STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 6/2/25 to 6/4/25, on-site visits were conducted at Sedgewood Commons for the purpose of completion of the annual Long Term Care Survey Process for Federal Recertification and complaint investigations #ME00048235, #ME00050325, #ME00050326, and #ME00051687. It was determined that Sedgewood Commons is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000	Sedgewood Commons provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. This plan of correction is prepared and submitted solely pursuant to the requirements under state and federal law.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meghan Weber	Market Operations Advisor	6/26/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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 (Hawthorne, Longfellow, and Millay). Findings: 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: Hawthorne Unit: -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. -The closet doors are misaligned and do not fully close in the following rooms: 3, 8, and 9.	F 584	The room divider curtains were repaired in rooms 2, 3, 5, 9,14,15. 21, 28, 31, 40, 41, 42, 43, 44, 47, 49, 53, and 56. Room 21 privacy curtain replaced. The closet doors were repaired in room 3, 8, and 9.19, 20, 21, 25, 26, 28, 29, 31, 34, and 35. The window curtains repaired in 7, 9, 10, 11, and 33. Bathroom toilet in room 1and 26 was repaired, removing shim. The stained ceiling tile outside of room 17 was replaced. Room 18: Wall inside of door was repaired. Room 19 cleaned removing strong urine like odor. The base of the toilet in room 22 was cleaned. The bathroom sink countertop in room 23 was repaired. The stain on the wall outside of room 34 was addressed. The longfellow stained ceiling tile in the common area was replaced. Just inside the Millay unit the hole was repaired and wallpaper repaired. Outside room 47 the two holes near the baseboard were repaired. Outside of room 48 the ceiling tile was replaced. Room 53 urine-like odor addressed. Room 31, 33, 43, 47 and 56 stains on bathroom floor addressed.	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 -The window curtains are off track and do not fully close in the following rooms: 7, 9, 10, and 11. -Room 1: Bathroom toilet is on a shim sticking out from the base. -Room 17: There is a stained ceiling tile outside the room. Longfellow Unit: -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. -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. -Room 18: Wall inside of door has holes from previous TV. -Room 19: Has a strong urine-like odor. -Room 21: The room privacy curtain is torn. -Room 22: The base of toilet has a large brown ring around it. -Room 23: The bathroom sink countertop has two chips in the edge creating an uncleanable surface. -Room 26: The toilet has a large shim at the base. -Room 31: The bathroom floor has a stain. -Room 33: The bathroom floor has a stain, and the window curtains are off track and do not fully close. -Room 34: Stain on the wall outside of room. -There is a stained ceiling tile in the common TV area. Millay Unit: -Just inside unit to the right has hole and torn wallpaper. -The room divider curtains are off track and will	F 584	Cont'd from pg 2: All other resident rooms and resident living areas have been audited for same or similar environmental concerns and corrections have been made. The facility provides a safe, clean, comfortable, and homelike environment. Facility maintenance director and housekeeping staff will be re-educated to this process. The facility Administrator or designee, will conduct weekly rounds of the facility common areas and a rotating selection of resident rooms weekly x 4 weeks and monthly x 3 months thereafter. Work orders will be submitted for needed cleaning and repairs. Follow up inspections to ensure the completion of the work orders will be completed to ensure environmental issues have been fully addressed. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 not fully close to allow for resident privacy in the following rooms: 40, 41, 42, 43, 44, 47, 49, 53, and 56. -Room 43: Stained bathroom floor. -Room 47: Outside of the room there are two holes near the baseboard, and there is a stain on the bathroom floor. -Room 48: Outside of the room there is a stained ceiling tile. -Room 53: Has a strong urine-like odor. -Room 56: Stain on bathroom floor 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.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623	The incident happened in the past and cannot be corrected. All residents discharged or transferred have the potential of being affected by this practice. The Center informs the patient/resident representative, when there is a decision to transfer or discharge the patient from the Center. The patient and resident representative is notified in writing and in a language and manner they understand. Licensed staff will be re-educated to this process. DON/Designee will complete audits of discharged/transferred residents weekly x4 weeks and then monthly x3 months to ensure policy and procedures are being met. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6 for a facility-initiated transfer/discharge for 2 of 3 sampled residents transferred/discharged to an acute care facility. (Resident #13 and #66) Findings: 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. 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. 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.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625	The events happened in the past and can't be corrected for resident #10 and #66. All residents have the potential to be affected. The facility provides required notice of the bed-hold policy in writing before transferring a resident to the hospital. The business office manager and licensed staff will be re-educated to this process.	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 7 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: 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). Findings: 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. 2. Documentation in Resident #66's clinical	F 625	Cont'd from Page 7: NHA/Designee will complete audits of residents who discharge or transfer to the hospital to validate that the appropriate notice of bed-hold policy was provided before transferring a resident. These audits will be weekly x 4 weeks then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 8 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. 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.	F 625		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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 (Longfellow) for 1 of 3 days of survey (6/2/25). Findings: 1. On 6/2/25 at 10:14 a.m., observation of an unsecured container of CaviWipes on a bedside table in Room 35. At this time, the Director of	F 689	The caviwipes were removed on 06/02/2025. An audit of the facility was completed on 06/02/2025 to validate that the facility was free from potential accident hazards. The facility ensures that the resident's environment remains free of accidents hazards including the proper storage of caviwipes. Facility nursing staff will be educated to this process. NHA/Designee will conduct audits to validate the facility is free of accident hazards including the proper storage of caviwipes. These audits will be weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 Nursing removed the CaviWipes from the resident's room, stating that these wipes should not be in resident rooms or care areas. 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".	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761	The events happened in the past and can't be corrected. An audit of med rooms and medication refrigerators was completed to validate that staff are checking the temp of the refrigerator twice a day for med refrigerators storing vaccines and daily for med refrigerators not storing vaccines. The facility follows policy and procedures for checking and recording medication refrigerator temps daily or twice a day for med refrigerators that are storing vaccines. Licensed staff will be re-educated to this process.	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 10 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to monitor temperature controls for 2 of 3 refrigerators observed and 3 of 3 months of medication refrigerator logs reviewed. Findings: 1. On 6/2/25 at 1:30 p.m., observation of the Longfellow medication storage room refrigerator with Registered Nurse #1 (RN) which contained 1 Pneumococcal 20 (PCV 20) vaccination, 6 multi-use vials of influenza vaccinations (Afluria), and a multi-use vial of Tuberculin Purified Protein. On 6/2/25 a surveyor reviewed the facilities "Temperature Log For Medication/Vaccine Refrigerators" for months of March, April, and May. March 1st through March 31st lacked evidence of twice daily temperature readings for 15 out of the 31 days. April 1st through April 30th lacked evidence of twice daily temperature readings for 24 out of the 30 days. May 1st through May 31st lacked evidence of twice daily temperature readings for 25 out of the 31 days.	F 761	Cont'd from Page 10: DON/Designee will complete audits of medications refrigerator logs to validate staff are following the policy and procedure for checking and recording medication refrigerator temps daily or twice a day for med refrigerators that are storing vaccines. These audits will be weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11 2. On 6/2/25 at 2 p.m., observation of the Hawthorne medication storage room refrigerator with RN #1, which contained 1 Pneumococcal 20 (PCV 20) vaccination and a multi-use vial of Tuberculin Purified Protein. On 6/2/25 a surveyor reviewed the facilities "Temperature Log For Medication/Vaccine Refrigerators" for months of March, April, and May. March 1st through March 31st lacked evidence of twice daily temperature readings for 31 out of the 31 days. April 1st through April 30th lacked evidence of twice daily temperature readings for 28 out of the 30 days. May 1st through May 31st lacked evidence of twice daily temperature readings for 30 out of the 31 days. On 6/2/25 at 2:30 p.m., during an interview, the above findings were confirmed with the Market Clinical Advisor at this time she states they follow Center of Disease and Control (CDC) guidelines for vaccination and medication storage. Review of the CDC guidelines regarding vaccine storage, last revised 3/19/24, states facilities should check and record current temperatures a minimum of 2 times daily.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880	The events happened in the past and cant be corrected. All residents have the potential to be affected by the deficient practice. The facility staff will apply Transmission Based Precautions, in addition to Standard Precautions, to patients who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. Licensed staff will be re-educated to this process. DON/Designee will complete audits of residents with known or suspected infected or colonized with certain infectious agents to validate appropriate controls and transmission based precautions are in place to prevent the spread of infection. These audits will be weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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. Findings: Reviewed Facility Policy "Infection Control Policies and Procedures IC306 Transmission Based Precautions" last revised 5/1/25. 8. Initiating Transmission Based Precautions: 8.1 Nursing Staff may place patients with	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 suspected or confirmed infectious diarrhea, influenza or symptoms consistent with a communicable disease on Transmission Based Precautions/isolation (TBP) empirically while awaiting confirmation. 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. 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. A review of U.S. Centers for Disease Control and Prevention document titled "C-Diff: Facts for Clinicians" states: "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." 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." 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

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.

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.

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.

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205159	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEDGEWOOD COMMONS	22 NORTHBROOK DR FALMOUTH, ME 04105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 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. 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. On 6/4/25 at 3:00 p.m. a surveyor discussed the above findings with the Market Clinical Advisor and the IP Nurse.	F 880		

Market Operations Advisor 57ype text he