

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205159	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Sedgewood Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Northbrook Dr Falmouth, ME 04105	

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 0584</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 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 maintain adequate housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in 36 of 56 resident rooms and on 3 of 3 units ([NAME], [NAME], and [NAME]).</p> <p>Findings:</p> <p>On 6/4/25 at 8:00 a.m. a surveyor conducted an environmental observation tour with the Administrator, and the Maintenance Supervisor following were observed:</p> <p>[NAME] Unit:</p> <ul style="list-style-type: none"> <li>-The room divider curtains are off track and do not fully close to allow for resident privacy in the following rooms: 2, 3, 5, 9, 14, and 15.</li> <li>-The closet doors are misaligned and do not fully close in the following rooms: 3, 8, and 9.</li> <li>-The window curtains are off track and do not fully close in the following rooms: 7, 9, 10, and 11.</li> <li>-room [ROOM NUMBER]: Bathroom toilet is on a [NAME] sticking out from the base.</li> <li>-room [ROOM NUMBER]: There is a stained ceiling tile outside the room.</li> </ul> <p>[NAME] Unit:</p> <ul style="list-style-type: none"> <li>-The room divider curtains are off track and do not fully close to allow for resident privacy in the following rooms: 21, 28 and 31.</li> </ul> <p>(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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The closet doors are misaligned and do not fully close in the following rooms: 19, 20, 21, 25, 26, 28, 29, 31, 34, and 35.</p> <p>-room [ROOM NUMBER]: Wall inside of door has holes from previous TV.</p> <p>-room [ROOM NUMBER]: Has a strong urine-like odor.</p> <p>-room [ROOM NUMBER]: The room privacy curtain is torn.</p> <p>-room [ROOM NUMBER]: The base of toilet has a large brown ring around it.</p> <p>-room [ROOM NUMBER]: The bathroom sink countertop has two chips in the edge creating an uncleanable surface.</p> <p>-room [ROOM NUMBER]: The toilet has a large [NAME] at the base.</p> <p>-room [ROOM NUMBER]: The bathroom floor has a stain.</p> <p>-room [ROOM NUMBER]: The bathroom floor has a stain, and the window curtains are off track and do not fully close.</p> <p>-room [ROOM NUMBER]: Stain on the wall outside of room.</p> <p>-There is a stained ceiling tile in the common TV area.</p> <p>[NAME] Unit:</p> <p>-Just inside unit to the right has hole and torn wallpaper.</p> <p>-The room divider curtains are off track and will not fully close to allow for resident privacy in the following rooms: 40, 41, 42, 43, 44, 47, 49, 53, and 56.</p> <p>-room [ROOM NUMBER]: Stained bathroom floor.</p> <p>-room [ROOM NUMBER]: Outside of the room there are two holes near the baseboard, and there is a stain on the bathroom floor.</p> <p>-room [ROOM NUMBER]: Outside of the room there is a stained ceiling tile.</p> <p>-room [ROOM NUMBER]: Has a strong urine-like odor.</p> <p>-room [ROOM NUMBER]: Stain on bathroom floor</p> <p>On 6/4/25, at approximately 9:30 a.m., at the end of the observational tour the Administrator stated that he knows that there is a lot of work to be done and confirmed all the above findings.</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 2 of 3 sampled residents transferred/discharged to an acute care facility. ( Resident #13 and #66)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Documentation in Resident 13's clinical record indicated that he/she was transferred to an acute hospital on 4/2/25 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.</li> <li>2. Documentation in Resident 66's clinical record indicated that he/she was transferred to an acute hospital on 5/7/25 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.</li> </ol> <p>On 6/4/25 at 10:30 a.m., in an interview with the surveyor, the Market Clinical Advisor confirmed that she was unable to locate evidence that a transfer/discharge form for Resident #13 and Resident #66 was completed and provided to the resident or resident representative at the time of transfer to the hospital.</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>Based on record reviews and interviews, the facility failed to issue a written bed hold notice to a resident, known family member or legal representative for 2 of 3 sampled residents who had been transferred to an acute care facility (Resident #13 and #66).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. in Resident #13's clinical record indicated that he/she transferred to an acute care hospital on 4/2/25 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.</li> <li>2. Documentation in Resident #66's clinical record indicated that he/she transferred to an acute care hospital on 5/7/25 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.</li> </ol> <p>On 5/25/25 at 10:30 a.m., in an interview with the Market Clinical Advisor confirmed that she was unable to locate evidence that the facility issued a written bed hold notice to the resident, a family member, or a legal representative upon transfer for Resident #13 and #66.</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 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 the storage of chemicals being properly secured on 1 of 3 units ([NAME]) for 1 of 3 days of survey (6/2/25).</p> <p>Findings:</p> <p>1. On 6/2/25 at 10:14 a.m., observation of an unsecured container of CaviWipes on a bedside table in room [ROOM NUMBER]. At this time, the Director of Nursing removed the CaviWipes from the resident's room, stating that these wipes should not be in resident rooms or care areas.</p> <p>The Safety Data Sheet for CaviWipes Section 4. First Aid Measures states Inhalation: Move the 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 so. Continue rinsing. If eye irritation persists: get medical advice/attention . Ingestion: Rinse mouth thoroughly with water. DO NOT induce vomiting. Call poison control or a doctor if you feel unwell.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on observations, record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification, dated 6/4/25, were effective. The Federal citations F761 and F880 were cited again during the re-visit for the Annual Long Term Care Recertification Survey, completed 9/10/25. Finding:During the follow-up survey on 9/10/25, it was determined that F761 and F880 would be re-cited: F761 for failure to monitor medication refrigerator temperatures daily and F880 for failure to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to apply appropriate interventions relating to the use of Enhanced Barrier Precautions (see F761 and F880).On 9/10/25 at 2:55 p.m., the above was discussed during the exit conference with the Administrator and the Region [NAME] President of Operations.</p>		

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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 observations, interviews and record reviews, the facility failed to have an effective infection prevention and control program (IPCP) for the surveillance and transmission prevention of Gastrointestinal disease for 1 out of 6 residents reviewed for infection control.</p> <p>Findings:</p> <p>Reviewed Facility Policy Infection Control Policies and Procedures IC306 Transmission Based Precautions last revised 5/1/25.</p> <p>8. Initiating Transmission Based Precautions:</p> <p>8.1 Nursing Staff may place patients with suspected or confirmed infectious diarrhea, influenza or symptoms consistent with a communicable disease on Transmission Based Precautions/isolation (TBP) empirically while awaiting confirmation.</p> <p>8.2 Notify the attending physician or Medical Director (in the absence of the attending physician) and the Infection Preventionist if there is reason to believe that an individual has an infectious disease.</p> <p>8.3 An order for Transmission Based Precautions will be obtained for patients who are known or suspected to be infected or colonized with infectious agents that require additional controls to prevent transmission effectively.</p> <p>A review of U.S. Centers for Disease Control and Prevention document titled C-Diff: Facts for Clinicians states:</p> <p>If a patient has had three or more stools in 24 hours: isolate patients with possible C-Diff immediately, even if you only suspect CDI (C-Diff Infection) and Order a C-diff test if other etiologies of diarrhea such as a stool softener or laxative were not used.</p> <p>On 6/4/25 a surveyor reviewed the progress notes in Resident #62 's Electronic Medical Record (EMR) and found the following nursing note dated 6/1/25 at 7:08 a.m., Resident had 3 episodes of watery stool with significant mucous and foul odor this night shift. Declined any oral (P.O.) fluids offered.</p> <p>On 6/4/25 at 12:40 p.m., a surveyor interviewed Certified Nursing Assistant (CNA) #1 and learned that they were told Resident #62 didn't need precautions because they were colonized but they suspected the resident had real C-diff again because of the smell and appearance of the stool and they didn't know what to do because they were told not to use TBP or do anything different but it smells so bad.</p> <p>On 6/4/25 at 12:45 p.m., surveyor observed Resident #62's room and found no transmission-based precaution sign posted and no personal protective equipment available. There was a strong fecal-like odor noted in the room and detectable from the doorway of the room. Resident #62 was in the common room.</p> <p>(continued on next page)</p>		

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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>On 6/4/25 at 12:48 p.m. surveyor interviewed CNA #2 and learned that Resident #62 always had frequent loose stools but lately it has been much smellier with mucous like when she had C-diff before. It smells and looks like C-diff. CNA #2 stated that they had used Contact Precautions for resident before but they were told she didn't need precautions anymore.</p> <p>On 6/4/25 at 1:00 pm a surveyor interviewed CNA - Medication Tech #1 and was told that Enhanced Barrier Precautions (EBP) signs went up all over the unit Monday morning and no one told us why. For Resident #62, we were told to not use Contact Precautions, but it sure looks and smells like C-diff. They never tell us anything.</p> <p>On 6/4/25 at 1:20 p.m. surveyor interviewed the Infection Preventionist (IP) Nurse and the Market Clinical Advisor and stated they were unaware that Resident #62 was showing acute symptoms of gastrointestinal disease but that note could indicate the possibility of an active infection. Contact Precautions were immediately initiated, and a stool sample was ordered.</p> <p>On 6/4/25 at 2:14 p.m., a surveyor observed outside Resident #62's room Contact precaution signage with PPE and a bleach odor was present. A review of Resident #62's EMR found an order for Contact Precautions and a stool sample.</p> <p>On 6/4/25 at 2:37 p.m., surveyors interviewed the facility provider and was told that Resident #62 was complicated because they had chronic diarrhea and was considered colonized with C-diff but changes to the stool described in the note from 6/1/25 would warrant initiation of transmission-based precautions and another stool sample to rule out an active infection. They were not notified of the changes described in the note on 6/1/25 and had not seen the note.</p> <p>On 6/4/25 at 3:00 p.m. a surveyor discussed the above findings with the Market Clinical Advisor and the IP Nurse.</p>