STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205103	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Rock Healthcare	88 Harbor Drive Saco, ME 04072

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 51331 Based on record review and interview, the facility failed to ensure that resident's Power of Attorney (POA) was notified of a significant change in medical condition for 1 of 2 residents reviewed for Respiratory Syncytial Virus (RSV) (Resident #29). Findings: On 3/17/25 Division of Licensing received a complaint that Resident #29, was transported to the Hospital on 3/15/25 due to mental status changes. The hospital notified the POA that, according to the facility records, Resident #29 had tested positive for RSV on 3/7/25. The POA was not made aware of this diagnosis. On 4/2/25, a review of Resident #29's medical record lacked evidence of nursing documentation and/or labs to verify that he/she was tested or positive for RSV. At 3:25 p.m., during an interview with the Advance Practice Registered Nurse (APRN) she confirmed that Resident #29 was seen by the provider and swabbed for RSV on 3/7/25, which resulted in him/her testing positive for RSV. The APRN was able to obtain the positive lab results through the lab documentation. The medical record lacked evidence of his/her POA being notified of the positive RSV results. On 4/2/25 at 3:35 p.m., during an interview with the facility Administrator the above information was confirmed.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51331 Based on record review and interviews, the facility failed to ensure a physician order was followed for 1 of 1 resident reviewed for diabetes management. (Resident #29) Findings: On 4/2/25 a surveyor reviewed Resident #29 clinical record which showed an active physician order initiated on 11/5/24 for blood glucose monitoring one time a day every Tuesday and to call the provider if blood sugars are less than 100 or above 200. Further review shows the blood sugar levels on 3/4/25 was 285, on 3/11/25 was 311, on 3/25/25 was 298, and on 4/1/25 was 253. The clinical record lacked evidence of physician notification for the above levels. On 4/2/25 at 4:38 p.m. and at 5:50 p.m., during an interview, the Family Nurse Practitioner stated that she was aware of Resident #29 blood sugar being elevated on 4/1/25. However, she was unable to recall if she was made aware of any other elevated glucose levels for Resident #29. On 4/2/25 at 4:38 p.m., during an interview, Licensed Practical Nurse #1 stated, when he gets a high blood sugar reading, he will either call the provider, if the provider was in the facility he would speak to them in person, and if the glucose reading was elevated overnight, he would call the on-call provider. He then stated he would document this information in the residents' chart. On 4/2/25 at 6:00 p.m., during an interview, the Facility Administrator confirmed that the residents clinical record lacked evidence of physician communication for the elevated sugars on the dates above.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on observations, interviews and record review the facility failed to ensure nursing staff immediately initiated isolation/contact precautions for residents who were exhibiting symptoms of gastroenteritis (GI) (i.e. diarrhea, vomiting, abdominal pain, and/or fever) and ensure that Personal Protective Equipment (PPE) supplies were available for use for these residents. This has resulted in the spread of GI symptoms throughout the facility which began on 3/24/25 and Norovirus being confirmed on 4/2/25. Findings: 1. On 4/2/25 at 8:45 a.m., upon entry to the facility, 2 surveyors observed no posting or signage on the door of any infections/symptoms occurring in the building. In an interview, the Administrator stated there is something GI going around, a few residents have had it and believed there is one resident who was having symptoms. She then stated that both the Director of Nursing (DON) and the Assistant Director of Nursing/Infection Preventionists (ADON/IP) were out sick with nausea, vomiting and diarrhea. On 4/2/25 at approx. 8:50 a.m., 2 surveyors completed an initial tour of the facility. During this tour, the following first floor units; Eagle Island, Ram Island, Bluff Island, [NAME] Island, were observed with no isolation/contact precautions in place requiring the use of PPE. The second-floor units: Beach Island, Gooseberry Island and [NAME] Island were observed with no isolation/contact precautions in place requiring the use of PPE. On 4/2/25 at 11:13 a.m., during an interview with the Family Nurse Practitioner (FNP) and the Advanced Practice Registered Nurse (APRN. The FNP provided the surveyor with a list of 30 residents, located on all units of the facility, who have had or currently have GI symptoms with the first symptoms reported on 3/24/25. The FNP stated the main symptoms were nausea, vomiting and diarrhea. Almost everybody had fatigue, lack of appetite and lethargy for 48-72 hours. She confirmed there was a stool sample pending for Resident #27. At this time, the FNP reviewed Nordex for the stool sample results. Resident #27 results were positive for Norovirus. She stated, she had notified the facility a week ago, via email, of the concern for a norovirus outbreak and asked them to ensure isolation precautions are put into place, cleaning and use soap and water for hands not hand sanitizer stating, I sent it to everyone, the Administrator, DON and the ADON, I asked them to stop activities, and I was told its residents rights, we can't do that. At this time, FNP stated she will notify the facility of Resident #27's positive norovirus results. Review of the email the FNP sent the facility, dated 3/26/25 stated, I believe we are about to have large norovirus outbreak here: already five people have nausea and vomiting, within a 24 hour period. We will be sending some stool samples, will keep you posted. If they are positive and this continues, suspect probable outbreak. Precautions should be in place. Gowns, gloves, signage, please. Isolation should be onset of symptoms/exposure to 2 days after s/s resolve. Treatment is supportive: antiemetics, push fluids. Hand sanitizer is ineffective. Soap and water for hands, bleach for surfaces, to clean. Can Seal Rock please communicate with housekeeping to alert his staff? (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Additional interviews with facility nursing staff confirmed the lack of isolation/contact precautions being initiated upon GI symptoms and knowledge of what residents were having these symptoms requiring isolation precautions and use of PPE: On 4/2/25 at 9:23 a.m., during an interview with Licensed Practical Nurse (LPN#1), stated he is the nurse in charge for the second-floor units which included Resident #27. The surveyor asked if any residents were experiencing GI symptoms of n/v/d. He stated he was aware of one that had n/v/d that started this weekend, one who started with loose stools yesterday and another who started with loose stools last night. He stated there has not been any testing since it started, and he is unaware of any current testing being completed. When asked what he would do if a resident showed signs of GI symptoms, he stated he would notify the provider, put in a change of condition in the resident's chart, notify the family, and put up PPE. At this time, the surveyor asked why the residents he mentioned did not have Isolation/Contact precautions posted and a PPE cart outside of their room. He stated, he relies the Unit Coordinator/CNA (on Eagle/Ram unit, first floor) to put up the PPE for residents needing to go on precautions and he was going to be putting up precaution signs on the rooms however he is busy but will do it this morning. When asked the follow up question if there are any difficulties obtaining PPE, he stated that finding a cart to hold the PPE and the signage is very challenging. On 4/2/25 at 9:50 a.m., during an interview with Registered Nurse (RN#1) on the first floor, she stated there are a few residents who are experiencing GI symptoms, one with nausea and diarrhea, another with vomiting and diarrhea with a stool sample sent out and they are awaiting results, one who is experiencing nausea and dry heaves that started last night, one who has been vomiting since last night and another one who had been vomiting since yesterday and there are orders to collect a stool sample. At this time, RN#1 stated she cannot confirm if there are PPE carts available or at these residents' rooms, but they all should be on precautions. On 4/2/25 at 9:55 a.m., during an interview with LPN #2 on the first floor, she stated she would only get a report when she is the nurse in charge. She confirmed she was not the nurse in charge, only passing medications and did not receive a report. The surveyor asked if she was aware of any residents having GI symptoms of n/v/d, she stated one had emesis yesterday, and another resident had signs and symptoms of norovirus, and the doctor said to get a stool. On 4/2/25 at 10:05 a.m., during an interview, with RN #2 on the first floor she stated, the facility has a lot of Noro cases; one resident was sent out to the hospital yesterday for GI issues, another had symptoms over the weekend which have resolved, one who started having stomach cramps this morning, one who started having diarrhea this morning and one who started vomiting this morning. RN #2 then stated that she herself had GI issues on Friday 3/28/25, called out Saturday but returned to work Sunday 3/30/25. She then stated, a lot of staff have been getting it along with the residents. On 4/2/25 at 10:15 a.m., during an interview, with LPN #3 working on first floor, she stated one resident started to have nausea about a half hour ago and denies anyone else having GI symptoms. The surveyor asked if she gets a report on who requires PPE and/or isolation precautions, she stated, we don't, there's a sign on the door for people on precautions that we follow. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at approx. 10:18 a.m., during an interview with the Administrator, 2 surveyors discussed the lack of Isolation/Contact precautions posted, the lack of available PPE carts, the lack of staff knowledge of residents who are experiencing GI symptoms, staff entering the rooms of residents with GI symptoms without the use of PPE and are unaware of the risks and the GI symptoms have been spreading throughout the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on interviews, observations and record review the Administration failed to follow the facility's Infection - Clinical Protocol policy and procedures by not following the Family Nurse Practitioner's (FNP) recommendation of isolation/contact precautions for residents who were exhibiting symptoms of gastroenteritis (GI) (i.e. diarrhea, vomiting, abdominal pain, and/or fever) and ensure that Personal Protective Equipment (PPE) supplies were available for use for these residents. In addition, Administration failed to ensure the infection Preventionist was following the facilities Infection prevention and Control Program which included oversight, outbreak management, prevention of infection and monitoring employee health and safety. This has resulted in the spread of GI symptoms throughout the facility. The administration was notified of the potential outbreak on 3/26/25 and Norovirus being confirmed on 4/2/25 Finding: On 4/2/25 at 8:45 a.m., upon entry to the facility, 2 surveyors observed no posting or signage on the door of any infections/symptoms occurring in the building. In an interview, the Administrator stated there is something GI going around, a few residents have had it and believed there is one resident who was having symptoms. She then stated that both the Director of Nursing (DON) and the Assistant Director of Nursing/Infection Preventionists (ADON/IP) were out sick with nausea, vomiting and diarrhea. On 4/2/25 at approx. 8:50 a.m., 2 surveyors completed an initial tour of the facility. During this tour, the following first floor units; Eagle Island, Ram Island, Bluff Island, [NAME] Island, were observed with no isolation/contact precautions in place requiring the use of PPE. The second-floor units: Beach Island, Gooseberry Island and [NAME] Island were observed with no isolation/contact precautions in place requiring the use of PPE. On 4/2/25 at 11:13 a.m., during an interview with the Family Nurse Practitioner (FNP) and the Advanced Practice Registered Nurse (APRN. The FNP provided the surveyor with a list of 30 residents, located on all units of the facility, who have had or currently have GI symptoms with the first symptoms reported on 3/24/25. The FNP stated the main symptoms were nausea, vomiting and diarrhea. Almost everybody had fatigue, lack of appetite and lethargy for 48-72 hours. She confirmed there was a stool sample pending for Resident #27. At this time, the FNP reviewed Nordex for the stool sample results. Resident #27 results were positive for Norovirus. She stated, she had notified the facility a week ago, via email, of the concern for a norovirus outbreak and asked them to ensure isolation precautions are put into place, cleaning and use soap and water for hands not hand sanitizer stating, I sent it to everyone, the Administrator, DON and the ADON, I asked them to stop activities, and I was told its residents rights, we can't do that. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the email the FNP sent the facility, dated 3/26/25 stated, I believe we are about to have large Norovirus outbreak here: already five people have nausea and vomiting, within a 24 hour period. We will be sending some stool samples, will keep you posted. If they are positive and this continues, suspect probable outbreak. Precautions should be in place. Gowns, gloves, signage, please. Isolation should be onset of symptoms/exposure to 2 days after s/s resolve. Treatment is supportive: antiemetics, push fluids. Hand sanitizer is ineffective. Soap and water for hands, bleach for surfaces, to clean. Can Seal Rock please communicate with housekeeping to alert his staff? The facilities Infections - Clinical Protocol policy and procedure last revised on 3/2025 states, under Assessment and Recognition, 1. The physician or provider will help identify individuals who have had a recent infection or who are at high risk for developing an infection. 2. Infection may be suspected based on clinical signs and symptoms and/or temperature. 3. Nursing staff will notify the physician or provider of all pertinent details about the residents condition. Under section Cause Identification, 1. Based on the preceding information, the physician or provider and staff will discuss and determine whether an infection exists or is likely, whether additional evaluations or testing is indicated, and whether other active conditions related to an infection also need to be managed simultaneously. 3. Based on the overall clinical picture, including the severity of the current illness, the physician or provider will help the staff address the following issues: whether an infection is present . 4. The physician or provider and staff will identify infection transmission risks and (in conjunction with the Infection Preventionist) will implement relevant precautions. The facilities Infections Prevention and Control Program policy and procedure last revised 3/2025 states, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Under Elements of the IPCP, 1. Coordination and oversight . Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: documented IPCP incidents and corrective actions taken, whether provider management of infection is optimal, whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion and whether there is appropriate follow up of acute infections. 2. Surveillance and reporting . Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. 6. Outbreak Management . Outbreak management is a process that consists of: determining the presence of an outbreak, managing the affected residents, preventing the spread to other residents, documenting information about the outbreak, quoting the information to the appropriate public health authorities, educating the staff and the public, monitoring for reoccurrences . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Prevention of infection . Important facets of infection prevention include: identifying possible infections or potential complications of existing infections Cortana instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, communicating the importance of standard precautions and respiratory hygiene to visitors and family members, screening for possible significant pathogens . implementing appropriate enhanced barrier or transmission-based precautions when necessary and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). 8. Monitoring employee health and safety . The facility has established policies and procedures regarding infection preventions and control among employees, contractors, vendors, visitors, and volunteers, including: . situations when these individuals should report their infections or avoid the facility (for example . active respiratory infections with considerable coughing and sneezing, or frequent diarrhea stools). Please see F880 for details related to Norovirus

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on observations, interviews and record review, the facility failed to identify and implement isolation/contact precautions for residents who were exhibiting symptoms of gastroenteritis and failed to follow the Nurse Practitioner's recommendation to ensure that Personal Protective Equipment (PPE) supplies were available for use for these residents. In addition, the facility failed to ensure all staff were knowledgeable about which residents were experiencing these symptoms and ensure PPE were used while providing care. This resulted in the spread of gastroenteritis [nflammation that spreads from your stomach into your intestines, causing pain, vomiting and diarrhea symptoms] (GI) symptoms creating an immediate jeopardy situation to 17 out of 90 residents', on 6 of 7 units: Eagle Island, Ram Island, Bluff Island, [NAME] Islan, Beach Island and Gooseberry Island. (Resident #27 #26, #25, #22, #9, #10, #13, #14, #16, #34, #4, #32, #6, #5, #7, #33, and #3) Findings: 1. On 3/17/25 the Division of Licensing and Certification received a complaint regarding quality-of-care concerns and that a resident tested positive for Respiratory Syncytial Virus (RSV). The family was not notified of a resident being positive for RSV and the facility had not implemented isolations precaution with use of PPE and signage posted notifying staff and visitors of the precautions. On 4/1/25 during a telephone interview, the complainant stated Norovirus (contagious gastroenteritis) is currently active in the facility, there is no PPE out for use, staff are not utilizing PPE and there is no posted/signage of isolation precautions out. On 4/2/25 at 8:45 a.m., upon entry to facility, during an observation, there was no posting or signage on the door of any infections/symptoms occurring in the building. In an interview, the Administrator stated there is something GI going around, a few residents have had it and believed there is one resident who was having symptoms. She then stated that both the Director of Nursing (DON) and the Assistant Director of Nursing/Infection Preventionists (ADON/IP) were out sick with nausea, vomiting and diarrhea. On 4/2/25 at approx. 8:50 a.m., 2 surveyors completed an initial tour of the facility. During this tour, the following first floor units; Eagle Island, Ram Island, Bluff Island, [NAME] Island, were observed with no isolation/contact precautions in place requiring the use of PPE. The second-floor units: Beach Island, Gooseberry Island and [NAME] Island were observed with no isolation/contact precautions in place requiring the use of PPE. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/2/25 at 11:13 a.m., during an interview with the Family Nurse Practitioner (FNP) and the Advanced Practice Registered Nurse (APRN. The FNP provided the surveyor with a list of 30 residents, located on all units of the facility, who have had or currently have GI symptoms with the first symptoms reported on 3/24/25. The FNP stated the main symptoms were nausea, vomiting and diarrhea. Almost everybody had fatigue, lack of appetite and lethargy for 48-72 hours. She confirmed there was a stool sample pending for Resident #27. At this time, the FNP reviewed Nordex for the stool sample results. Resident #27 results were positive for Norovirus. She stated, she had notified the facility a week ago, via email, of the concern for a norovirus outbreak and asked them to ensure isolation precautions are put into place, cleaning and use soap and water for hands not hand sanitizer stating, I sent it to everyone, the Administrator, DON and the ADON, I asked them to stop activities, and I was told its residents rights, we can't do that. At this time, FNP stated she will notify the facility of Resident #27's positive norovirus results. Review of the email the FNP sent the facility, dated 3/26/25 stated, I believe we are about to have large norovirus outbreak here: already five people have nausea and vomiting, within a 24 hour period. We will be sending some stool samples, will keep you posted. If they are positive and this continues, suspect probable outbreak. Precautions should be in place. Gowns, gloves, signage, please. Isolation should be onset of symptoms/exposure to 2 days after s/s resolve. Treatment is supportive: antiemetics, push fluids. Hand sanitizer is ineffective. Soap and water for hands, bleach for surfaces, to clean. Can Seal Rock please communicate with housekeeping to alert his staff? On 4/2/25 at 11:24 a.m., observation of Resident #7, #25 and #26 rooms to now have a Contact precaution sign posted with a PPE cart near the door. Resident #27 did not have isolation/contact precaution sign posted or PPE cart near the door. On 4/2/25 at 2:18 p.m., 2 surveyors observed Resident #27's room again with no isolation/contact precautions posted or PPE available. Resident #27's significant other was observed visiting sitting with the resident. On 4/2/25 at 3:39 p.m. during an observation with the Administrator and the surveyor, Resident #27's room lacked isolation/contact precautions or a PPE cart by the room. At this time, the surveyor confirmed the Administrator was aware that Resident #27 was positive for norovirus. On 4/2/25 at 5:47 p.m., during an observation, Resident #27's room continued not to have isolation/contact precautions posted and PPE available in a cart near the door. The facilities Infections Prevention and Control Program policy and procedure last revised 3/2025 states, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 7. Prevention of infection . Important facets of infection prevention include: identifying possible infections or potential complications of existing infections Cortana instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, communicating the importance of standard precautions and respiratory hygiene to visitors and family members, screening for possible significant pathogens . implementing appropriate enhanced barrier or transmission-based precautions when necessary and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Additional interviews with facility staff confirmed the lack of isolation/contact precautions being initiated upon first GI symptoms and knowledge of what residents were having these symptoms requiring isolation precautions and use of PPE: On 4/2/25 at 9:04 a.m., during an interview with Certified Nurses Aid (CNA#3) stated, we had norovirus going around, for the most part, it's cleared up. The surveyor asked if she was given a report of any residents with current GI symptoms. She stated Resident #22 did have symptoms but was not having any right now and Resident #17 had symptoms a few days ago but nothing yesterday or today. At this time, CNA #3 confirmed she had worked on 4/1/25 on the unit and both yesterday and today she was unaware of any new GI symptoms. On 4/2/25 at 9:16 a.m., during an interview, the Certified Nurses Aid (CNA#1) on Beach Island and Gooseberry Island, stated she was unaware of any resident's experiencing GI symptoms of nausea/vomiting/diarrhea (n/v/d). The surveyor asked how she would be made aware if a resident was on isolation precautions requiring PPE for care. She stated it would be posted on the resident's door. On 4/2/25 at 9:23 a.m., during an interview with Licensed Practical Nurse (LPN#1), stated he is the nurse in charge of Beach Island, Gooseberry Island and [NAME] Island (the nurse in charge of Resident #27). The surveyor asked if any residents were experiencing GI symptoms of n/v/d. He stated, he was aware of Resident #26 had n/v/d that started this weekend, Resident #25 started with loose stools yesterday and Resident #22 started with loose stools last night. He stated there has not been any testing since it started, and he is unaware of any current testing being completed. The surveyor asked if the [NAME] Island unit had any GI symptoms, he stated, a few days back but nothing since. When asked what he would do if a resident showed signs of GI symptoms, he stated he would notify the provider, put in a change of condition in the resident's chart, notify the family, and put up PPE. At this time, the surveyor asked why the residents he mentioned did not have Isolation/Contact precautions posted and a PPE cart outside of their room. He stated, he relies the Unit Coordinator/CNA (on Eagle/Ram unit, first floor) to put up the PPE for residents needing to go on precautions and he was going to be putting up precaution signs on the rooms however he is busy but will do it this morning. When asked the follow up question if there are any difficulties obtaining PPE, he stated that finding a cart to hold the PPE and the signage is very challenging. On 4/2/25 at 9:37 a.m., during an interview with Certified Nurses Aid - Medication technician (CNA-M #2) on Beach Island, Gooseberry Island and [NAME] Island, stated she is unaware of any residents having GI symptoms of n/v/d or the need to wear PPE. The surveyor asked how she would know if a resident was on isolation/contact precautions and PPE was required. She stated it would be on their door, posted with gloves and gowns. On 4/2/25 at 9:40 a.m., during an interview, with Housekeeper on Beach Island and Gooseberry Island, stated she just returned from 3 days off. The Surveyor asked if she was aware of any residents having GI symptoms of n/v/d, she stated, nope, The surveyor asked how she would know if she needed to wear PPE prior to going into the rooms, she stated, it would tell you, on the door what you have to wear. On 4/2/25 at 9:45 a.m., during an interview, with CNA #2 on Beach Island, Gooseberry Island and [NAME] Island, stated she was not given any report regarding residents having GI symptoms or anyone on precautions other than Enhanced Barrier Precautions (EBP). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205103	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seal Rock Healthcare	88 Harbor Drive Saco, ME 04072

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/2/25 at 9:50 a.m., during an interview with Registered Nurse (RN#1) on the Bluff Island and [NAME] Island, stated that there are a few residents who are experiencing GI symptoms, Resident #9 is experiencing nausea and diarrhea, Resident #10 has vomiting and diarrhea with a stool sample sent out and they are awaiting results, Resident #13 is experiencing nausea and dry heaves that started last night, Resident #14 has been vomiting since last night, Resident #16 has been vomiting since yesterday and there are orders to collect a stool sample. At this time, RN#1 stated she cannot confirm if there are PPE carts available or at these residents' rooms, but they all should be on precautions. On 4/2/25 at 9:55 a.m., during an interview with LPN #2 on Bluff Island and [NAME] Island, stated she would only get a report when she is the nurse in charge. She confirmed she was not the nurse in charge, only passing medications and did not receive a report. The surveyor asked if she was aware of any residents having GI symptoms of n/v/d, she stated, Yes, Resident #14 had emesis yesterday, nobody else as far as I know .Resident #34 had signs and symptoms of norovirus. The doctor said to go ahead and get a stool. Nobody I know of on Bluff side. On 4/2/25 at 10:05 a.m., during an interview, with RN #2 on the Ram Island, stated she believes that the facility has a lot of Noro cases; Resident #4 was sent out to the hospital yesterday for GI issues, Resident #32 had symptoms over the weekend which have resolved, Resident #6 started having stomach cramps this morning, Resident #5 started having diarrhea this morning and Resident #7 started vomiting this morning. RN #2 then stated that she herself had GI issues on Friday 3/28/25, called out Saturday but returned to work Sunday 3/30/25. During the week of 3/28/25 she had Resident #33 who had GI symptoms. She then stated, a lot of staff have been getting it along with the residents. On 4/2/25 at 10:15 a.m., during an interview, with LPN #3 working on Eagle Island, stated Resident #3 started to have nausea about a half hour ago and denies anyone else having GI symptoms. The surveyor asked if she gets a report on who requires PPE and/or isolation precautions, she stated, we don't, there's a sign on the door for people on precautions that we follow. On 4/2/25 at approx. 10:18 a.m., during an interview with the Administrator, 2 surveyors discussed the lack of Isolation/Contact precautions posted, the lack of available PPE carts, the lack of staff knowledge of residents who are experiencing GI symptoms, staff entering the rooms of residents with GI symptoms without the use of PPE and are unaware of the risks and the GI symptoms have been spreading throughout the facility. At this time, the Administrator stated again that both the Director of Nursing (DON) and Assistant Director of Nursing/Infection Preventionist (ADON/IP) were out sick. On 4/2/25 at 10:22 a.m. during an interview with both CNA #6 and CNA #7 on Eagle Island and Ram Island. CNA #6 stated he does not know of any residents, on his side, that are having GI symptoms or anyone needing contact precautions. CNA #7 then stated that she knows Resident #7 having symptoms and Resident #4 being sent to the hospital yesterday due to GI symptoms. The surveyor asked both CNA's which residents are on contact precautions. CNA #7 stated, the only one on my side is Resident #2 who is on EBP. Based on the above information, IJ was called on 4/2/25 for the facility's failure to to identify and implement isolation/contact precautions for residents who were exhibiting symptoms of gastroenteritis, failed to follow the Nurse Practitioner's recommendation to ensure that Personal Protective Equipment (PPE) supplies were available for use for these residents, and failed to ensure all staff were knowledgeable about which residents were experiencing these GI symptoms and ensure PPE was available. The facility's failure to provide these services constituted an immediate jeopardy situation. (continued on next page)

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