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	07/07/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of the facility's transport policy and interviews, a facility Transportation Aid failed to follow the transport a resident to an appointment safely by not attaching the shoulder harness strap and seat belt resulting in resident sliding from wheelchair during a transport and sustaining a fracture of the left femur for 1 of 3 residents reviewed for facility transports. (#1)Resident #1 was admitted to the facility in March of 2025 following a fall, for rehabilitation and treatment of a fracture of the resident's left distal femur, right proximal humerus, Type 2 Diabetes Mellitus, Atrial Fibrillation, and depression. The fracture of the left distal femur was not healing well, and the resident had an appointment with the Orthopedic Surgeon.During a review of the facility investigation, on 6/26/25, at approximately 8:30 a.m. the facility Transportation Aid (TA) loaded the resident into the van and secured the wheelchair. The Transportation Aid did not fasten the shoulder harness/seat belt combination because it was not working. She then got into the van and started to pull away from the facility and she heard the resident fall out of her chair onto the floor of the van. She stopped the van and immediately called 911. The rescue team came and transported the resident to the hospital. Transport Aside knew the safety belts were not working properly and did not report the issue. Hospital Discharge summary dated [DATE] stated recent right proximal humerus fracture s/p ORIF(Open Reduction and Internal Fixation) on 3/26/25 complicated by left distal radius fracture and left distal femur fracture who presents with left thigh pain after a fall in wheelchair van and admitted for comminuted left femur fracture.On 7/7/25 at approximately 10:00 a.m. in an interview with a surveyor, the Transportation Aid stated that she has been with the facility since 2013 but has only been driving the van for the last 2 weeks. When asked what education she had received, she stated she had watched the training videos and had been given an orientation to the van by the Maintenance Director. When asked about the day of the transport she stated that she had loaded the resident into the van and locked the wheels in place. When I went to fasten the shoulder strap it would not move, and I could not get it buckled. I thought that because the distance to the appointment was close and I could drop off the resident and come back and report it to Maintenance. When asked if the Maintenance staff was at the facility at the time she found the issue with the shoulder strap? She said, Yes they were. When asked why she did not have them look at it at that time? She stated, I thought it would be OK.On 7/7/25, at approximately 11:15 a.m., in an interview with the Administrator she stated, When the incident happened, the van was removed from service immediately. It was due for normal maintenance, so we had that done and also an inspection of the safety straps was done by the Maintenance Director. On 6/26/25, during the inspection, it was discovered that the seatbelt straps were not attached properly, and the issue was fixed. The Maintenance Director was designated to be the van driver trainer.On 7/7/25, during a review of the facility's policy for Motor Vehicle Rules & Requirements, dated 3/1/25, the policy states that there is A notification sign must be visibly placed in the vehicle that reads. 'SAFETY BELTS MUST BE WORN'. The driver and all passengers must properly wear seat/safety belts at all times during operation of the motor vehicle.On 7/7/25, at approximately 8:55 a.m. during an observation of the transport van, no signs requiring the use of seat belts were found. This was reported to the Administrator at that time.As a result of the facility's investigation, the following corrective actions were initiated:- 0n 6/26/25, Van was placed out of commission until its safety was confirmed- On 6/26/25, the Maintenance Director inspected the inside of van completely to include all the equipment to ensure proper functionality. Specifically focusing on the seatbelt and tie downs.- On 6/26/25, the Maintenance Director was designated to be Van Transport Trainer.- On 6/26/25 Education provided to staff how to secure a passenger was placed in van for reference.- On 6/27/25 Involved staff were retrained on van safety with return demonstration.- On 6/30/25 Passenger Loading Instructions Audit tool developed for random audit to be done by the Maintenance Director.- On 6/30/25 Daily Wheelchair Van Safety Checklist developed for transport aid to complete before using the van.- On 6/30/25 current Van Driver completed training.