during the initial observation of the kitchen with Food Service Manager (FSM) the following were observed and confirmed. <ul style="list-style-type: none"> - Floor of walk-in fridge and freezer had a sticky substance on the floor. - Several stained ceiling tiles and overall heavy concentration of dust build up on the ceiling above the area of the clean dishes, exit, the dish machine and other areas of the ceiling. - Flat surface near the entrance of the kitchen was covered in a heavy layer of dust and grease. On 6/25/25 at 7:30 a.m. during observation of the [NAME] kitchenette, was a black powdery substance on the top shelf of the freezer door. The refrigerator contained an open unlabeled/dated container of fruit. At this time, the above was confirmed with the Registered Nurse #1. On 6/25/25 at 8:15 a.m. during the return visit to the kitchen with the Food Service Manager the following was observed and confirmed. <p>After reviewing the cleaning duties documents, the FSM was asked how often the ceiling is cleaned. He stated, he thinks it is on a yearly schedule and In some areas that is probably not enough. The surveyor showed him the large section of the ceiling that appeared to be covered in dust and debris in the entry to the kitchen. The FSM took a cloth and wiped the ceiling and the debris came off, confirming that it was dust and dirt that should and can be removed.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to demonstrate staff competency for Infection Control in the areas of Transmission Based Precautions (TBP) and Enhanced Barrier Precautions (EBP) in 3 out of 3 units surveyed for Infection Control and Prevention. ([NAME] Unit, Black/Wolf Unit, and [NAME] Unit).</p> <p>Findings:</p> <p>Facility Policy Titled Transmission Based Precautions states:</p> <p>Contact Precautions:</p> <p>In addition to standard Precautions Contact Precautions for residents known or suspected of infection with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. It also directs Wear gloves (clean, non-sterile) when entering the room and wear a disposable gown upon entering the Contact Precautions room</p> <p>Facility Policy Titled Enhanced Barrier Precautions states:</p> <p>These residents will be identifiable by colored tint of their name plate outside their room. Personal Protective Equipment (PPE) will be stored in PPE bags on the inside of resident's door or the outside of the bathroom door inside the resident room. EBP is only necessary when performing high-contact activities and may not need to be donned prior to entering the resident's room. Staff who do not engage in high-contact resident care would not need to utilize PPE such as answering the call light, speak with a resident or provide medications.</p> <p>Review of the Centers for Disease Control and Prevention (CDC) Contact Precautions signage states:</p> <p>Everyone Must: Clean their hands before entering and when leaving the room. Providers and Staff Must also:</p> <p>Put on gloves before room entry. Discard gloves before room exit. Put on Gown before room entry. Discard Gown before room exit.</p> <p>On 6/23/25 at 8:45 a.m. a surveyor observed a resident room on Black/Wolf Unit with PPE hanging from the door in a caddy, but no signage indicating when or what PPE to utilize. A Registered Nurse (RN#2) was observed about to enter the room. This surveyor stopped RN#2 and inquired what the PPE on the door was for. RN#2 was unable to tell the surveyor and went to ask another staff member. RN#2 returned and stated it was for EBP for (a drug-resistant organism) in the urine so she didn't need to wear PPE to give medications.</p> <p>On 6/23/25 at 9:10 a.m. a surveyor interviewed CNA#7 on Black/Wolf Unit about the PPE on resident's doors with no signage and where they would learn why it was on the door, CNA#7 stated it was shared in report, and it was also available in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/23/25 at 9:15 a.m. A surveyor interviewed an Environmental Services worker (ES#1) who was cleaning a room on Black/Wolf Unit with PPE on the door and no signage. They were unable to correctly tell me what kind precautions the resident was on and what PPE they should be utilizing in that room. They were observed wearing gloves in the room.</p> <p>On 6/23/25 at 1:30 p.m. a surveyor interviewed RN #1 on [NAME] Unit who was caring for the resident who was on Contact precautions. When asked about what PPE to use in this room, RN#1 stated it's confusing if they should use Contact precautions or EBP. The signage on the door was a CDC sign for Contact precautions</p> <p>On 6/24/25 at 10:00 a.m a surveyor interviewed CNA-M#1 on [NAME] Unit and learned that the PPE on the doors with no signage was for EBP if the name was also highlighted in yellow.</p> <p>On 6/24/25 at 10:24 a.m. a surveyor interviewed CNA#8 on [NAME] Unit to ask why some resident names were highlighted in yellow. The surveyor was told, it doesn't mean anything.</p> <p>On 6/25/25 at 8:56 a.m. a surveyor interviewed CNA#2 on [NAME] Unit and she/he was able to verbalize the difference between Contact precautions and EBP but she/he was confused because there was one resident with a Contact precautions sign posted on their door but the PPE had been placed inside the room beyond the bathroom like they do for EBP which meant they had to enter the room completely to obtain PPE.</p> <p>On 6/25/25 at 9:00 a.m. a surveyor interviewed CNA#10 on [NAME] Unit who when asked the difference between Contact precautions and EBP stated that Contact precautions meant that they only used PPE if they were doing personal care and EBP meant they had to use PPE every time they entered the room. The surveyor explained to CNA#10 that it was the reverse.</p> <p>On 6/25/25 at 9:40 a.m. a surveyor interviewed CNA #9 on [NAME] Unit as they were about to enter a room with EBP. I asked if this room was EBP or Contact precautions and to explain the PPE that was needed, and they were unable to say for sure.</p> <p>A record review of the facility's Enhanced Barrier Precautions Performance Improvement Plan showed it was initiated on 6/20/24 and last revised on 12/19/24. There is no evidence that the plan has been reviewed or revised since that date. There is no evidence that the staff were assessed for competency or knowledge since the initiation of the plan or evidence the plan was revised since 12/19/24.</p> <p>On 6/25/25 at 10:11 a.m. the surveyor met with the Infection Preventionist and discussed the concerns with staff competency around TBP and EBP. The surveyor learned this was an issue they recognized when EBP was initiated which is why they initiated the Performance Improvement Plan but stated that it wasn't working and staff still didn't understand.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to ensure that the CNA attended the mandatory yearly Resident Rights training for 5 of 5 CNA's reviewed. Furthermore, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 2 of 5 randomly selected CNAs employed greater than 1 year. (CNA #2, #3, #4, #5, #6)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. CNA #2 was hired in April of 2023. Review of CNA #2 Employee In-service/attendance records lacked evidence of Resident Rights training for 2024. 2. CNA #3 was hired in June of 2005. Review of CNA #3 Employee In-service/attendance records lacked evidence of Resident Rights training for 2024. 3. CNA #4 was hired in March of 2017. Review of CNA #4 Employee In-service/attendance records lacked evidence of Resident Rights training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024. 4. CNA #5 was hired in November of 2003. Review of CNA #5 Employee In-service/attendance records lacked evidence of Resident Rights training for 2024. 5. CNA #6 was hired in October of 2020. Review of CNA #6 Employee In-service/attendance records lacked evidence of Resident Rights training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024. <p>On 6/24/25 at 2:07 p.m., the above information was confirmed with the Director of Nursing.</p>		