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	205136	A. BUILDING _____ B. WING _____	06/26/2024

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SOUTHRIDGE REHAB & LIVING CTR	10 MAY ST BIDDEFORD, ME 04005

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F 000	INITIAL COMMENTS From 6/24/24 through 6/26/24, on-site visits were conducted at Southridge Rehabilitation & Living Center for the purpose of the annual Long Term Care Survey Process. It was determined that Southridge Rehabilitiation & Living Center was not in substantial compliance with 42 CFR 483, subpart B-Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

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

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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 217 - Window curtain stained, Resident Room 219 - Window curtain off track, Resident Room 223 - Stained ceiling tile above bed A Resident Room 225 - 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 228 - Window curtain stained, Resident Room 242 - Resident bathroom toilet will not stop running.	F 584		

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F 584	Continued From page 2 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 101 - Both resident's bed curtains have missing hooks and chipped paint in the middle of the ceiling, Resident Room 107 - Left lower drawer under sink has chip in the laminate, creating a hazard and an uncleanable surface. Resident Room 109 - 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.	F 584		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the facility Falls	F 684		

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F 684	Continued From page 3	F 684		

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 7/21/21, 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 2/16/23, 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.

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3. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #35 who was admitted on 6/15/21, 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 9/15/21, 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.

5. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #39 who was admitted on 1/27/23, 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

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F 684	Continued From page 5	F 684		

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.

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.

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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. "

1. On 6/25/24, a surveyor reviewed the Electronic Medical Record (EMR) for Resident #1 who was admitted on 1/26/24 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 6/2/2021 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 (Kim) to request additional documentation on the facility follow up to resident falls. One undated

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F 684	Continued From page 7 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.	F 684		
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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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	F 689		

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F 689	Continued From page 8 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 onto 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.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

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F 812	Continued From page 9	F 812		

serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
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

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F 812	Continued From page 10 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.	F 812		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		

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F 883	Continued From page 11 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883		

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immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
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 1/26/24. 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:

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(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 883	Continued From page 13 "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.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative	F 887		

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

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F 887	Continued From page 14	F 887		

receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National

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F 887	Continued From page 15	F 887		

Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
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 1/26/24. 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."

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F 887	Continued From page 16 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.	F 887		