| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205103 | A. BUILDING _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEAL ROCK HEALTH CARE | 88 HARBOR DRIVE SACO, ME 04072 |

| (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<br><br>On 7/12/23, an unannounced on-site visit was conducted at Seal Rock for the purpose of an investigation of complaint #ME00044093 It was determined that Seal Rock was not in substantial compliance with 42 CFR 483, Sub-part B-Requirements for Long Term Care Facilities | F 000 | | |
| F 677 SS=E | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to provide residents a whirlpool/shower as directed by a residents plan of care/shower schedule for 5 of 6 sampled residents (Resident #2, #3, #4, #5 & #6).<br><br>Findings:<br><br>1. The Certified Nursing Assistant (CNA) Assignment sheet indicates that Resident #2's scheduled shower/whirlpool day is every Monday on the 7-3 shift. Review of Resident #2's current Care Plan, dated 2/9/23, indicates the following: "[Resident #2] requires 1 assist to help bathe and 2 assist to transfer to the shower chair.<br>Electronic clinical records reviewed from 5/15/23 to 7/8/23 indicated Resident #2 did not receive a scheduled shower on 5/15/23, 5/22/23, 5/29/23, 6/5/23, 6/12/23, 6/19/23, 6/26/23, 7/3/23 and 7/10/23.<br><br>2. The CNA Assignment sheet indicates that | F 677 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205103 | A. BUILDING _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SEAL ROCK HEALTH CARE** | **88 HARBOR DRIVE SACO, ME 04072** |

| (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 677 | Continued From page 1<br>Resident #3's scheduled shower/whirlpool day is every Thursday on the 3-11 shift. Review of Resident #3's current Care Plan, dated 3/6/23, indicates the following: "[Resident #3] bathes with the help of 2 people, to transfer and 1 assist for washing. "I prefer showers." Electronic clinical records reviewed from 5/15/23 to 7/8/23 indicated Resident #3 did not receive a scheduled shower on 5/18/23, 5/25/23, 6/1/23, 6/8/23 6/15/23, 6/22/23, 6/29/23 and 7/6/23.<br><br>3. On 7/12/23 at 10:24 a.m., during an interview with the surveyor, the family member of Resident #4, stated "I don't think he/she is getting his/her weekly showers." The CNA Assignment sheet indicates that Resident #4's scheduled shower/whirlpool day is every Tuesday on the 7-3 shift. Electronic clinical records reviewed from 5/15/23 to 7/8/23 indicated Resident #4 did not receive a scheduled shower on 5/16/23, 5/23/23, 5/30/23, 6/6/23, 6/13/23, 6/20/23, 6/27/23, 7/4/23 and 7/22/23.<br><br>4. The CNA Assignment sheet indicates that Resident #5's scheduled shower/whirlpool day is every Friday on the 3-11 shift. Review of Resident #5's Significant change Minimum Data Set 3.0 (MDS) dated 6/12/23 shows Section F: Preferences for Customary Routine and Activities: F0400-How important is it to you to choose between tub bath, shower, bed bath or sponge bath? SOMEWHAT IMPORTANT(Resident response). Review of Resident #5's current Care Plan dated 6/12//23 indicates the following: "[Resident #5] I bathe with the help of 1 person, to help me transfer, to help me wash. I transfer with the help of 2 people, not bearing my weight, transfer me with a full body mechanical lift. Electronic clinical records reviewed from 5/15/23 | F 677 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205103 | A. BUILDING _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEAL ROCK HEALTH CARE | 88 HARBOR DRIVE SACO, ME 04072 |

| (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 677 | Continued From page 2<br>to 7/8/23 indicated Resident #5 did not receive a scheduled shower on 5/19/23, 5/26/23, 6/2/23, 6/9/23, 6/16/23, 6/23/23, 6/30/23 and 7/7/23.<br><br>5. The CNA Assignment sheet indicates that Resident #6's scheduled shower/whirlpool day is every Monday on the 7-3 shift. Review of Resident #6's Annual MDS 3.0, dated 5/18/23, shows Section F: Preferences for Customary Routine and Activities: F0400-How important is it to you to choose between tub bath, shower, bed bath or sponge bath? SOMEWHAT IMPORTANT (Resident response). Review of Resident #6's current Care Plan, dated 5/23/23, indicates the following: "[Resident #6] I bathe with the help of 1 person doing 100% of the effort. Electronic clinical records reviewed from 5/15/23 to 7/8/23 indicated Resident #6 received a shower on 6/5/23 and did not receive a scheduled shower/whirlpool on 5/15/23, 5/22/23, 5/29/23, 6/12/23, 6/19/23, 6/26/23, 7/3/23 and 7/10/23.<br><br>On 7/12/23 at 2:00 p.m., a surveyor discussed the above findings in an interview with the Administrator. | F 677 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals | F 761 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205103 | A. BUILDING _____ B. WING _____ | C 07/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SEAL ROCK HEALTH CARE | 88 HARBOR DRIVE SACO, ME 04072 |

| (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 3<br>§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.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure a treatment cart containing multiple medicated creams, powders, ointments, syringes, insulin and inhalation treatment medications was locked on 1 of 7 units.<br><br>Finding:<br><br>On 7/12/23 at 12:15 p.m., a surveyor noted an unattended, unlocked treatment cart outside the Bluff Stratton nurses station containing multiple medicated creams, powders, ointments, syringes, insulin and inhalation treatment medications in corridors where residents and unauthorized personnel cross through.<br><br>A surveyor confirmed the above finding, at the time of observation, with the Administrator and Director of Nursing (DON). | F 761 | | |