

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2026
NAME OF PROVIDER OR SUPPLIER  Seal Rock Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on record reviews and interviews, the facility failed to ensure that the resident and/or resident representative was provided with written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, or appoint a surrogate, was completed for 10 of 23 residents reviewed for advance directives (Resident #1, #6, #8, #17, #36, #50, #89, #103, #107, and #110).</p> <p>1. Resident #1 was admitted to the facility in January of 2026. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>2. Resident #6 was admitted to the facility in May of 2015. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>3. Resident #8 was admitted to the facility in February of 2024. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>4. Resident #17 was admitted to the facility in January of 2026. A review of the residents' electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>5. Resident #36 was admitted to the facility in February of 2026. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>6. On 3/30/26 during the record review, it was discovered that Resident #50 did not have documentation of an Advanced Directive being in place nor was there documentation that Advanced Directives were ever discussed with the resident.</p> <p>7. Resident #89 was admitted to the facility in September of 2017. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to (continued on next page)</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the resident and/or resident representative.</p> <p>8. Resident #103 was admitted to the facility in March of 2026. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>9. Resident #107 was admitted to the facility in March 2026. A review of the resident's electronic medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>10. Resident #110 was admitted to the facility in March 2026. A review of the resident's electronic medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.</p> <p>On 3/31/26 five surveyors requested several advance directives from the Director of Social Services.</p> <p>On 4/1/26 at 11:30 a.m. in an interview with five surveyors, the Director of Social Services stated that she gave a list to the DON which included those who have advanced directives but there was some she could not find. She stated she would look back in her files for dates she offered advanced directives and that she is trying to change the way she does this process.</p> <p>On 4/1/26 at 2:15 p.m. in an interview with five surveyors, the Director of social services presented a list that stated she does not have any documentation for advance directives for these residents.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on interview and record review, the facility failed to ensure a resident remained free of misappropriation of property in the form of theft of a resident's personal credit card and multiple unauthorized purchases for 1 of 27 residents screened for abuse and misappropriation in the initial pool. Findings: On 3/30/26 at 10:30 a.m., in an interview with a surveyor, Resident #89 stated, I had someone take my credit card and my social security card on Christmas Eve (2025). She (Certified Nursing Assistant - CNA) also took the debit card of the resident across the hall, and someone downstairs, and another lost a necklace, \$900 something on her card. I was lucky, she (CNA) got a lot out of the lady across the hall. Resident #89 stated there were all kinds of charges, (to a) motel, gas station, Target, etc. They (the stores) all had cameras and they caught them. Resident #89 stated he/she reported the charges on his/her credit card to the facility and staff acted on it immediately. Resident #89 stated I called the (credit card) company and they took the charges off. The CNA was arrested and is going to trial. On 3/30/26 at 11:05 a.m., in an interview with a surveyor, the facility's Administrator stated as soon as Resident #89 made him aware of the charges on his/her credit card, he contacted the local police department, and he initiated an investigation. The Administrator stated the employee was an agency staff (CNA) and that the local police department has kept him in the loop. The Administrator stated the CNA was arrested in Mississippi and is facing multiple charges and will be going to court soon. On 3/31/26 at 3:30 p.m., in an interview with a surveyor, the facility's Senior Health Care Operations Consultant (Consultant) stated on 1/2/26, she was notified of the credit card theft of a resident. She reported this to the police and initiated an investigation. During the investigation, the Consultant noted all staff had returned her calls for interviews except one agency CNA. Approximately one week later, two other residents reported credit card losses, which were reported to the local police. The police informed the Consultant that there was an active warrant for the agency CNA's arrest, and approximately one week ago, the police informed the Consultant that the CNA had been arrested in Mississippi. The Consultant stated the CNA had worked a total of 3 times and then left the State. All residents were reimbursed for the unapproved charges by their credit card companies. The Consultant stated she was unaware of the theft of a necklace and that no resident had reported this. Review of the CNA's personnel file noted he/she had no disqualifying offenses at the time the Maine Background Check was completed. The CNA had also received training for abuse, neglect and misappropriation. As a result of the facility's investigation the following corrective actions were taken: Incidents were reported to the appropriate State Agencies and local police. All direct care staff were required to complete education on resident rights, abuse, neglect, and reporting requirements. The CNA was no longer employed and had left the State of Maine.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to a patient lift on 1 of 1 unit and the storage of chemicals being properly secured for 1 of 1 observation for 1 of 4 days of survey. (3/30/26 through 4/2/26) Findings: 1. On 3/30/26 at 10:10 a.m., 2 surveyors observed an EZ Sit to Stand Lift missing both of its safety pins available for use outside of room [ROOM NUMBER]. On 3/30/26 at 10:14 a.m., in an interview with Registered Nurse #1, who confirms that the sit to stand lift is missing it's safety pins. At this time, she removes the lift from the unit. On 3/30/26 at 2:08 p.m., in an interview with the Director of Nursing (DON), the above information was confirmed. At this time, she states maintenance has taken the machine off the floor and ordered new pins that should be here in a few days. 2. On 3/31/26 at 8:26 a.m., observation of an unsecured container of CaviWipes on the medication cart outside of room . There were no staff noted in sight. On 3/31/26 at 8:31 a.m., during an interview with Medication Technician #1, who confirms that the CaviWipes should have been in a secure location as there are vulnerable and ambulatory residents on this unit. At this time, she placed the wipes in a secure location. Review of the Safety Data Sheet for CaviWipes under the section First-aid Measures states; Inhalation: Move affected person to fresh air. Get medical attention if symptoms occur. Skin: Gently wash with plenty of soap and water. Seek medical attention if irritation develops. Eyes: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If irritation persists: Get medical advice/attention. Ingestion: Rinse mouth thoroughly with water. Do not induce vomiting. Call a poison center or a doctor if you feel unwell. Symptoms/effects: May cause moderate irritation to the eyes. Repeated exposure may cause skin dryness or cracking. Inhalation of vapors may cause respiratory irritation. On 3/31/26 at 8:40 a.m., the above information was discussed with the DON.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 Abuse and Neglect along with Resident Rights training for 1 of 6 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 1 of 6 randomly selected CNAs employed greater than 1 year. (CNA #1) Findings: CNA #1 was hired in June of 2023. Review of CNA #1 Employee In-service/attendance records lacked evidence of Resident Rights training and Abuse and Neglect training for 2025. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2025. On 4/2/26 at 1:30 p.m., in an interview with the Director of Nursing (DON) who confirmed CNA #1 did not have 12 hours of education, Abuse and Neglect training, and Resident Rights training. She then add that CNA#1 is a per-diem employee and is unsure how many hours she worked in 2025. On 4/2/26 at 4:00 p.m., in an interview with the Senior Healthcare Operations worker, she confirms that CNA #1 worked 199.25 hours in 2025.</p>

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<p>F 0584</p> <p>Level of Harm - Potential for minimal 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and interviews, the facility failed to adequately maintain maintenance services necessary to maintain in good repair. On 4/1/26 at 12:40 an environmental tour was done with the Administrator and the Director of Maintenance and the following were found and confirmed at that time. First floor - room [ROOM NUMBER] - the floor threshold between the room and the bathroom has duct tape on each side, creating an uncleanable surface. Second floor - room [ROOM NUMBER], the wall on the right upon entrance has many small gouges in it from her wheelchair. The are also abrasions on the wall behind her lift chair from it rubbing the wall when it rises. room [ROOM NUMBER], the wall in the bathroom has a hole just below the towel rack.</p>