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 _____	03/29/2024

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 March 26, 2024 to March 29, 2024, 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 #ME00042158, #ME00042207, #ME00042436, #ME00043027, #ME00044095, #ME00044696, #ME00044812, #ME00044848, #ME00044927, #ME00045549, #ME00045653, #ME00045819, #ME00046843, and #ME00046954. 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. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations.	
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,	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/30/2024

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 _____	03/29/2024

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 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are 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 interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 2 of 3 units (Millay and Longfellow) for 1 of 1 environmental tour (3/29/24). Findings: On 3/29/24 from 8:30 a.m. to 9:01 a.m., an environmental tour was conducted with the Maintenance Director in which the following was observed: Millay Unit: >The shower room had a laydown shower chair with orange colored coating under the chair edge and rim, the floor next to shower stall was raised with cracks and cove base peeling away from the	F 584	Millay Unit: The shower chair was removed from the unit on 03/29/24. The bathroom floor in the shower room is scheduled to be repaired. Resident #32's wheelchair was cleaned on 03/29/24. Room 50's door was adjusted and working in proper order on 04/03/24. Room #55's wall light cover was replaced on 04/02/24. The wallpaper on Resident #56's room was replaced on 04/03/24. The wallpaper in the TV room was fixed on 04/03/24. Longfellow Unit: Both chairs within the shower rooms were cleaned on 03/29/24. Room 22's cracked tiles were replaced on 04/02/24 and the black substance was removed on 04/02/24.	05/07/24

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 _____	03/29/2024

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 wall. >Resident #32 wheelchair seat is coated with dirt/debris. >Room 50 the bedroom bottom door sticks making it difficult to open. >Room 55 wall light near room door is missing the light cover. >Wallpaper peeling up and stapled to wall next to room 56. >Wallpaper peeling up across from the TV viewing room. Longfellow Unit: >The shower room had a bariatric shower chair and lay down shower chair both with orange colored coating under the chair edge and rim. >Room 22 bathroom has 2 cracked tiles under the sink, black built-up substance around the base of the toilet. >Room 23 bathroom has a urine hat stored on top of the toilet wedged between the toilet and wall. >Room 26-27 shared bathroom has an unlabeled urinal hanging on the toilet grab bars. On 3/29/24 at 9:01 a.m., in an interview, the Director of Maintenance confirmed the findings.	F 584	Room 23 bathroom urine hat was removed on 03/29/2024. Room 26-27 bathroom urinals were removed and replaced with labeled urinals on 03/29/2024. A facility wide audit of shower rooms', bathrooms and common areas will be completed and any areas in need of cleaning or repair will be cleaned or replaced. Administrator/ Designee will complete audits to ensure soiled and/or damaged equipment is cleaned and/or replaced weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months. Rotating hallway weekly Quality of Life Rounds will be initiated and Director of Maintenance/designee will attend all rounding and ensure all findings are addressed in a timely manner. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		

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 _____	03/29/2024

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 645	Continued From page 3 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645	A PASARR was completed for resident #46 on 04/02/2024. An audits of residents records was completed to validate a PASARR was completed prior to admission for all residents and for those meeting criteria that a PASRR Level I Screen was forwarded to the State Mental Health Authority to determine if the resident met the State of Maine's definition of a serious mental health disorder and to determine if a Level II assessment was needed. The facility requires that all admissions have a Preadmission Screening prior to entry into the facility. The facility requires a full PASARR for those individuals with a mental disorder and individuals with intellectual disability if the stay is expected to be >30 days. NHA, Social Services, and DON will be re-educated to this process.	05/07/24

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 _____	03/29/2024

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 645	Continued From page 4 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to coordinate assessments for Pre-Admission Screening and Resident Review (PASRR) Level I and Level II programs for 1 of 1 residents reviewed for PASRR (#46). Findings: A review of the clinical record for Resident #46 revealed he/she was admitted to the facility on 6/19/23, and had diagnoses including Dementia and Post Traumatic Stress Disorder. The clinical record lacked evidence that the PASRR Level I Screen was forwarded to the State Mental Health Authority to determine if the resident met the State of Maine's definition of a serious mental health disorder and to determine if a Level II assessment was needed.	F 645	NHA/Designee will complete audits to validate all residents have a PASARR completed prior to admission and for those who have a with a mental disorder and individuals with intellectual disability have a full PASARR completed for stays >30 days. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and 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 _____	03/29/2024

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 645	Continued From page 5 On 3/27/24 at 1:35 p.m., in an interview with a surveyor, the facility's Social Worker confirmed that the PASRR Level I screening had not been completed and he/she would proceed with the PASSR at that time. On 3/27/24 at 2:19 p.m., the finding was discussed with the Market President.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657	Resident #32's missed care plan meetings happened in the past and cannot be corrected. His next quarterly ARD date is 4/13/24 and IDT meeting is scheduled for by 5/4/24. An audit of all residents' records was conducted to validate that IDT meetings were appropriately scheduled in conjunction with completed MDS quarterly/comprehensive assessments.	05/07/24

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 _____	03/29/2024

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 657	Continued From page 6 assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each assessment (Resident #32). Finding: On 3/26/24 at 9:34 a.m., during an interview, Resident #32 stated he/she is not invited or remembers having care plan meetings. Review of Resident #32's medical record, the surveyor noted Minimum Data Set (MDS) Quarterly assessments, dated 11/2/23 and 2/2/24 were completed. The medical record lacked evidence that a care plan meeting had been held by the IDT after both assessments. On 3/28/24 at 1:31 p.m., during an interview, the Licensed Social Worker confirmed the above findings.	F 657	The facility ensures that IDT meetings, inclusive of resident and the resident's representative, are conducted after each quarterly and comprehensive MDS assessments. Facility IDT members will be re-educated to this process. DON/Designee will complete IDT audits weekly x 4 weeks, then bi-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.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to meet the personal	F 677		

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 _____	03/29/2024

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 677	Continued From page 7 hygiene preferences for 1 of 6 residents who are dependent on staff to complete Activities of Daily Living needs. (Resident #49) Findings: On 3/26/24 at 11:22 a.m., a surveyor observed Resident #49 with an unshaven face, and long fingernails with a dark substance built up under the nails. The resident was dressed in day clothing asleep on the bed. Record review revealed Resident #49 was admitted to the facility on 2/28/24 with a diagnosis of dementia and lower extremity amputation. Minimum Data Set (MDS) assessment dated 3/5/24 indicated that Resident #49 was assessed to need staff assistance for personal hygiene which includes nail care and shaving. On 3/26/24 at 12:30 p.m., a surveyor interviewed Resident #49's Certified Nursing Assistant (CNA) who confirmed that Resident #49 hasn't been shaved for "several days" and they weren't sure about when the nails were last done. The CNA confirmed that Resident #49 was dependent upon staff for nail care and shaving. On 3/27/24 at approximately 11:00 a.m., a surveyor interviewed Resident #49 and the Resident Representative together. Resident #49 had still not been shaved or provided nail care. The surveyor asked Resident #49 if he was growing a beard and he answered, "No, it needs to come off". The Resident representative stated, "I asked several days ago if he could be shaved. He doesn't like beards and makes fun of mine all the time."	F 677	Resident #49 is receiving ADL assistance of personal hygiene inclusive of shaving and nail care. An audit of all resident records and resident observations were conducted to validate that ADL care, inclusive of personal hygiene was conducted. The facility ensures that a resident who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal hygiene. Facility nursing staff will be re-educated to this process. DON/Designee will complete audits of personal hygiene weekly x 4 weeks, then monthly x 3 months to ensure personal hygiene, inclusive of shaving and nail care, is completed. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	05/07/24

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 _____	03/29/2024

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 677	Continued From page 8 On 3/27/24 at approximately 12:50 p.m., a surveyor interviewed the Unit Manager and was told that there wasn't a way to specifically document completed nail care or shaving but staff should document when a resident refused. There was no documentation available that Resident #49 had ever refused nail care or shaving. The surveyor confirmed with the unit manager that a resident should be shaved daily if that is a preference.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that a resident received treatment and services in accordance with the standards of practice for 1 of 2 residents reviewed for skin conditions (#343). Findings: On 3/26/24 at 12:27 p.m., during an interview with Resident #343's representative, the surveyor observed Resident #343 scratching/itching several small, scabbed areas on his/her upper right arm. At this time, the Resident Representative stated, the resident has a rash	F 684	Resident #343's bilateral arm rash has resolved after treatment. An audit of all resident records was conducted to validate residents' skin integrity status and the need for any preventative or treatment interventions is in place. The facility ensures that the nursing assistant will observe skin daily and report any changes or concerns to the nurse. The facility also ensures that the licensed nurse will evaluate and document any skin changes or wounds; as well as perform and document skin inspection weekly. Facility nursing staff will be re-educated to this process.	05/07/24

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 _____	03/29/2024

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 684	Continued From page 9 and was given a cream from the dermatologists that he will bring in. On 3/27/24 at 12:25 p.m., the surveyor observed Resident #343 wearing a long sleeve shirt and scratching/ itching at his/her right shoulder through the collar opening. On 3/28/24 at 11:37 a.m., during an additional interview with Resident #343's representative, the surveyor observed the resident continuing to scratch/itch at his/her right shoulder through the collar opening. At this time, the Resident Representative stated he had brought in the cream and gave it to nursing this morning stating, "[he/she] itches a lot, [he/she] got the dry skin pretty bad". Review of Resident #343's skilled documentation from admission on 3/22/24 through 3/28/24 lacked evidence of the nursing staff identifying the resident's rash. A review of the case line care plan initiated on 3/24/24 instructs nursing to "Observe skin condition daily with ADL care and report abnormalities". On 3/28/24 at 11:46 a.m., during an interview, the Registered Nurse (RN) confirmed she was not aware of a rash on his/her shoulders, stating. "Nurses do skin checks weekly, not sure when his/hers is due" and the "Certified Nurses Aids (CNA) generally report any skin concerns." The RN then reviewed the Electronic Medical Record and confirmed she did not see any documentation of a rash and then stated, the family brought in cream for which she needs to get a provider order to use. At this time, both the surveyor and RN observed the rash to Resident #343's upper bilateral extremities. The RN stated	F 684	DON/Designee will complete skin audits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months to ensure skin integrity is assessed, documented and if indicated, treated. 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 _____	03/29/2024

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 684	Continued From page 10 she will have the provider take a look. On 3/28/24 at 11:57 a.m., during an interview with the interim Director of Nursing the above was discussed, confirming the resident's rash was assessed after surveyor intervention.	F 684		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on performance evaluations and interview, the facility failed to complete annual performance evaluations at least every 12 months for 3 of 5 sampled Certified Nursing Assistants (CNA #3, CNA #4, and CNA #5). Findings: 1. CNA #3 was hired on 3/4/20. CNA #3's last performance evaluation was a 90-day progress report completed on 8/14/20. The facility was unable to provide evidence of a completed annual performance evaluation for 2021, 2022, 2023, or 2024. 2. CNA #4 was hired on 5/11/15. CNA #4's last performance evaluation was completed on 5/3/19. The facility was unable to provide evidence of a completed annual performance evaluation for 2020, 2021, 2022, or 2023.	F 730	CNA #3, #4 and #5 are scheduled for their annual performance review. An audit of annual performance reviews for all current CNAs has been conducted. The facility ensures that all CNAs receive a performance appraisal at least once every twelve months. Leadership staff will be re-educated to this process. DON/Designee will complete weekly audits x 4 weeks, then monthly audits x 3 months to ensure annual performance appraisals are administered to CNAs. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendation.	05/07/24

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 _____	03/29/2024

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 730	Continued From page 11 3. CNA #5 was hired on 7/31/18. CNA #5's last performance evaluation was completed on 9/26/19. The facility was unable to provide evidence of a completed annual performance evaluation for 2020, 2021, 2022, or 2023. On 3/27/24 at 4:15 p.m., in an interview with a surveyor, the Administrator, the Clinical Market Advisor, and the Market President confirmed staff performance evaluations had not been completed annually.	F 730		
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 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	F 761	The Longfellow and Millay unit medication room refrigerators have been replaced, are in good working order and are recording temperatures within the appropriate range of between 36-46 degrees Fahrenheit. All medication refrigerators are non-dormitory style and do not contain freezers. All open Purified Protein Derivatives (PPD) are labeled with the date they were opened. An audit of the remaining Hawthorne unit medication room refrigerator was conducted to validate temperatures and medication open dates.	05/07/24

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 _____	03/29/2024

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 12 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to properly store medications and biologicals in 2 out of 3 medication rooms refrigerators surveyed. (Longfellow House and Millay House) Findings: 1. On 3/26/24 at 11:38 a.m., a surveyor observed the Longfellow House medication room refrigerator with the Unit Manager and noted a dormitory style refrigerator with a freezer. Inside the refrigerator were influenza vaccines and a pneumococcal vaccine. A review of the recorded temperatures for the refrigerator showed an out-of-range temperature on 3/24/24 of 70.8 (F). A surveyor asked the unit manager what happened following the discovery of the out-of-range temperature, and they did not know. They were unable to deny or confirm that the vaccinations in the refrigerator were in the refrigerator at the time of the out-of-range temperature. 2. On 3/26/24 at 11:40 a.m., a surveyor observed the Millay House medication room refrigerator with a Licensed Practical Nurse (LPN), and found 2 opened and unlabeled vials of Purified Protein Derivative (PPD) which is used to test for tuberculosis for staff and residents. A surveyor confirmed with the LPN during the observation that these should have an open date and be discarded 30 days after opening. They were immediately removed. It was also noted that the refrigerator had significant ice buildup along the	F 761	The facility ensures that staff check and document the internal refrigerator temperatures used to store medications and vaccinations. The facility also ensures that if the internal refrigerator temperature is out of the acceptable range, that medications and/or vaccinations are immediately removed and notifications are made to Maintenance, Director of Nursing, and Pharmacist for further guidance. Facility licensed staff will be re-educated to this policy. DON/Designee will complete audits on internal refrigerator temperatures and dates of opened refrigerated medications 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 _____	03/29/2024

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 13 back inside surface. Also stored in the refrigerator were pneumococcal, respiratory syncytial virus (RSV), Spikevax (Covid-19), and influenza vaccines. On 3/26/24 at 11:45 a.m., during an observation of the Longfellow House and Millay House medication room refrigerators with the Interim Director of Nursing (IDON), the vaccines in the Longfellow medication room refrigerator had been removed, but the IDON confirmed they were not removed at the time the out-of-range temperature was discovered. The IDON also confirmed that a dorm style refrigerator with a freezer section was not appropriate for storing vaccinations. The IDON also confirmed that ice build up in the back of a refrigerator. On 3/27/24 at 11:50 a.m., a surveyor reviewed the facility policy titled: Infection Control Policies and Procedures IC401 Medication and Vaccine refrigerator/freezer temperatures last revised 8/7/23 which states: "If temperatures fall outside the acceptable range: 2.1 Notify Maintenance and Director of Nursing Immediately 2.2 Move medications and/or vaccines to another refrigerator/freezer. 2.3 Contact pharmacist for guidance regarding handling of medications or vaccines 2.4 Do not discard medication or vaccine unless directed to by pharmacist. 2.5 Notify vaccine distributor. 2.6 Complete Medication/Vaccine Storage Troubleshooting record and discuss at QAPI" On 3/27/24 at 12:20 p.m., a surveyor interviewed the Clinical Market Advisor and confirmed that a dorm style refrigerator with a freezer was being	F 761		

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 _____	03/29/2024

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 14 used to store vaccinations. Also confirmed that ice buildup in a fridge, confirmed the facility policy was not followed after the discovery of the out-of-range temperature leading to incorrect storage of vaccinations.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 1 of 1 initial kitchen tour completed on 3/26/24. Additionally, the facility failed to ensure that food temperatures were recorded at the time of cooking breakfast on the morning of 3/26/24. Findings:	F 812	The ceiling vents were cleaned and free of film on 03/26/24. The surfaces were cleaned of dust on 03/26/24. The kitchen is currently being maintained in a clean and sanitary manner. Additionally, the kitchen is ensuring that food temperatures are recorded at the time of meal service. Dietary staff will be educated to the policy pertaining to the recording of food temperatures. FSD/designee will complete audits on the cleanliness of the kitchen environment as well as food temperature documentation 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.	05/07/24

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 _____	03/29/2024

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 812	Continued From page 15 1. On 3/26/24 at 9:10 a.m., a surveyor conducted an initial tour of the kitchen with the Cook in which the following findings were observed and confirmed. - A light amount of dust, debris, and staining on the ceiling vents - A sticky, dusty film on all flat surfaces of the Kitchen - A lack of documentation of food temperatures being taken during dinner on 3/23/24, all day on 3/24/24, all day on 3/25/24 and breakfast on 3/26/24. The above findings were confirmed with the cook at that time.	F 812		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883	The facility offers the recommended pneumonia vaccines to all eligible residents upon admission. The facility obtains consent forms and provides VIS sheets for the PCV13, PCV15, PCV20 vaccinations as well as PPSV23. The facility ensures that all patients/representatives are provided education (Vaccine Information Statement (VIS) regarding the benefits and potential side effects of the pneumonia vaccination.	05/07/24

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 _____	03/29/2024

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 883	Continued From page 16 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on review of the facility's "Pneumococcal Vaccination" policy and procedure, interviews, and record review the facility failed to provide the	F 883	Facility licensed staff will be re-educated to this policy. DON/Designee will complete audits to validate that VIS education is provided on admission for all pneumonia vaccinations 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 _____	03/29/2024

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 883	Continued From page 17 Resident and/or the Resident's Representatives with the Vaccine Information Statement (VIS) prior to immunizing a resident with the pneumococcal vaccine (Prevnar) for all residents receiving the Prevnar vaccine. Findings: The facilities "Pneumococcal Vaccination" policy and procedure, revised on 11/1/23 states, "Provide the patient/representative education (Vaccine Information Statement (VIS)) regarding benefits and potential side effects of vaccination." On 3/27/24 at 11:43 a.m., during an interview, the facility's Infection Preventionist (IP) confirmed that the facility does offer the recommended pneumonia vaccines (PPSV23, PCV13, PCV15, PCV20) for those residents who are illegible and upon admission. She then stated the admission packet contains the consent forms with information explaining the risks versus the benefits (called the VIS) for having the pneumococcal vaccination. The surveyor and the IP reviewed the facilities admission packet which contained the VIS sheet for only the PPSV23 and the "Pneumococcal Vaccine Informed Consent" for Pneumovax (PPSV23), Prevnar 13 (PCV13), Prevnar 15 (PCV15) and Prevnar 20 (PCV20) which states, "VIS provided to patient/representative and questions answered, as needed." The admission packet lacked evidence of VIS sheets for the PCV13, PCV15 and PCV20 vaccines. At this time the IP confirmed the Residents and/or Resident Representatives have not received the required VIS sheets upon admission. On 3/27/24 at 2:24 p.m., during an interview, the	F 883		

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 _____	03/29/2024

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 883	Continued From page 18 Marketing Clinical Advisor confirmed the facility has not provided residents and/or resident representatives with the Prevnar vaccine VIS sheet upon admission to the facility and/or prior to administration of these vaccines. The facility is currently only providing the Pneumococcal Polysaccharide vaccine (PPSV23) VIS sheet.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff	F 887	Residents who received the COVID-19 (Spikevax) vaccination were provided education on the benefits, risks and potential side effects of the COVID-19 (Spikevax) vaccination. The facility has conducted education to all staff regarding the benefits, risks and potential side effects of the COVID-19 (Spikevax) vaccination. The facility ensures that the benefits, risks and potential side effects of the COVID-19 (Spikevax) vaccination are presented to all residents on admission and all staff on orientation. Facility licensed staff will be re-educated to this policy.	05/07/24

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 _____	03/29/2024

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 887	Continued From page 19 member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on review of the facility's "COVID-19 Vaccination" policy and procedures, interviews and record review the facility failed to ensure each resident, or the resident representative received education regarding the benefits, risks and potential side effects associated with the COVID-19 vaccine prior to immunizing a resident with the COVID-19 vaccine for all residents who received the COVID-19 vaccine. In addition, the facility failed ensure staff were provided education regarding the benefits and potential risks	F 887	DON/Designee will complete audits weekly x 4 weeks, then monthly x 3 months to ensure VIS and education is provided to all residents and all staff. 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 _____	03/29/2024

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 887	Continued From page 20 associated with COVID-19 vaccine. Findings: The facilities "COVID-19 Vaccination" policy and procedure revised, 2/7/24 states, "Centers will provide the opportunity to receive COVID-19 vaccinations following Centers for Disease Control and Prevention (CDC) recommendation" and the facility will obtain consent using the "Patient Informed Consent or Declination COVID-19" form. On 3/27/24 at 11:43 a.m., during an interview, the facility's Infection Preventionist (IP) confirmed that the facility does offer the recommended COVID-19 vaccine for those residents who are illegible and upon admission stating, the admission packet contains the COVID-19 (Spikevax) vaccine education and consent form. The surveyor and IP reviewed the admission packet which contained the "Patient Informed Consent or Declination COVID-19 vaccine form" which states, "I have read or had explained to me the Emergency Use Authorization Fact Sheet or Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits." At this time, the IP confirmed the admission packet lacked evidence of education regarding the benefits, risks and potential side effects associated with the COVID-19 vaccine. In addition, the IP confirmed that staff are not provided education regarding the benefits and potential risks associated with COVID-19 vaccine. Stating, there's "nothing formal" and upon hire in October of 2023 she was not provided COVID-19 vaccine education however did decline the vaccine.	F 887		

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 _____	03/29/2024

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 887	Continued From page 21 On 3/27/24 at 12:24 p.m., during an interview, the Nurse Practice Educator (NPE) stated, she has not done any education for COVID and was unable to provide evidence of staff education regarding the benefits and potential risks associated with COVID-19 vaccine (Spikevax). At this time, a Registered Nurse (RN) was in the office with the NPE for day 2 of orientation. She stated, she has already provided her vaccinations but has not had any education on the new Spikevax COVID-19 vaccine. On 3/27/24 at 12:36 p.m., during an interview, the surveyor asked the Licensed Practical Nurse (LPN) if she was educated on the new Spikevax, COVID-19 vaccine. The LPN stated, "I can't say for sure, typically when stuff like that comes out we get the sheets to sign." On 3/27/24 at 2:24 p.m., during an interview, the Marketing Clinical Advisor confirmed the facility has not provided residents and/or resident representatives with the VIS education on the COVID-19 vaccine upon admission to the facility and/or prior to administration of these vaccine. At this time. Both the surveyor and the Marketing Clinical Advisor looked in the employee break room and around the common area/time clock for any COVID-19 (Spikevax) education but was unable to find any.	F 887		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the	F 947		

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 _____	03/29/2024

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 947	Continued From page 22 continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee record review and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on Resident Rights for 2 of 5 Certified Nursing Assistant (CNA) staff reviewed (CNA #1, CNA #2). Findings: On 3/27/24, the following employee records were reviewed: 1. CNA #1 was hired on 12/26/23. There was no documented training regarding Resident Rights. 2. CNA #2 was hired on 12/4/23. There was no documented training regarding Resident Rights. On 3/27/24 at 4:15 p.m., in an interview with a surveyor, the Clinical Market Advisor confirmed there was no documentation of the staff attending the required annual training regarding Resident	F 947	CNA #1 and #2 are scheduled to receive documented education on resident rights. An audit of all employee files was completed to validate that all CNAs have received their required mandatory education. The facility ensures that CNAs receive no less than 12 hours of annual training that is inclusive of dementia management and resident abuse prevention. Facility leadership and CNAs will be re-educated to this process. DON/Designee will complete audits of CNA mandatory education completion weekly x 4 weeks, then bi-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.	05/07/24

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 _____	03/29/2024

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 947	Continued From page 23 Rights.	F 947		