STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205074	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seaside Healthcare LLC	850 Baxter Boulevard Portland, ME 04103

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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure resident records contained information regarding the transfer or discharge of a resident to a hospital, and failed to provide transfer, discharge and bed hold information to the resident, or designated representative, for 3 of 9 residents reviewed for hospitalization (R1, R6, R11).Findings:1.On 9/30/25 at 9:35 a.m., in an interview with a surveyor, Resident #6 (R6) stated he/she had been sent to the hospital since initial admission but was unable to remember why and did not remember if he/she had received transfer, discharge or bed hold notices at the time of transfer.On 11/17/25, a review of R6's medical record noted an admission date of 8/29/25. R6 was discharged home on 9/30/25. The provider's Discharge summary, dated [DATE], stated Had Emergency Department visit on 9/27/25 at his/her request due to vomiting. The surveyor was unable to locate evidence of nursing progress notes, assessments, or transfer, discharge and bed hold notices having been completed. R6's record contained no information regarding R6's return or the outcome of the ER visit. On 11/18/25 at 9:40 a.m., in an interview with a surveyor, the Director of Nursing confirmed R6's record lacked documentation of the circumstances surrounding the resident's transfer to the hospital and return to the facility, as well as lacked evidence that transfer, discharge and bed hold notices were provided to R6 or the designated representative.2. On 9/29/25 at 11:46 a.m., in an interview with a surveyor, R11 stated he/she had to go back to the hospital 1 week ago but did not know if he/she had received transfer, discharged or bed hold notices.On 10/1/25, a review of R11's clinical record revealed an admission date of 8/22/25, and a discharge to the hospital on 9/22/25, with a readmission to the facility on 9/26/25. The surveyor was unable to locate evidence that transfer, discharge or bed hold notices had been provided to the R11 or the designated representative.On 10/1/25 at 2:55 p.m., in an interview with a surveyor, the Skilled Nurse Manager reviewed R11's record and confirmed transfer, discharge and bed hold notices had not been provided.3. On 11/17/25 at 1:30 p.m. the surveyor reviewed R1's medical record and identified that the facility failed to provide transfer, discharge, and bed hold information to the resident, or designated representative prior to his/her emergency transfer to the hospital on 5/17/25.On 11/17/2025 at 3:05 p.m. during an interview with a surveyor, the Administrator confirmed the missing transfer, discharge, and bed hold notice for R1.

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure care plans were developed and implemented in the areas of accident hazards, unnecessary medications, and urinary tract infection, for 3 of 7 residents reviewed for care planning (R11, R29, R39). Findings: 1. On 9/29/25 at 11:43 a.m., in an interview with a surveyor, R11 stated he/she goes outside to smoke 2-3 times daily.A review of R11's clinical record noted an admission date of 8/22/25. A Smoking Assessment completed on 8/22/25 indicated R11 demonstrated balance problems while sitting or standing, unable to hold tobacco products safely, unable to extinguish tobacco safely, does not follow facility's policy on location and time of smoking. On 9/26/25, staff completed a Late entry for 9/21/25-Smoking and Safety, which stated Smoking status: Resident uses tobacco products. Resident has balance problems while sitting or standing. Resident follows the facility's policy on location and time of smoking. Smoking safety note: wheelchair baseline for transfers. A review of the current care plan, last revised on 9/29/25, did not include interventions to address safety and R11's smoking. On 10/1/25 at 12:58 p.m., in an interview with a surveyor, the Administrator, confirmed R11 is on the facility's smoking list. The surveyor advised that R11's current care plan does not include smoking and a previous assessment found R11 to be unsafe to smoke. The Administrator stated a safe smoking assessment would be completed that day and R11's care plan updated. 2. On 9/29/25 at 12:17p.m., a surveyor observed a Personal Protective Equipment (PPE) station outside of R29's room. On 11/17/25, review of R29's clinical record noted a re-admission date of 9/15/25. R29 was transported to the ER on [DATE] and again on 10/15/25, at which time R29 was admitted to the hospital with a diagnosis of hemorrhagic cystitis. A review of the hospital admission noted a history of ESBL (Extended Spectrum Beta Lactamase) and VRE (Vancomycin Resistant Enterococci), multi-drug resistant organisms.A review of R29's hospital Discharge summary, dated [DATE], stated Principal diagnoses: Hemorrhagic Cystitis - Polymicrobial urinary tract infection with Escherichia coli and Enterococcus faecalis. Precaution Alert: ESBL, MRSA (Methicillin Resistant Staphylococcus Aureus), VRE. Updated culture results on 10/19/25: Enterococcus faecalis VRE resistant to tetracycline and vancomycin. Escherichia coli resistant to tetracycline.A review of R29's care plan, initiated on 9/16/25, and revised on 10/31/25, did not address R29's requirement for Contact Precautions due to the current infection with multi-drug resistant organisms. On 11/17/25 at 10:25 a.m., in an interview with a surveyor, CNA2 stated R29 is on precautions for VRE and staff wear full PPE when providing care, especially for toileting. On 11/17/25 at 11:40 a.m., in an interview with the Director of Nursing and the Assistant Director of Nursing, the surveyor discussed R29's history of VRE and ESBL and staff's use of full PPE when providing care. However, the need for precautions and the history of MDRO's was not included in care plan. The Director of Nursing and Assistant Director of Nursing confirmed the need for enhanced barrier precautions should be included in the care plan. 3. On 9/30/25, R39 was observed receiving an intravenous antibiotic for a surgical site infection of the leg. R39 was discharged home later the same day. A review of the clinical record for R39 noted an admission date of 9/3/25. Diagnoses included: Infection of deep incisional surgical site, displaced bimalleolar fracture of left lower leg, polyneuropathy, anxiety disorder, attention deficit hyperactivity disorder, alcohol use, depression and insomnia. A review of provider orders noted R39 was receiving Hydromorphone (a narcotic for pain), Quetiapine (an antipsychotic medication for anxiety and insomnia), Daptomycin (an intravenous antibiotic for infection), Gabapentin (an anticonvulsant for nerve pain), Mirtazapine (an antidepressant), Hydroxyzine (an antihistamine used for anxiety), Atomoxetine (used to treat attention deficit hyperactivity disorder), and Lovenox (an anticoagulant used to prevent blood clots). Provider orders revealed on 9/22/25, Lovenox was discontinued due to multiple episodes of bleeding from the nose. A Minimum Data Set (MDS) 3.0 admission Assessment, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed on 9/9/25, Section N. Medications, noted the use of antipsychotic, antidepressant, antibiotic, anticoagulant, and opioid medications. A review of R39's care plan, initiated on 9/3/25, did not include the use of psychotropic or anticoagulant medications, and did not include any revisions to address changes. On 11/18/25 at 9:40 a.m., in an interview with a surveyor, the Director of Nursing, confirmed R39's care plan did not address the use of psychotropic medications.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to ensure that residents were served a meal in a homelike setting and treated with dignity and respect during a meal service observation on 1 of 6 units (400 unit).Findings: On 10/1/25 at 8:15 a.m., two surveyors observed the breakfast meal service in the common dining area on Unit 400. All residents received their meals on a serving tray placed on the table in front of them, with no dishes being removed. In addition, surveyors observed CNA1 (Certified Nursing Assistant) standing over a resident feeding them. A surveyor asked CNA1 if the residents always have the dishes left on the trays and CNA1 stated, Yes. When a surveyor asked CNA1 if this was the residents' choice, CNA1 stated, I never asked them. A surveyor brought this to the attention of the Nurse Manager for Unit 300, who confirmed the findings.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, 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 10 sampled residents reviewed for new admissions (#27). Findings: On 9/29/25 at 3:29 p.m., in an interview with a surveyor, R27's family member stated an interdisciplinary meeting was held on 9/15/25, but they had not been invited. A copy of the care plan was provided on 9/19/25. The family member stated there had never been a formal meeting with the family and the whole team. A review of the clinical record for Resident #27 (R27) revealed an admission date of 9/10/25 with diagnoses including acute cystitis and fall. R27's base line care plan was not initiated until 9/15/25. A revision was completed on 9/29/25. A copy of the care plan conference from 9/29/25 indicated the family was invited but did not attend. On 11/18/25 at 1:20 p.m., in an interview with a surveyor, the Director of Nursing confirmed the baseline care plan had not been initiated within 48 hours of admission.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure that physicians' orders were obtained for treatment of an existing wound for 1 of 1 resident who was admitted on [DATE] resulting in a delay of treatment for the wound (R165).Findings: 1. On 11/18/25 at 1:34 p.m. the surveyor reviewed R165's medical records that contained a pre-admit nurse to nurse note dated 2/13/25 that states the resident has a stage II coccyx wound that occurred at home.On 11/18/25 at 2:16 p.m. the surveyor reviewed R#165's medical record that contained a consult from the hospital with a date range of 2/2/25 to 2/3/25 that states, skin concerns; noted small 0.3 cm (centimeter) open area over gluteal cleft. On 11/18/25 at 1:45 p.m. the surveyor reviewed orders for wound treatment dated 2/27/25, written 14 days after admission to the facility.On 11/18/25 at 1:45 p.m. the surveyor interviewed the Wound Nurse who presented pictures of the resident's wound that was evaluated 2/26/25 and confirmed the finding that orders for treatment of the wound were not written until 2/27/25.On 11/18/25 at 3:49 p.m. during an interview with the Administrator the surveyor confirmed these findings.