

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Durgin Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 9 Lewis Rd Kittery, ME 03904	
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation and interview, the facility failed to ensure a resident was treated with respect and dignity regarding personal privacy. Facility staff exposed a resident's bare leg and wound dressing, and initiated a clinical dressing removal in a public area of the facility. This affected 1 of 1 resident observed for dignity during treatments (Resident #3 [R3]). Finding: On 6/9/26 at approximately 10:45 a.m., Resident #3 (R3) was observed sitting in a wheelchair at the nurses' station of the Marion's Way unit. R3's right pant leg was pulled up, exposing his/her bare lower leg and an active wound dressing. At the same time, Registered Nurse #1 (RN #1) was observed standing at the public nurses' station cutting the dressing off R3's right lower leg using bandage scissors. The Nurse Manager was present during this observation. On 6/9/2026 at approximately 10:45 a.m., the Nurse Manager was asked if performing a dressing removal at the nurses' station was the standard facility procedure. The Nurse Manager did not state it was standard procedure and requested that RN #1 take R3 to his/her room to provide the dressing change. On 6/9/2026 at approximately 11:25 a.m., the surveyor, RN #1, and the Nurse Manager reviewed the incident. RN #1 stated he was running behind schedule and made the wrong decision to remove the dressing at the nurses' station. RN #1 stated he had done it at that location before. RN #1 confirmed that his choice of location was wrong. RN #1 confirmed that he failed to respect the privacy and dignity of R3. During the same review on 6/9/2026 at 11:25 a.m., the Nurse Manager confirmed that performing a dressing change at the nurses' station was a privacy and dignity issue for R3.		

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and clinical record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all the resident's pre- and post-discharge medications for 1 of 1 residents reviewed for discharge to the community (Resident #79). Finding: On review of Resident #79's clinical record, a surveyor noted an admission date of 5/6/26. The record indicated that on 5/13/26, Resident #79 and family decided to return to the resident's previous assisted living facility (ALF) with hospice services. On 5/15/26, Resident #79 discharged back to the ALF with referrals for hospice services. The clinical record noted Resident #79 and family initiated discharge and signed the discharge notice on 5/13/26 with a known discharge date of 5/15/26. The facility faxed orders for hospice to the ALF and hospice agency, however, no recapitulation of stay was completed which included a physician's discharge summary, a reconciliation of pre- and post-discharge medications and summaries from all involved disciplines, including physical and occupational therapies. On 6/10/26 at 12:00 p.m., in an interview with the Director of Nursing, the surveyor discussed the findings.		