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	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Rehab & Living Ctr	10 May Street 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, and interviews, the facility failed to ensure that care plans were developed in the area of comfort care for 1 of 2 reviewed for hospice care (Resident #22), in the area of wandering for 1 of 1 reviewed for elopement (Resident #4), in the area of dialysis for 1 of 1 reviewed for dialysis needs (Resident #6), and in the area of pain for 1 of 1 resident reviewed for pain management (Resident #25). Findings: 1.Review of Resident #22's medical record stated they were admitted to the facility in November of 2021. A review of a hospice follow-up noted dated 12/29/25 states, Problem 1Hospice care Z51.5, Continue comfort-focused hospice management, Respect patient preference for minimal intervention. On 4/29/26 at 12:50 p.m., a surveyor reviewed resident #22's current care plan which lacked identification of comfort care with interventions. On 4/29/26 at 12:55 p.m RN #1 confirmed with surveyor that the resident does not have Hospice (comfort measures) listed on their care plan. 2. Review of the orders for Resident #25 show: 04/23/2026 oxycodone 5 mg tablet 1.5 Tablet Oral 2 Times Daily and 04/23/2026 oxycodone 5 mg tablet 1 Tablet Oral PRN Every 4 Hours for 30 Days. Record review of Resident #25's care plan there is no documentation addressing pain. The charge nurse stated that the nurses on the unit do not create the care plan, that is done by the MDS coordinator and she has only been here a short while. 3. Resident #4 was admitted to the facility on [DATE] with a diagnosis of Dementia. Review of the admission MDS dated [DATE], Section E (Behavior), revealed the resident was coded for wandering behavior. The MDS further indicated the residents wandering placed the resident at risk of entering a potentially dangerous area, including outside the facility. Resident #4's admission assessment indicated the resident was at risk for elopement, and a wander bracelet was applied. Additional nursing progress notes dated 4/1/26 through 4/26/26 documented repeated wandering and exit seeking behaviors including attempts to leave the unit through secured doors. Residents #4's care plan lacked evidence of a wander/elopement risk and/or safety issues with intervention and goals. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/26 at 1:05 p.m., the surveyor confirmed the above finding with the Senior [NAME] President of Development and Operations 4. On 4/27/26 at 1:37 p.m., during an interview with Resident #6, a surveyor observed a double lumen, central line catheter at the right chest area with a dressing covering the insertion site. Clinical record review revealed Resident #6 was admitted in March, 2026. Diagnoses included End Stage Renal Disease (ESRD) and hemodialysis. The Minimum Data Set (MDS) 3.0, admission assessment, dated 3/16/26, noted in Section O, Special Treatments and Procedures, that Resident #6 receives dialysis and has IV (intravenous) access. A review of Resident #6's current care plan, initiated on 3/11/26, and revised 3/19/26, includes the following focus area and interventions: Dialysis: Risk of fluid volume excess/deficit and risk for infection related to End-Stage Renal Failure. Interventions: Fistula site will remain free of infection and will be patent for use at dialysis over the next 90 days. Dialysis per physician orders and dialysis center schedule. Daily fluid restriction. Monitor and report weight gain/loss as ordered by physician. Weights and vital signs as ordered. Consult with dietitian as needed. Monitor and report labs per physician orders. Inspect fistula site daily for thrill/bruit and signs of infection. Monitor for extremity pain, numbness/tingling, or swelling distal to access site. Observe for bleeding at dialysis site and for free bleeding (nose bleeds, frequent bruising) and report to MD. Review of the admission progress note, completed by nursing and dated 3/10/26, noted left arm has AV (arteriovenous) fistula, thrill and bruit positive, right chest has a central line. Review of an inpatient hospital note from nephrology, dated 2/23/26, stated Access: TDC (tunneled dialysis catheter), placed by interventional radiology 1/23/26. Has AVG (arteriovenous graft) but avoiding use given pseudoaneurysm close to site of prior cannulation. Review of a provider's note, dated 4/9/26, stated Labs are managed by the dialysis team, and he/she is currently receiving dialysis Monday-Wednesday-Friday.at [NAME] County Dialysis. On 4/29/26 at 2:50 p.m., in an interview with the Director of Nursing, the Infection Preventionist and the Assistant Director of Nursing, a surveyor discussed that Resident #6's care plan did not include the days he/she goes to dialysis or the location of the dialysis center. In addition, the care plan did not include the presence of a central line for dialysis access and did not include instructions for monitoring the site before and after dialysis, or address emergency procedures. A review of the facility's Dialysis Care Policy, dated 2/28/23, noted in the section Procedure. 6. Care plan should include access site inspections, fluid restrictions, dialysis schedule, and Dialysis Center and contact number.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, neglect, exploitation and misappropriation of resident property by failing to ensure that 2 of 5 Certified Nursing Assistants (CNAs) reviewed for in-service training completed the required training (#1 , #2 & #3). Findings: On 4/29/26 during a review of facility staff education records the following were noted: CNA #1 was hired on 6/20/25. Review of the employee record lacked evidence CNA #1 completed mandatory abuse neglect and dementia training upon hire. CNA #2 was hired on 10/14/25. Review of the employee record lacked evidence CNA #2 completed mandatory dementia training upon hire. CNA #3 was hired on 10/16/24. The last abuse neglect and dementia training received by CNA #3 was completed in 2024. The employee record lacks evidence of mandatory abuse & neglect and dementia training in 2025. On 4/30/26 at 1:05 p.m., the surveyor confirmed the above finding with the Senior [NAME] President of Development and Operations.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on record review, interview, and facility policy, the facility failed to ensure current provider orders reflected a resident's self-administration of respiratory medication, and failed to complete an assessment of a resident's ability to safely self-administer medication for 1 of 1 residents reviewed for tracheostomy care (R3).Findings: Review of the clinical record for R3 noted diagnoses which included: Chronic Obstructive Respiratory Disease (COPD), Chronic respiratory failure, and Tracheostomy. Review of R3's current provider orders, signed 4/24/26, included the following:An order originally written 6/12/25, for ipratropium 0.5 mg (milligrams) (2.5 mg base)/3 ml (milliliter) nebulization solution, (1) ampule for nebulization two times daily for COPD.An order originally written 12/18/25, for sodium chloride 3% for nebulization (1 unit) inhalation administer 1-3 ml every 4 hours via tracheostomy to help clear tracheal secretions. Review of R3's current care plan, with a revision date of 3/30/26, included the following focus areas and interventions: Respiratory: (R3) is unable to maintain oxygen saturation secondary to Chronic Respiratory Failure and COPD as evidenced by tracheostomy, need for respiratory medications/treatments, and supplemental oxygen. Interventions: (R3) is able to self-administer medications/treatments, nebulizer treatment as ordered by the Provider.And, R3 self-administers respiratory medications, i.e., nebulizers, etc. Medications will be stored in the Nurse Treatment Cart. Interventions: Ask (R3) if all medications are needed and document when they have been taken.Review appropriateness of continuing self-administration of medications. A review of R3's clinical record did not contain evidence that the facility had completed an assessment for R3's ability to safely self-administer medications. On 4/29/26 at 1:25 p.m., in an interview with a surveyor, the Assistant Director of Nursing (ADON) confirmed R3 self-administers nebulizer treatments. The ADON reviewed the provider orders and confirmed there was no current order for R3 to self-administer medications. The surveyor asked if staff had completed an assessment for the resident's ability to safely self-administer medications. The ADON stated yes, that the staff and physician meet with the resident and a form is completed. At the time of the interview, the ADON stated she was unable to locate evidence that an annual assessment for safe self-administration of medication had been completed. On 4/29/26 at 1:45 p.m., the ADON provided the surveyor a copy of the last assessment for R3's ability to safely self-administer medications, dated 3/22/24. The ADON also provided copies of provider orders, dated 2/23/24, which stated R3 could self-administer budesonide and ipratropium/albuterol via nebulizer. The ADON stated the order for R3 to self-administer nebulizer treatments had been dropped off when the orders were last changed. The ADON confirmed the current orders do not specify the resident may self-administer nebulizer treatments, and that the last assessment for safe self-administration of medication had been completed 2 years ago. A review of the facility's policy for Self-Administration of Medications, stated in Section II. Procedure. G. If resident is self-administering his/her own medications, completion of the self-administration screen will be completed initially, quarterly, and with a change in resident's medical condition.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to ensure the Minimum Data Set (MDS) Version 3.0 assessments were accurately coded in the areas of Hospice for 1 of 2 sampled residents (Resident #48).Finding:A review of Resident #22's clinical record revealed a physician's order dated 8/27/25 Admit the resident to hospice if appropriate due to suspected 6 months or less .Resident #22's quarterly MDS Version 3.0 assessment dated [DATE], Section O - Special Treatments, Procedures, Programs, was incomplete in the section for Hospice.On 4/29/26 at 3:30 p.m MDS coordinator confirmed the above finding with 3 surveyors.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on policy review, observation, and interview, the facility failed to provide appropriate treatment to prevent the risk of complications related to enteral feeding for 1 of 1 resident reviewed for tube feeding (Resident #8).Finding:Enteral Tube Policy last revised 7/22 states, enteral feeding tube placement will be verified prior to the initiation of feeding and/or medication administration. X-ray's is the only way to verify placement.On 4/28/26 at 11:05 a.m., a surveyor observed Registered Nurse (RN) #1 administer medications via a gastrostomy tube for Resident #8 without checking tube placement.On 4/28/26 at 2:13 p.m in an interview with a surveyor, RN #1 confirmed they only check the tube placement if I feel something is wrong and they also confirmed that the order states to check placement each shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to follow professional standards of practice with usage of Personal Protective Equipment (PPE) (Resident #39). Findings: On 4/27/26 at 10:41 a.m., a surveyor observed a Contact Precautions sign and Personal Protective Equipment (PPE) caddy posted on the door of room [ROOM NUMBER]. The Contact Precautions sign instructed staff to wear gloves and gown for all care and resident contact and to remove PPE prior to exiting the residents room. The surveyor observed RN #2 carrying a supply caddy containing diabetic testing supplies. RN #2 donned gloves upon entering the room, greeted the resident, and placed the supply caddy on the bed next to Resident #39's legs while obtaining the resident's blood glucose. Following the blood glucose check, RN #2 exited the room and removed his/her gloves. During an interview following the observation, RN #2 stated the Resident #39 is on Contact Precautions for Extended-Spectrum Beta-Lactamase (ESBL) in the urine. When asked about the protocol for contact precautions. RN #2 stated gowns and gloves were to be worn during personal care; however, she was not providing personal care at the time. On 4/27/26 at 10:48 a.m., the surveyor discussed the observation of RN #2 and interview findings with the Unit Manager. The Unit Manager stated staff were required to wear appropriate PPE when providing care to any resident on Contact Precautions, including while obtaining a blood glucose reading The Unit Manager confirmed RN #2 should not have placed the diabetic testing supply caddy on the residents bed, as the caddy would require disinfection due to the potential for contamination and additional staff education regarding Contact Precautions was needed. On 4/27/26 at 3:00 p.m., a surveyor discussed the above finding with the Administrator.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews, the facility failed to ensure that mail was delivered to all residents on 1 of 6 days, Monday through Saturday. (Saturday) Finding: During a group interview on 4/27/26 at 2:15 p.m., four residents voiced concerns regarding not receiving mail on Saturdays.On 4/30/26 at 1:05 p.m., during an interview, the Senior [NAME] President of Development and Operations confirmed mail was not routinely delivered on Saturdays because mail had previously been lost. The Senior [NAME] President of Development and Operations stated the weekend supervisor will be delivering the mail as needed on Saturdays.