STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Rehab & Living Ctr	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of the complaint report, facility internal investigation, clinical record review, facility General Dose Preparation and Medication Administration Policy and Procedure, and interviews, the facility failed to identify the resident prior to administering medications, failed to follow the facilities policy on resident identification resulting in Resident #1 being given another's residents medication resulting in the need for a hospital evaluation for 1 of 1 residents reviewed (Resident #1) Findings: The Division of Licensing and Certification received a complaint that indicated on the morning of 5/20/25, Resident #1 received another resident's medications which resulted in lethargy and poor oxygen profusion. Resident #1 was transported to the emergency room for further evaluation. On 6/2/25, a review of the facility's internal investigation was completed. The investigation indicated that on 5/20/25, during morning medication pass, Certified Nurse Assistant-Medication (C.N.A.-M #1) administered the wrong medications (Eliquis - an anticoagulant medication used to prevent blood clots, Metformin used to treat type 2 diabetes; Flexeril used to treat muscle spasms; Lyrica used to treat nerve pain; Furosemide used to treat fluid retention; Potassium chloride a supplement to treat low potassium; Risperidone a antipsychotic medication used to treat a variety of mental health conditions; and Vitamin B) to Resident #1. C.N.A.-M #1 administered Resident #2's medications to Resident #1 in error. The physician' s noted dated 5/20/25 stated, Medication error: Patient inadvertently received another resident's medications (metformin, furosemide, risperidone, paroxetine, Eliquis, pregabalin, cyclobenzaprine). Based on the medication types and estimated dosages given, current presentation is not consistent with a toxic overdose. Poison Control was not contacted at this time, though the situation will continue to be monitored closely given the potential for delayed adverse effects. Patient remains clinically stable at time of evaluation, with only mild drowsiness noted. No signs of respiratory distress, hemodynamic instability, or neurologic changes . if any changes in mental status, vital signs, or neurologic function occur, the patient is to be transferred to the ED for further evaluation. Review of the nursing documentation, dated 5/20/25 at 4:10 p.m. stated, resident was given another resident medication. Provider notified and POA (Power of Attorney) notified as well. Monitoring vitals Q6 (every 6 hours) per doctor and monitoring sugars. Resident has been stable so far, only side effect was being a little drowsy, B/P (blood pressure) and Pulse continues to be WNL (with in normal limits). BS(blood sugars) has also been WNL. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205136	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Rehab & Living Ctr	10 May St Biddeford, ME 04005

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing note, dated 5/20/25 at 8:03 p.m., stated, around 4:30 p.m. MedTech entered room to give evening medications and found resident to be unresponsive to voice and touch but breathing. Nurse attempted to get resident to respond but was unsuccessful . immediately 911 was called. EMS arrived and took patient to the hospital. Report given to hospital, all medications given in error told to hospital. Call received around 8:00 p.m. stating resident would be returning to facility sometime this evening. Nursing note, dated 5/20/25 at 11:08 p.m. stated, Resident returned to facility around 9:30 p.m., via stretcher transport . resident still lethargic and according to the hospital physician it is expected. Hospital reached out to poison control who told them to monitor [him/her] for 2 hours at the hospital and then send [him/her] back if stable. Reporting nurse stated all labs were WNL and BS (blood sugar) was 103, 10 minutes before return to facility. On 6/2/25 at 11:42 a.m., during an interview, the Registered Nurse (RN) manager for B2 unit stated she was working that day as the charge nurse and notified the doctor immediately of the medication error. The doctor gave orders to check vitals every 6 hours and blood sugars. The incident happened around 11:30-12pm and the residents vitals were stable, but [he/she] was not talking and sleeping very heavy, not responding with touch and it was then when she was sent to the hospital. On 6/2/25 at 11:59 a.m., during an interview, The Director of Nursing (DON) stated education on medication administration has been started and currently in place for nursing staff who administer medications. Education should be completed by 6/9/25. The facilities General Dose Preparation and Medication Administration policy and procedure, revised 11/15/24, under procedure 3.1 states, Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time for the correct resident. On 6/2/25 at 2:15 p.m., during the exit interview with the Administrator and the DON, the above failure to identify the resident prior to administering medications, failure to follow facility policy on resident identification resulting in Resident #1 being given another's residents medication and the need for a hospital evaluation was confirmed.