Department of Health and Human 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 05/12/2025

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) COMPLETE DATE
T 001	Initial Comments On 5/12/2025, an on-site investigation was conducted at Springbrook Center to investigate complaint #ME00051566 . It was determined that Sprinbrook Center was not in substantial compliance with 101-44 CMR Chapter 110-Regulation Governing Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001		
T 439	17.E.6. Resident Identification Resident Identification There shall be provision for assuring proper identification of residents by all personnel administering medications. This REQUIREMENT is not met as evidenced by: Based on the complaint intake form, clinical record reviews, interviews, and facility policy, the facility failed to identify the appropriate resident when passing medications resulting the CNA-M admisistering medications to the incorrect resident that resulted in a resident being transported to an Acute Care Emergency Department and later admitted to the hospital critical care unit for monitoring and treatment of low blood pressure. (Resident #1) Findings: The Division of Licensing and Certification received an Adult Protective Services (APS) complaint that indicated on 5/8/25, at 9:20 a.m.,	T 439	The event occurred in the past and cannot be corrected. Immediately following the incident it was validated that the resident had both an identification bracelet on and a photo in the electronic medical record. All residents have the potential to be affected by this deficient practice. The DON or designee will validate that all residents have a proper identification bracelet and photo in the electronic medical record to aid in proper identification of patients during medication administration. The DON or designee will provide education to licensed nurses and medication technicians on policies NSG108: Identification of Patient and 7.1 Medication Administration General Guidelines. The DON or designee will assess medication administration competency for licensed nurses and medication technicians. The DON or designee will observe medication passes weekly for four weeks then monthly for three months or until resolved to ensure patients are properly identified during medication administration and report findings at the monthly QAPI meeting.	6/4/25

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T 439	Continued From page 1 Resident #1 received another resident's medications which resulted in a hypotensive episode. Resident #1 was transported to the emergency room and subsequently admitted to the critical care unit (CCU). A review of nursing documentation dated 5/8/25 at 9:33 a.m., stated, "[Med tech] approached me [Nurse] and stated that she gave the meds of [Room 6B to Room 6A]. On assessment, patient appears to be stable and no complaints. Vital signs were taken immediately and stable. Reported incident immediately to [Doctor] and [Nurse Practice educator]. He/she was reevaluated by MD immediately." A review of the physician note dated 5/8/25, signed at 11:18 a.m., stated, "I was asked to see [Resident #1] acutely as [he/she] received the wrong medications on morning pass. Meds taken at 09:20 this morning incorrectly received: Amlodipine 10 mg (milligram), Aspirin 81 mg, Calcium carbonate 500 mg, Clonidine 0.3 mg, Furosemide 80 mg, Losartan 100 mg, Metoprolol tartrate 100 mg, Nephro-Vite 0.8 mg, Omeprazole 20 mg, Prednisone 30 mg, Sertraline 100 mg, Sevelamer 800 mg ... My greatest concern is for [his/her] blood pressure, having received amlodipine 10/clonidine 0.3/losartan 100/metoprolol 100 as well as furosemide 80 (but [he/she] usually takes torsemide 10 mg daily). Blood pressure checks every 15 minutes through 8 PM ... As such, we will have a low threshold for sending to ER, but currently with a strong BP (Blood Pressure) and safe to continue to monitor here with frequent checks." A nursing note dated 5/8/25 at 1:57 p.m., stated, [Resident #1] was transferred to hospital for abnormal Vital Signs.	T 439		

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T 439	Continued From page 2 On 5/12/25 at 1:08 p.m., during an interview with Certified Nurse's Assistant - Medication Aide (CNA-M) #2, she stated she had grabbed the medication cards from the slot labeled 6A (indicating the medications were for the resident in Room 6 bed A). She then opened up the Medication Administration Record for the name on the card and began preparing the medications. She then entered the room and asked the resident in 6A if he/she was [the name on the medication cards]. The resident stated he/she was that name and was given the medications. When the CNA-M #2 returned to the cart, she realized she had given resident in Room 6A resident in Room 6B's medications. She immediately notified the nurse. At this time, the CNA-M #2 confirmed she failed to identify the resident using the picture and the identification bracelet he/she had on. The facilities "Identification of Patient" policy and procedure revised on 10/15/24 states, Purpose: "To identify a method of patient identification." Practice Standards: Staff will use at least two patient identifiers to verify patient identity while being evaluated or prior to undergoing procedures/treatments. The facilities "Medication Administration General Guidelines" policy and procedure revised on 1/25 states, "Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include: Check identification band, Check photograph attached to medical record, Verify resident identification with another nursing care center personnel. Note: the residence room number or physical location is not used as an identifier."	T 439		

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T 439	Continued From page 3 On 5/12/25 at 4:20 p.m., during the exit interview with the Market Clinical Advisor, Administrator, Administrator in Training, and the Director of Nursing, the above failure to identify the resident prior to administering medications, failure to follow basic principles of medication administration safety and the facilities own policy on resident identification resulting in Resident #1 being admitted to the CCU was confirmed. On 5/12/25 Resident #1 remained at the hospital being treated for receiving the wrong medications.	T 439		