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	205136	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE REHAB & LIVING CTR	**10 MAY ST BIDDEFORD, ME 04005**

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F 000	INITIAL COMMENTS	F 000		

On 2/19/25 and 3/5/25, the Division of Licensing and Certification conducted on-site visits at Southridge Rehab & Living Center for the purpose of completing a complaint investigation for #ME00050625. It was determined that Southridge Rehab & Living Center was not in compliance with 42 Code of Federal Regulation (CFR) Part 483, Subpart B, Requirements for Long Term Care Facilities.

At 42 Code of Federal Regulations (CFR) Part 483, Subpart §483.25(d)(2), - F689; the facility failed to provide supervision to a resident after staff found resident in closet in another resident room, with an open window, for a resident identified as an elopement risk and had previous exit seeking attempts. Shortly after, the resident was found outside in a snowbank with a second story window open. Noncompliance with this requirement constituted a determination of immediate jeopardy (IJ), beginning on 2/17/25. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. See §483.25(d)(2), also known as F689, for details.

On 3/4/25 at 12:26 p.m., the Administrator was provided written notification (IJ template for F689) related to the IJ situation, and a removal plan was requested.

On 3/5/25 at 2:43 p.m., the facility summitted an acceptable removal plan. The removal plan was reviewed and approved by the State Agency on

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

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F 000	Continued From page 1 3/5/25 at 2:58 p.m. This removal plan indicated the following: - Windows of B2 and A1 Units were retrofitted to limit opening distance. - Staff education provided for Safety protocols for residents with behaviors, when to call Doctor or on call provider, one on one, and documentation requirements. - Secure doors checked on 2/18/25. - A Root Cause Analysis was completed. - Staff education provided to Nursing Staff on Exit Seeking Safety Plan which includes the following: 1. Stay with resident. 2. Medicate if necessary. 3. Observe medication efficacy. 4. Call provider to report exit seeking behaviors and to report if medication not effective. 5. Call family for support, if available. 6. Documentation of behaviors. 7. Contact Director of Nursing or Administrator. On 3/5/25, a surveyor verified that the facility's removal plan was implemented and effective by the observations of window stops, interviews with staff regarding education and understanding, review of educational content and staff completion of education. The surveyor determined the removal of the IJ was on 3/5/25.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		

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representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the physician when interventions were ineffective in relieving resident's distress. In addition, the facility failed to notify the physician after the resident was missing and required a search to locate or when the resident experienced a life-threatening elopement.

Findings:

On 2/17/25 the Division of Licensing and Certification received a facility reported incident, which indicated Resident #1 was found outside in a snowbank having fallen from a second story window.

Review of facility policy "Resident Elopement Policy" last revised 9/23 states under:
II. PROCEDURE
-Section D vii - "The physician and resident's responsible party will be notified."
-Section G. "The resident's plan of care is to be updated with appropriate interventions to meet the resident's current needs"
-Section H "Document in medical record. Indicate time the search began and the time the search ended."

On 2/19/25, druing review of Resident #1's the Medication Administration Record, stated a PRN (as needed) medication for anxiety was given with

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F 580	Continued From page 4 no effect on 2/15/25 at 7:34 p.m. and 2/16/25 at 6:00 p.m.. There is no evidence to support that other interventions were tried and effective/ineffective or that a physician was notified. On 2/19/25, during review of Resident #1's electronic medical record (EMR), Clinical notes stated that Resident#1 had been found missing from his/her bed on 2/16/25 and located in the closet of another room where a window had also been found open. The notes lacked evidence the time the search began and time when resident was found. The notes also stated that interventions and medications had been unsuccessful to relieve resident's agitation. There is no evidence that a provider was notified. On 2/17/25 at approximately 1:00 a.m., Resident #1 was found outside in a snowbank underneath an open second story window. Resident #1 was transferred to the hospital and diagnosed with hypothermia and frostbite. The medical record lacked evidence that the facility physician was notified. On 2/19/25 at 12:15 p.m., a surveyor discussed the above findings with the Administrator and Director of Nursing and confirmed that physician was not notified of resdient behaviors and elopement.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		

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implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

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This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to follow the baseline care plan implemented for Resident #1 in the area of Behaviors for 5 of 5 days that resident was in the facility.

Findings:

On 2/19/25, during review of Resident #1's baseline care plan, dated 2/12/25, stated in the area for Behaviors: Document behaviors in Treatment Administration Record (TAR) or on behavior monitoring form every shift.

A review of Resident #1's Electronic Medical record (EMR) under TAR and Clinical Notes, failed to show documented behaviors for every shift between 2/12/25 and 2/17/25.

On 2/28/25 at 8:51a.m., during an interview with CNA #1, who worked shifts with Resident #1 on 2/12/25, 2/13/25, 2/14/25, 2/15/25 and 2/16/25. CNA #1 stated that Resident #1 was wandering, exit seeking, refusing care, distressed frequently since arrival on B2 Unit. CNA #1 states that he/she was not told Resident #1 had eloped several times in Residential Care.

On 2/28/25 at 9:49 a.m., during an interview with CNA #2, who worked shifts with Resident #1 on 2/12/25, 2/13/25, 2/15/25 and 2/16/25. CNA #2, confirmed that Resident #1 had been experiencing frequent wandering and exit seeking behaviors and was very difficult to manage when his/her family was not present.

On 2/19/25 at 12:15 p.m., during an interview with

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F 655	Continued From page 7 the Administrator and the Director of Nursing, were unable to provide additional evidence or an explanation for not following the care plan for montoring behaviors.	F 655		
F 689 SS=J	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 interviews, observations and record reviews, the facility failed to provide supervision to a resident after staff found resident in closet in another resident room, with an open window. Resident was previously identified as an elopement risk and had previous exit seeking attempts for 1 of 2 residents identified for elopement risk. Shortly after, the resident was found outside in a snowbank with a second story window open. This failure created an immediate jeopardy situation. (Resident #1) Findings: On 2/17/25 the Department of Licensing and Certification received a facility reported incident indicating [Resident #1] fell into snow from second floor on 2/17/24. [Resident #1] found in snowbank at approximately 1:00 a.m. Medical record indicated that on 2/12/25,	F 689		

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Resident #1 was transferred from the facility residential care unit to a secured long term care unit(B1 Unit). The transfer was related to safety due to increased dementia behaviors including exit seeking and recent elopements from the residential care facility.

Resident #1 is 92 years old with a diagnosis of dementia. On 2/12/25 the facility completed elopement assessment and determined Resident #1 was a High Risk for elopement. Resident#1 was wearing a Secure Care anklet (monitor for wandering residents).

On 2/19/25, during review of Resident #1's nursing progress notes, stated on 2/14/25 at 11:51 a.m., a nurse administered as needed medication for anxiety and initiated a 1:1 for safety from staff due to wandering, exit seeking and refusal of care. Documentation states that medication was effective and daughter visiting.

Resident #1's Medication Administration Record (MAR), stated on 2/15/25 at 1:29 p.m., and on 2/15/25 at 7:34 p.m., a nurse administered as needed medication for anxiety and both times the response was "not effective."

Resident #1's nursing progress notes stated on the night of 2/16/25 and into the early morning of 2/17/25, Resident #1 exhibited exit seeking behaviors, pacing, not responding to redirection and medications were not effective.

On 2/28/25 at 9:49 a.m. during an interview with CNA#1, by phone, stated a bed check was done on 2/17/25 around 12:20 a.m. and Resident #1 was found missing. The staff searched and found Resident #1 in the closet of another resident

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room. The window in that room was also found open. The residents in that room were both asleep when Resident #1 was found. CNA #1 stated that neither resident sleeping in that room would have been able to exit their bed independently to open the windows.

On 2/28/25 at 11:41 a.m., during an interview with PSS #1 stated that at on 2/17/25 1:00 a.m. he/she was taking a break outside with another staff member from Residential Care and found Resident #1 on a snowbank underneath an open second floor window. Resident #1 was assessed by a facility nurse and found to be alert, tearful, oriented to self, scrapes on knees and a bump on his/her head. PSS#1 called 911 and went to alert the facility staff that resident was outside. The long-term care unit staff were unaware Resident #1 had gone missing again. Resident #1 was transferred by Emergency Medical Services (EMS) to the Emergency Room.

During review of Residents #1 Hospital Discharge Summary, dated 2/20/25, stated that Resident #1 was diagnosed with hypothermia, metabolic encephalopathy secondary to hypothermia and hypoxia and frostbite. Resident discharged back to facility on 2/2025 with orders by facility provider included comfort measures only and hospice.

According to the archived records from the National Weather Service, the temperature range on 2/16/25 was 17-23 degrees Fahrenheit with light snow.

On 2/19/25 at 10:00 a.m., during an interview with the facility Maintenance Director, all facility windows on B2 and A1 units had been assessed and retrofitted with window blockers that limited

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F 689	Continued From page 10 opening windows to 6 inches. Prior to this, according to the Maintenance Director, the windows could be easily opened. Some of the facility windows had very low sills and could be easily accessed. This was completed by 2/18/25 around 11:00 a.m. "Resident Elopement policy" last revised 9/2023 and found under section II (Procedure), Item G. "The resident's plan of care is to be updated with appropriate interventions to meet resident's current needs." And under section II, Item H. "Document in medical record. Indicate time the search began and the time the search ended." There is no documentation to support that staff followed the facility's policy when Resident #1 went missing the first time on the night of 2/17/25. Based on the above information, IJ was called on 3/4/25 for the facility's failure to provide adequate supervision to a resident with a history of exit seeking and elopement that resulted in a fall from a second story window into a snowbank. Staff on B2 were unaware the resident had been missing a second time until alerted by residential care staff after the fall. The facility's failure to provide these services constituted an immediate jeopardy situation. Please see F-0000 Initial Comments related to the IJ removal plan.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		

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F 757	Continued From page 11 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to monitor targeted behaviors to support the use of antipsychotic and antianxiety medications for 1 resident reviewed for unnecessary medications and behavior monitoring. Findings: Review of Resident #1's Physician Order Sheet has the following orders for Psychotropic Medications: -Sertraline 100 mg(milligram) tablet one time daily oral for Unspecified dementia, Moderate, with mood disturabance. -Clonazepam 0.5 mg tablet two times daily oral for Generalized Anxiety disorder -Lorazepam 100 % power (0.25 ml) topical As needed Every Four Hours for Ninety Days for Generalized Anxiety Disorder	F 757		

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Review of Resident #1's Physician Order Sheet order, dated 2/12/25 that states: "Behavioral/Psychotropic Medication Monitor Notes: Behavior monitoring for psychotropic medications below: Antipsychotics, Antianxiety, Antidepressants, Sedative/hypnotics *Please document ALL behaviors including those "Normal" for the resident. Physical Monitors: 1. Behavioral Symptoms/Effective?/Non-Pharmacological Interventions/Number of Episodes/Psychoactive Side Effects" Frequency: Three Times Daily (Nurse Day Shift, Nurse Evening Shift, Nurse Night Shift).

Review of Resident #1's Care plan included under interventions "Monitor, report and document changes in mentation" and "If [Resident #1] is agitated or restless, provide distration"

Resident #1 was admitted to Long Term Care Unit from Residential Care with diagnosis of dementia due to with exit seeking and wandering behaviors.

On 2/19/25, during review of the Treatment Administration Record (TAR) for Resident #1, between the dates of 2/12/25 and 2/17/25 there is no documentation on the TAR that nursing followed this monitoring behaviors ad physician order directed.

The Medication Administration Record (MAR) showed 4 documented times that an "as needed" psychotropic medication was given between 2/12/25 and 2/17/25. There is no documentation as to why this drug was administered for 3 of 4

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

(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 757	Continued From page 13 times it was administered to Resident #1. During review of progress notes for Resident #1, between the dates of 2/12/25 and 2/17/25, the nursing notes failed that supported the ordered behavior monitoring for psychotropic medications. In addition, nursing notes do not explain why an "as needed" medication was administered or what nonpharmacological interventions were attempted prior to administering an as needed medication. On 2/19/25 at 12:15 p.m., during an interview with the Administrator and the Director of Nursing and discussed the above findings.	F 757		