STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205065	A. BUILDING _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER RIDGE CENTER	3 BRAZIER LANE KENNEBUNK, ME 04043

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F 000	INITIAL COMMENTS On 5/28/2025 an unannounced on-site visit was conducted at River Ridge Center to investigate complaint #ME00051628, #ME00051654, #ME00051664 and #ME00051007. It was determined that River Ridge Center was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000	RiverRidge provides this plan of correction without admitting or denying the validity of existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609	The events for Resident #6 happened in the past and cannot be corrected. All residents have the potential to be affected. The Administrator and DON will be educated on OPS300 Genesis Policy - Abuse Prohibition inclusive of timely reporting for any allegations of abuse, neglect, exploitation, or mistreatment. Audits on risk events will be weekly x 4 weeks then monthly x 3 months to ensure timely reporting. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	6/30/2025

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

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F 609	Continued From page 1	F 609		

incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to report a fall with suspicion of negligence and significant injury within the required time frame for 1 out of 1 resident. (Resident #6)

Findings:

The Department of Licensing and Certification (DLC) received a report from the facility on 5/15/25 at 3:50 p.m. about a resident who fell on 5/13/25 at 10:50 p.m. The report was labeled as FINAL. There was no initial report received by the department. The report indicated Resident #6 had fallen from an elevated bed after being left alone.

On 5/28/25 a surveyor reviewed the Genesis Health OPS-300 Policy - Abuse Prohibition that stated under Section 7
"Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following."
"7.3 Report all allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if the event results in serious bodily injury."
"7.4 Report all allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of

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F 609	Continued From page 2 unknown source), suspected criminal activity, and misappropriation of patient property within 24 hours if the event does not result in serious bodily injury." On 5/28/25 a surveyor reviewed the Facility Risk Management Report #772, dated 5/14/25 in the Electronic Medical Record (EMR) that confirmed Resident #6 had experienced a fall on 5/13/25 at 10:50 p.m. after Certified Nursing Assistant (CNA) #3 had raised the bed and left the resident unsupervised. On 5/28/25, a surveyor reviewed Resident #6's EMR. A Progress Note, dated 5/14/25 at 12:20 a.m., documented an x-ray of the lower back had been ordered on 5/14/25 for Resident #6 following the fall due to increased pain in the lower back and leg for a suspicion of fracture(s). On 5/28/25 a surveyor reviewed a Record of Death for Resident #6 dated 5/15/25 with a time of 7:50 a.m. On 5/28/25 2:23 p.m. a surveyor met with the Administrator and the Market Clinical Advisor to discuss the above findings and confirmed an initial report was not sent timely following the incident.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		

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F 689	Continued From page 3 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, the facility failed to ensure that a resident received adequate supervision when resident was left unattended in a raised bed. This action resulted in resident fall d injury for 1 of 6 residents reviewed for falls (Resident #6). In addition, the facility failed to ensure that the resident environment was free of accidents and hazards. Findings: 1. On 5/15/25 at 3:50 p.m. the Department of Licensing and Certification (DLC) received a facility reported incident that on 5/13/25 at 10:50 a.m. Resident #6 had been left alone in an elevated bed resulting in a fall between the wall and the bed. Record review of Resident #6's Minimum Data Set assessment (MDS), dated 4/19/25 under section GG indicated that Resident #6 was dependent on staff for almost all Activities of Daily Living (ADL) needs including bed mobility. On 5/28/25 a surveyor reviewed Resident #6's care plan and found a focus stating Resident #6 is at risk for falls with interventions including "Utilize low bed." On 5/28/25 a surveyor reviewed documentation of Certified Nursing Assistant (CNA) #3's verbal statement of the incident dated 5/15/25, "I was changing (Resident #6), I had the bed at my waist level and left the room to get more linens from the cart, when I heard a sound in (his/her) room. I	F 689	The events for Resident #1 happened in the past and cannot be corrected. All nursing staff will be educated in keeping the resident safe bed in proper position when leaving a resident unattended. The closet door with the missing doorknob and jagged edges was removed to ensure a safe surface and proper closure. The electrical/storage room door was immediately secured with a functioning lock, the jagged splintered wood beneath the keypad was repaired and access was restricted to authorized personnel only. The Maintenance Director conducted a facility-wide audit of all doors, storage areas, and electrical panels to ensure all doors had functioning locks to ensure resident safety.	6/30/2025

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F 689	Continued From page 4 came back in and saw that (Resident #6) was on the floor." On 5/28/25 a surveyor reviewed Resident #6's Electronic Medical Record (EMR) under progress notes and found a general , dated 5/14/25 at 12:20 a.m. that stated Resident #6 was found lying on the floor on the right side of the bed and was having lower back pain and left leg pain. The provider contacted at that time ordered an x-ray, suspecting a fracture. On 5/28/25 at 2:23 p.m., a surveyor met with the Administrator and the Market Clinical Advisor with the above findings. 2. On 5/28/25 at 12:46 p.m., during an environmental observation of the Ossipee unit hallway, a surveyor observed an empty closet located in the corridor. The closet door was missing a doorknob and had jagged splintered wooden edges on the side of the door. On 5/28/25 at 2:27 p.m., during an environmental tour of the Mousam unit hallway with the Unit Manager. A Surveyor observed the following: - An unlocked storage room that contained electrical panels and a locked cabinet labeled "Biohazard". - An unlocked door labeled Electrical Room. No Admittance. A sign on the door read "Danger Please keep door closed at all times." The door was equipped with a non-functional keypad lock and the area beneath the keypad was jagged with splintered wood. On 5/28/25 at 2:58 p.m. the surveyor confirmed the above findings with the Administrator and	F 689	All staff members will be re-educated on the facility's policy for reporting environmental hazards and maintenance needs promptly through the TELS system. The Maintenance Director or designee will audit all doors and locks for any hazards. These audits will be weekly x 4 weeks then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	6/30/2025

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F 689	Continued From page 5 Market Clinical advisor.	F 689		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842	The events #6 happened in the past and therefore cannot be corrected. An audit was completed to ensure that all residents that have experienced an unwitnessed fall recieved a neurological evaluation and continued neurological assessments. Licensed staff will be educated regarding performing neurological evaluations following an unwitnessed fall. DON/Designee will perform audit to ensure neurological evaluations are completed following any unwitnessed falls. Audits will be conducted weekly x4 weeks, then monthly x3 months and the results of these audits will be brought to QAPI for further	6/30/2025

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purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to maintain a complete medical record for 5 of 5 Residents reviewed for unwitnessed falls.

A surveyor reviewed the facility policy Titled "Centers' Nursing Policies - NSG215 Falls Management" last reviewed on 3/15/24 under

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Section 5.3 ;
"Any patient who sustains an injury to the head from a fall and/or has a fall unwitnessed by staff will be observed for neurological abnormalities by performing neurological check, per policy."

A surveyor reviewed the facility policy Titled "Centers' Nursing Policies - NSG204 Neurological Evaluation" last reviewed 2/1/23 reads;
"Neurological evaluation will be performed as indicated or ordered. When a patient sustains injury to the head or face and/or an unwitnessed fall, neurological evaluation will be performed:
Every 15 minutes x two hours, then
Every 30 minutes x two hours, then,
Every 60 minutes x four hours, then
Every eight hours until at least 72 hours has elapsed.

1. On 5/28/25 a surveyor reviewed Resident #1's Electronic Medical Record (EMR) under Progress notes and learned Resident #1 had an unwitnessed fall in March 2025. A Neurological Assessment Log was located for this incident but was found incomplete for the 72 hours following the fall. A review of the progress notes did not provide an explanation for the missing assessments.

2. On 5/28/25 a surveyor reviewed Resident #2's EMR under Progress notes and learned Resident #2 had an unwitnessed fall in March 2025 at. A Neurological assessment log was not located for this incident.

3. On 5/28/25 a surveyor reviewed Resident #3's EMR under Progress notes and learned Resident #3 had an unwitnessed fall in April 2025. A neurological assessment log was located for this

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F 842	Continued From page 8 incident but found incomplete for the 72 hours following the fall. A Review of the progress notes following the incident did not provide an explanation for the missing assessments. 4. On 5/28/25 a surveyor reviewed Resident #4's EMR under Progress notes and learned Resident #4 had an unwitnessed fall in May 2025. A Neurological Assessment log was not located for this incident. 5. On 5/28/25 a surveyor reviewed Resident #5's EMR under Progress notes and learned Resident #5 had an unwitnessed fall in May 2025. A Neurological assessment log was not located for this incident. On 5/28/25 at 3:50 p.m. a surveyor met with the Corporate Representative and learned the facility was unable to produce the missing logs or confirm that the neurological assessments were completed for 72 hours post fall for the above residents per facility policy.	F 842		