

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Dexter Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 64 Park Street Dexter, ME 04930	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on a clinical record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 sampled resident with a surgical wound. (Resident #1 [R1]). Finding: On 12/30/25 at 2:45 p.m., during a clinical record review for R1 there was an order dated 12/23/25 which instructed nursing to follow these instructions regarding wound dressing management. R1 should have daily dressing changes on surgical wound by his care team at the facility. He/she should also have his drain output recorded every 12 hours. The drain should stay in place until the first follow-up in the clinic in approximately 1 week. R1 had an amputation and returned to the facility with a surgical drain (supposed to stay in place 1 week until seen at the clinic), the nurse documented she found the drain almost out and that she called the surgical center and was told by the nurse to go and pull the drain. On 12/30/25 at 2:45 p.m. during interviews with the charge nurses and a review of the Treatment Administration Record (TAR) for December 2025 and the nursing notes for R1, documentation shows the drain was removed at this facility on 12/24/25 1 day after his/her return to facility. The clinical record lacked evidence of a written or verbal order from the Medical Provider/surgical team to remove the surgical drain. On 12/30/25 at 3:12 p.m. during an interview with the Director of Nursing the surveyor confirmed that R1's clinical record did not have a written or verbal order to remove the surgical drain.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 205115
		If continuation sheet Page 1 of 2

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on record review, observation, and interview, the facility failed to ensure infection control practices were implemented to prevent the spread of infections, including Enhanced Barrier Precautions (EBP) for open wounds. For 1 of 1 resident reviewed with open wounds. (Resident 1 [R1])Finding:A review of the sign posted on a resident's room indicated the following:Before entering the resident's room, a sign posted outside R1's room indicated that the Resident was on EBP. The sign indicated that staff were required to wear a gown, gloves protection when providing care.Review of facility policy on Enhanced Barrier Precautions, dated 11/2017 with a revised date of 3/2025, indicates that EBP are required for any residents with a history of Multidrug Resistant Organism (MDRO) infections, with an indwelling catheter, or a chronic wound infection. For these residents, Personal Protective Equipment (PPE) is required for high-contact resident care activities, including dressing, bathing/showering, transferring, providing hygiene or grooming, device care, and with bed mobility, changing linens, wound care, or prolonged high contact with items in the resident's room.On 12/30/25 at 12:45 p.m., the surveyor observed a Certified Nursing Assistant (CNA-1) enter R1's room to empty his/her catheter bag. A sign was posted outside of R1's room, indicating that R1 was on EBP and that staff providing direct care to the resident should be wearing a gown and gloves. Review of R1's clinical record revealed that he/she had been on EBP due to ileostomy, open surgical wound and open pressure ulcers. During this observation on 12/30/25 at 12:45 p.m., CNA1 stated she forgot R1 was on EBP and she needed to Donn a gown to empty his/her catheter bag. The surveyor confirmed this finding at the time of the observation.</p>