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	06/26/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44049 Based on observations and interviews, the facility failed to adequately maintain maintenance services necessary to maintain in good repair and in sanitary condition for 2 of 2 units. Findings: On 6/26/2024 at 2:00p.m. during an environmental tour with a Cooperate Quality Improvement Nurse, the following were observed: On the Second Floor - B-2 Unit Resident room [ROOM NUMBER] - Window curtain stained, Resident room [ROOM NUMBER] - Window curtain off track, Resident room [ROOM NUMBER] - Stained ceiling tile above bed A Resident room [ROOM NUMBER] - Large chip out of the laminate on the front of the sink creating an uncleanable surface, Laminate on the left side of the sink is loose and could break creating a hazard. Resident room [ROOM NUMBER] - Window curtain stained, Resident room [ROOM NUMBER] - Resident bathroom toilet will not stop running. Next to Second floor Nurses' station hand sanitizer dispenser has had the drip catch cup torn away leaving screw holes in the wall that are rough and could be an injury hazard; and it is an uncleanable surface. Second floor hallway ceiling tile has several hanging bits of dirt and debris all down the hallway. First Floor - B-1 Unit Resident room [ROOM NUMBER] - Both resident's bed curtains have missing hooks and chipped paint in the middle of the ceiling, (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER] - Left lower drawer under sink has chip in the laminate, creating a hazard and an uncleanable surface. Resident room [ROOM NUMBER] - Cob Webs along the wall on the left as you enter the room. All the above items were confirmed with Cooperate Quality Improvement Nurse at the time.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44049 Based on record reviews and interviews, the facility failed to follow the facility Falls Management Policy for 8 of 8 residents reviewed for falls thus far in 2024. Resident (#1,#6, #13,#30, #35, #36, #39 #41,) Findings: 1. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #13 who was admitted on [DATE], for Long Term Care and found that Resident #13 had fallen six times (1/7/24, 2/29/24, 3/1/24, 3/19/24, 4/12/24, and 5/20/24). The falls lacked complete documentation per facility's Fall Management Policy, including updated Fall prevention interventions in the care plan. Review of Resident #13's Progress Notes dated 1/7/24, 2/29/24, 3/1/24, 3/19/24, 4/12/24, and 5/20/24 shows that Post Fall Observations were done but all other required documentation is lacking, i.e. documentation for three shifts post fall and documentation of the Director of Nursing (DON) follow-up as stated in the facility's policy. 2. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #30 who was admitted on [DATE], for Long Term Care and found that Resident #30 had fallen one time (2/16/24). The fall lacked complete documentation per facility's Fall Management Policy, including updated Fall prevention interventions in the care plan. Review of Resident #30's Progress Notes dated 2/16/24, Review of Resident #30's Progress Notes dated 2/16/24 shows that Post Fall Observations were done but all other required documentation is lacking, i.e. documentation for three shifts post fall and documentation of the Director of Nursing (DON) follow-up as stated in the facility's policy. 3. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #35 who was admitted on [DATE], for Long Term Care and found that Resident #35 had fallen one time (6/16/24). The fall lacked complete documentation per facility's Fall Management Policy, including updated Fall prevention interventions in the care plan. Review of Resident #35's Progress Notes dated 6/16/24, Review of Resident #35's Progress Notes dated 6/16/24 shows that Post Fall Observations were done but all other required documentation is lacking, i.e. documentation for three shifts post fall and documentation of the Director of Nursing (DON) follow-up as stated in the facility's policy. 4. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #36 who was admitted on [DATE], for Long Term care and found that Resident #36 had 2 falls (2/16/2024 and 4/30/24). Each fall lacked complete documentation per facility's Fall Management Policy, including updated Fall prevention interventions in the care plan. Review of Resident 36daTED's Progress Notes dated 2/16/2024 and 4/30/24. Review of Resident 36's Progress Notes dated 2/16/24 and 4/30/24 shows that Post Fall Observations were done but all other required documentation is lacking, i.e. documentation for three shifts post fall and documentation of the Director of Nursing (DON) follow-up as stated in the facility's policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #39 who was admitted on [DATE], for Long Term Care and found that Resident 39 had 3 falls (4/10/24, 5/14/24, and 6/17/24). Each fall lacked complete documentation per facility's Fall Management Policy, including updated Fall prevention interventions in the care plan. Review of Resident 39's Progress Notes dated 4/10/23, 5/14/24, and 6/17/24 shows that Post Fall Observations were done but all other required documentation is lacking, i.e. documentation for three shifts post fall and documentation of the Director of Nursing (DON) follow-up as stated in the facility's policy. 48648 Based on record reviews and interviews, the facility failed to follow the facility Falls Management Policy for 8 of 8 residents reviewed for falls thus far in 2024. Resident (#1,#6, #13,#30, #35, #36, #39 #41,) Findings: North County Associates, Falls Management Policy, last revised 7/2019 IV. Fall Reduction Actions A. DNS or designee will review fall incident reports regularly and identify potential patterns or trends. B. Quality Measures will be reviewed monthly and residents who triggers for falls and/or falls with major injury will have a completed record review by the DNS and/or designee. C. All falls will be reviewed at Quality Assurance or Fall Committee meetings on a quarterly basis, at a minimum. V. Procedure A. Complete Fall Risk Screen upon admission, quarterly, and as needed. B. Determine Risk Level and care plan according to risk level. C. When a fall has occurred the charge nurse will be notified in order to appropriately assess the resident and determine their medical status. D. A fall incident report will be completed after a resident has had a fall, whether it is witnessed or not. E. Complete Post Fall Observation Tool, following a fall, to help identify if the cause of the fall is related to mental status changes, physical limitations or environmental factors. F. Documentation must be completed in the nurse's note on each shift x3 following the fall. Residents' care plan will be updated with all new interventions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #1 who was admitted on [DATE] for Long Term Care and found that Resident #1 had 8 falls (1/29/24, 1/31/24, 2/2/24, 2/2/24, 2/9/24, 2/27/24, 3/22/24, 4/7/24). Each fall lacked complete documentation per facility's Fall Management Policy; including updated Fall prevention interventions in the care plan which failed to show any updates in this area since 1/26/2024. Review of Resident #1's Progress Notes dated 2/20/24, 3/22/24, 4/11/24, 4/15/24 show increased pain due to injuries sustained from falls. 2. On 6/25/24 a surveyor reviewed the EMR for Resident #41 and found that Resident #41 admitted to the facility on [DATE] had 9 falls (2/17/24, 2/20/24, 3/1/24, 3/4/24, 3/7/24, 4/13, 24, 5/24/24, 5/27/24, 6/16/24. Each fall lacked complete documentation per facility's Fall Management Policy including revision of Fall Prevention Interventions in Resident #1's care plan. 3. 06/25/24 at 02:22 p.m. a surveyor spoke with ([NAME]) to request additional documentation on the facility follow up to resident falls. One undated monthly fall summary template was located and provided. 4. On 6/26/24 at 9:15a.m. surveyors met with Director of Nursing to discuss the monthly review for Quality Measures for falls and lack of consistent documentation following falls. The Director of Nursing stated they talk about falls all the time, but the documentation is not there.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48648 Based on record reviews and interviews, the facility failed to provide a call bell to obtain assistance while on the bedside commode for 1 of 3 residents assessed to be a high risk for falls (Resident #1) Findings: On 6/25/24 a surveyor reviewed Resident #1's Electronic Medical Record and found that Resident #1 was admitted to facility on 1/26/24 with respiratory failure with hypoxia and since has had 8 unwitnessed falls. Resident #1 was rated upon admission as being a high risk for falls. On 6/25/24 a surveyor reviewed the progress notes in Resident #1's Electronic Medical Record (EMR) dated 3/22/24 and found a nurse's note that stated Resident was assisted to bed-side commode, CNA left her with call-bell not within reach. She then called out and fell to knees then onto her back (per resident). On 6/25/24, a surveyor reviewed the facility's Resident Incident Reporting Form, dated 3/23/24, for an incident that occurred 3/22/24 at 5:00a.m. that states (Resident #1 was assisted to bedside commode, then reaching for call bell fell on to floor mat and was found lying on her back. On 6/25/24 at 9:15 a.m. surveyors interviewed the Director of Nursing who agreed that a resident assessed to be at high risk for falls should have had their call bell when using the commode.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44049 Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 2 of 2 initial kitchen observations completed on 6/24/24 and 6/25/24. Additionally, the facility failed to ensure that food temperatures were recorded. Findings: 1- On 6/24/24 at 8:50a.m. - Initial observation of the Kitchen: Observed two unlabeled and undated pans of deserts in the fridge - The Food Service Director (FSD) stated, That is today's desert. Observed soiled ceiling tiles - The FSD stated that the ceiling was last cleaned a couple of months ago. Observed a wall mounted fan with light to moderate dirt blowing on the cooking area. Observed a cart mounted fan with moderate to heavy dirt blowing on the cooking area When the cook was asked for the temperature log while cooking today's breakfast she stated, I did not get them on here. She showed the surveyor the log pages and it was noted that documentation of temperature while cooking was lacking since last Friday 6/21/2024. She stated that she was not here over the weekend, but that they have been out straight. Upon closer examination of the log sheets, it was discovered that there were no temperatures recorded for all meals on 6/16/24, Supper meal on 6/17/24, Supper meal on 6/18/24, Supper meal on 6/19/24, Supper meal on 6/20/24, Supper meal on 6/21/24, All meals on 6/22/24, All meals on 6/23/24, and Breakfast on 6/24/24. There was no log sheet even available for week of 6/23/24. 2. On 6/25/24 at 8:03 a.m., observed refrigerator in the B-2 Unit Common Dining area to have a heavy layer of dust on the top. In both the freezer compartment and the refrigerator there was a light to moderate amount of dirt and dried food. This was confirmed with the unit charge nurse at that time. 3. On 6/25/24 at 8:45a.m,. a surveyor observed the resident refrigerator on B-1 Unit. The base plate is covered with a heavy amount of dirt and rust. This was confirmed with the charge nurse at that time. 4. Additional findings during the 6/25/24 return observation of the Kitchen were: 3 employee drinks discovered in the 2 reach-in fridges in the Kitchen, and a half-eaten ice cream sandwich was found in walk-in freezer. This was called to the attention of the Cooperate Food Service Consultant at that time.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on record reviews and interviews, the facility failed to perform adequate screening and documentation for Pneumococcal and/or Influenza vaccination as required for 2 out of 5 residents screened for vaccinations. (Resident #1, Resident #6) Findings: 1. On 6/25/24, a surveyor reviewed Resident #1's Electronic Medical Record (EMR) and found no Pneumococcal vaccinations recorded under Immunizations. Resident #1 was admitted to the facility on [DATE]. A surveyor reviewed the physical medical record and did not locate any documentation that Resident #1 had received, been offered, or refused the Pneumococcal vaccination. 2. On 6/25/24, a surveyor reviewed Resident #6's EMR and found no Pneumococcal or Influenza vaccinations were recorded. Resident #6 was admitted to facility on 10/26/23. A surveyor reviewed the physical medical record and did not locate any documentation that Resident #6 had received, been offered, or refused the Pneumococcal or Influenza vaccinations. A surveyor reviewed the facility policy titled Infection Control Immunizations-Influenza, Pneumococcal Policy- last revised 3/22: Each resident will be offered an Influenza Vaccine October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period. Each Resident will be offered a Pneumococcal Vaccine, upon admission unless the immunization is medically contraindicated or the resident has already been immunized. Proof the resident either received the Influenza and/or Pneumococcal vaccine, the vaccine(s) was contraindicated for medical reasons, or the resident refused the vaccine(s). On 6/26/24 at 10:30 a.m., a surveyor interviewed the facility Infection Preventionist and the Corporate Quality Improvement Nurse and confirmed the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on record reviews and interviews, the facility failed to perform adequate screening and documentation for coronavirus (Covid-19) as required for 2 out of 5 residents screened for Covid-19 vaccinations. (Resident #1, Resident #6) Findings: 1. On 6/25/24, a surveyor reviewed Resident #1's Electronic Medical Record (EMR) and found no coronavirus (Covid-19) vaccinations recorded. Resident #1 was admitted to the facility on [DATE]. A surveyor reviewed the physical medical record and did not locate any documentation that Resident #1 had received, been offered, or refused the Covid-19 vaccination. 2. On 6/25/24, a surveyor reviewed Resident #6's EMR and found no coronavirus (Covid-19) vaccinations recorded. Resident #6 was admitted to facility on 10/26/23. A surveyor reviewed the physical medical record and did not locate any documentation that Resident #6 had received, been offered, or refused the Covid-19 vaccinations. Review of Centers for Disease Control (CDC) guidelines for Covid-19 vaccinations for Long Term Care (LTC) residents is as follows: Consent or assent for a COVID-19 vaccine is given by LTC residents (or people appointed to make medical decisions on their behalf called a medical proxy) and documented in their charts per the provider's standard practice. On 6/26/24 at 10:30 a.m., a surveyor interviewed the facility Infection Preventionist and confirmed the CDC is consulted for standard practice in Infection Control at the facility. On 6/26/24 at 10:10 am, in a discussion with the facility Infection Preventionist and the Corporate QUality Improvement Nurse, it was confirmed the facility did not have a Resident Immunization policy for Covid-19 nor did the facility follow the CDC recommendations for screening LTC residents for Covid-19 Vaccinations.