

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025	
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 609 SS=D	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. 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page 1 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	F 609			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page 5	F 689			
F 842	Market Clinical advisor.	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				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page 6 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	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page 7 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	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205065		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/28/2025	
NAME OF PROVIDER OR SUPPLIER RIVER RIDGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3 BRAZIER LANE KENNEBUNK, ME 04043			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
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			