Genesis

5/15/24

To: Celine Donohue, R.N.
Long Term Care Supervisor
Division of Licensing and Certification

Re: Springbrook Center
Plan of Correction

Dear Ms. Donohue,

On April 25, 2024 the Division of Licensing and Certification conducted a complaint survey at Springbrook Center. As a result of the survey, the surveyors alleged that the facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies with the facility's plan of correction for the alleged deficiencies. Preparation of the plan of correction does not constitute an admission by the facility of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.

Please consider this letter and the plan of correction to be the facility's credible allegation of compliance. The facility will achieve substantial compliance with the applicable certification requirements by May 28, 2024. Please notify me immediately if you do not find the plan of correction acceptable.

Thank you for your assistance with this matter. Please call me if you have any questions.

Sincerely,

Emily Saucier, MLA, MPH
Administrator
Springbrook Center
300 Spring St. Westbrook, ME
207-856-1240 ext. 1111

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205068 | A. BUILDING _____ B. WING _____ | C 04/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRINGBROOK CENTER | 300 SPRING ST WESTBROOK, ME 04092 |

| (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<br><br>On 4/25/2024, an unannounced on-site visit was conducted at Springbrook Center for the purpose of an investigation of complaints #ME00047149 and #ME00047169. It was determined that Springbrook Center was not in substantial compliance with 42 CFR 483, Sub-part B-Requirements for Long Term Care Facilities | F 000 | | |
| F 557 SS=D | Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interviews, the facility failed to ensure that a resident was treated with dignity and respect for 1 of 11 residents reviewed. (Resident #5)<br><br>Findings:<br><br>On 4/25/2024 at 8:20 a.m., Resident #5 was observed in the common area of Wayside Gardens Unit in his/her wheelchair sitting at the dining table naked from the waist down. Two CNAs were observed also in the dining area serving other residents and did nothing to preserve the resident's dignity. (CNA1 and CNA2) The LPN (LPN1) who was passing meds nearby was called to assist in removing resident | F 557 | Resident #5 will be interviewed for personal preferences related to grooming and clothing.<br><br>All residents have potential to be affected.<br><br>The DON or designee will provide education to direct care staff on Resident Right's and policy OPS213 Treatment: Considerate and Respectful.<br><br>The DON or designee will audit Residents' personal appearance weekly for four weeks then monthly for three months or until resolved to ensure care for grooming and clothing is provided in a considerate and respectful way and report findings at the monthly QAPI meeting. | 5/28/24 |

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

NHA | 5/15/24

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205068 | A. BUILDING _____ B. WING _____ | C 04/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRINGBROOK CENTER | 300 SPRING ST WESTBROOK, ME 04092 |

| (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 557 | Continued From page 1<br>to his/her room.<br><br>At 8:30 a.m. the Director of Nursing came to the unit and the above findings were confirmed with him at that time. | F 557 | | |