

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Southridge Rehab & Living Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 10 May St Biddeford, ME 04005	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48648 Based on record reviews and interviews, the facility failed to notify the physician when interventions were ineffective in relieving resident's distress. In addition, the facility failed to notify the physician after the resident was missing and required a search to locate or when the resident experienced a life-threatening elopement. Findings: On 2/17/25 the Division of Licensing and Certification received a facility reported incident, which indicated Resident #1 was found outside in a snowbank having fallen from a second story window. Review of facility policy Resident Elopement Policy last revised 9/23 states under: II. PROCEDURE -Section D vii - The physician and resident's responsible party will be notified. -Section G. The resident's plan of care is to be updated with appropriate interventions to meet the resident's current needs -Section H Document in medical record. Indicate time the search began and the time the search ended. On 2/19/25, during review of Resident #1's the Medication Administration Record, stated a PRN (as needed) medication for anxiety was given with no effect on 2/15/25 at 7:34 p.m. and 2/16/25 at 6:00 p.m There is no evidence to support that other interventions were tried and effective/ineffective or that a physician was notified. On 2/19/25, during review of Resident #1's electronic medical record (EMR), Clinical notes stated that Resident#1 had been found missing from his/her bed on 2/16/25 and located in the closet of another room where a window had also been found open. The notes lacked evidence the time the search began and time when resident was found. The notes also stated that interventions and medications had been unsuccessful to relieve resident's agitation. There is no evidence that a provider was notified. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/17/25 at approximately 1:00 a.m., Resident #1 was found outside in a snowbank underneath an open second story window. Resident #1 was transferred to the hospital and diagnosed with hypothermia and frostbite. The medical record lacked evidence that the facility physician was notified. On 2/19/25 at 12:15 p.m., a surveyor discussed the above findings with the Administrator and Director of Nursing and confirmed that physician was not notified of resident behaviors and elopement.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48648 Based on record reviews and interviews, the facility failed to follow the baseline care plan implemented for Resident #1 in the area of Behaviors for 5 of 5 days that resident was in the facility. Findings: On 2/19/25, during review of Resident #1's baseline care plan, dated 2/12/25, stated in the area for Behaviors: Document behaviors in Treatment Administration Record (TAR) or on behavior monitoring form every shift. A review of Resident #1's Electronic Medical record (EMR) under TAR and Clinical Notes, failed to show documented behaviors for every shift between 2/12/25 and 2/17/25. On 2/28/25 at 8:51a.m., during an interview with CNA #1, who worked shifts with Resident #1 on 2/12/25, 2/13/25, 2/14/25, 2/15/25 and 2/16/25. CNA #1 stated that Resident #1 was wandering, exit seeking, refusing care, distressed frequently since arrival on B2 Unit. CNA #1 states that he/she was not told Resident #1 had eloped several times in Residential Care. On 2/28/25 at 9:49 a.m., during an interview with CNA #2, who worked shifts with Resident #1 on 2/12/25, 2/13/25, 2/15/25 and 2/16/25. CNA #2, confirmed that Resident #1 had been experiencing frequent wandering and exit seeking behaviors and was very difficult to manage when his/her family was not present. On 2/19/25 at 12:15 p.m., during an interview with the Administrator and the Director of Nursing, were unable to provide additional evidence or an explanation for not following the care plan for monitoring behaviors.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on interviews, observations and record reviews, the facility failed to provide supervision to a resident after staff found resident in closet in another resident room, with an open window. Resident was previously identified as an elopement risk and had previous exit seeking attempts for 1 of 2 residents identified for elopement risk. Shortly after, the resident was found outside in a snowbank with a second story window open. This failure created an immediate jeopardy situation. (Resident #1) Findings: On 2/17/25 the Department of Licensing and Certification received a facility reported incident indicating [Resident #1] fell into snow from second floor on 2/17/24. [Resident #1] found in snowbank at approximately 1:00 a.m. Medical record indicated that on 2/12/25, Resident #1 was transferred from the facility residential care unit to a secured long term care unit(B1 Unit). The transfer was related to safety due to increased dementia behaviors including exit seeking and recent elopements from the residential care facility. Resident #1 is [AGE] years old with a diagnosis of dementia. On 2/12/25 the facility completed elopement assessment and determined Resident #1 was a High Risk for elopement. Resident#1 was wearing a Secure Care anklet (monitor for wandering residents). On 2/19/25, during review of Resident #1's nursing progress notes, stated on 2/14/25 at 11:51 a.m., a nurse administered as needed medication for anxiety and initiated a 1:1 for safety from staff due to wandering, exit seeking and refusal of care. Documentation states that medication was effective and daughter visiting. Resident #1's Medication Administration Record (MAR), stated on 2/15/25 at 1:29 p.m., and on 2/15/25 at 7:34 p.m., a nurse administered as needed medication for anxiety and both times the response was not effective. Resident #1's nursing progress notes stated on the night of 2/16/25 and into the early morning of 2/17/25, Resident #1 exhibited exit seeking behaviors, pacing, not responding to redirection and medications were not effective. On 2/28/25 at 9:49 a.m. during an interview with CNA#1, by phone, stated a bed check was done on 2/17/25 around 12:20 a.m. and Resident #1 was found missing. The staff searched and found Resident #1 in the closet of another resident room. The window in that room was also found open. The residents in that room were both asleep when Resident #1 was found. CNA #1 stated that neither resident sleeping in that room would have been able to exit their bed independently to open the windows. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/28/25 at 11:41 a.m., during an interview with PSS #1 stated that at on 2/17/25 1:00 a.m. he/she was taking a break outside with another staff member from Residential Care and found Resident #1 on a snowbank underneath an open second floor window. Resident #1 was assessed by a facility nurse and found to be alert, tearful, oriented to self, scrapes on knees and a bump on his/her head. PSS#1 called 911 and went to alert the facility staff that resident was outside. The long-term care unit staff were unaware Resident #1 had gone missing again. Resident #1 was transferred by Emergency Medical Services (EMS) to the emergency room . During review of Residents #1 Hospital Discharge Summary, dated 2/20/25, stated that Resident #1 was diagnosed with hypothermia, metabolic encephalopathy secondary to hypothermia and hypoxia and frostbite. Resident discharged back to facility on 2/20/25 with orders by facility provider included comfort measures only and hospice. According to the archived records from the National Weather Service, the temperature range on 2/16/25 was 17-23 degrees Fahrenheit with light snow. On 2/19/25 at 10:00 a.m., during an interview with the facility Maintenance Director, all facility windows on B2 and A1 units had been assessed and retrofitted with window blockers that limited opening windows to 6 inches. Prior to this, according to the Maintenance Director, the windows could be easily opened. Some of the facility windows had very low sills and could be easily accessed. This was completed by 2/18/25 around 11:00 a.m. Resident Elopement policy last revised 9/2023 and found under section II (Procedure), Item G. The resident's plan of care is to be updated with appropriate interventions to meet resident's current needs. And under section II, Item H. Document in medical record. Indicate time the search began and the time the search ended. There is no documentation to support that staff followed the facility's policy when Resident #1 went missing the first time on the night of 2/17/25. Based on the above information, IJ was called on 3/4/25 for the facility's failure to provide adequate supervision to a resident with a history of exit seeking and elopement that resulted in a fall from a second story window into a snowbank. Staff on B2 were unaware the resident had been missing a second time until alerted by residential care staff after the fall. The facility's failure to provide these services constituted an immediate jeopardy situation. Please see F-0000 Initial Comments related to the IJ removal plan.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48648 Based on record review and interviews, the facility failed to monitor targeted behaviors to support the use of antipsychotic and antianxiety medications for 1 resident reviewed for unnecessary medications and behavior monitoring. Findings: Review of Resident #1's Physician Order Sheet has the following orders for Psychotropic Medications: -Sertraline 100 mg(milligram) tablet one time daily oral for Unspecified dementia, Moderate, with mood disturbance. -Clonazepam 0.5 mg tablet two times daily oral for Generalized Anxiety disorder -Lorazepam 100 % power (0.25 ml) topical As needed Every Four Hours for Ninety Days for Generalized Anxiety Disorder Review of Resident #1's Physician Order Sheet order, dated 2/12/25 that states: Behavioral/Psychotropic Medication Monitor Notes: Behavior monitoring for psychotropic medications below: Antipsychotics, Antianxiety, Antidepressants, Sedative/hypnotics *Please document ALL behaviors including those Normal for the resident. Physical Monitors: 1. Behavioral Symptoms/Effective?/Non-Pharmacological Interventions/Number of Episodes/Psychoactive Side Effects Frequency: Three Times Daily (Nurse Day Shift, Nurse Evening Shift, Nurse Night Shift). Review of Resident #1's Care plan included under interventions Monitor, report and document changes in mentation and If [Resident #1] is agitated or restless, provide distraction Resident #1 was admitted to Long Term Care Unit from Residential Care with diagnosis of dementia due to with exit seeking and wandering behaviors. On 2/19/25, during review of the Treatment Administration Record (TAR) for Resident #1, between the dates of 2/12/25 and 2/17/25 there is no documentation on the TAR that nursing followed this monitoring behaviors ad physician order directed. The Medication Administration Record (MAR) showed 4 documented times that an as needed psychotropic medication was given between 2/12/25 and 2/17/25. There is no documentation as to why this drug was administered for 3 of 4 times it was administered to Resident #1. During review of progress notes for Resident #1, between the dates of 2/12/25 and 2/17/25, the nursing notes failed that supported the ordered behavior monitoring for psychotropic medications. In addition, nursing notes do not explain why an as needed medication was administered or what nonpharmacological interventions were attempted prior to administering an as needed medication. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 12:15 p.m., during an interview with the Administrator and the Director of Nursing and discussed the above findings.		