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 _____	07/19/2024

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 From 7/15/24 through 7/19/24, on-site visits were conducted at Springbrook Center for the purpose of annual Long Term Care Survey Process for Federal Recertification and investigating complaint #ME00044018, #ME00044045, #ME00044279, #ME00045022, #ME00045037, #ME00045074, #ME00045909, #ME00046120, #ME00046521, #ME00046797, #ME00047177, #ME00047415, and #ME00047864. 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 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,	F 584	The walls in resident room King 1 and walls in resident bathrooms Wayside 4, Wayside 7, and King 7 were repaired. The doors in resident rooms Saccarappa 8, Mayflower 2, King 6, and King 8 were repaired or replaced. The floors in resident bathroom Wayside 7 and the 3rd floor clean utility room were cleaned. The window screen in Saccarappa 10 was repaired. The ceiling tiles in the 3rd floor common area were replaced. The King unit kitchenette counter was replaced.	9/2/24

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

ADMINISTRATOR 8/16/24

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.

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §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 interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and sanitary conditions on 4 of 7 units (Wayside, Mayflower, Saccarappa and King), the clean utility room, the 3rd floor common area for 1 of 1 Environmental tours. Findings: 1. On 7/19/24 from 10:15 a.m. to 10:45 a.m., a surveyor conducted an environmental tour with the Administrator in which the following findings were observed and confirmed: Wayside Unit: -Resident Room 4 - the bathroom walls were observed to be gouged, and/or water damaged	F 584	The Administrator or designee will review walls, floors, and doors in resident rooms and bathrooms and repair additional identified areas in need of repair. The Administrator or designee will provide education to the Maintenance and Housekeeping staff on Code of Federal Regulations part 483.10(i)(1)-(7) The Administrator or designee will audit walls, floors, and doors in resident rooms and bathrooms weekly for four weeks then monthly for three months or until resolved to ensure areas are in good repair and sanitary condition and report findings at the monthly QAPI meeting.	

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F 584	Continued From page 2 with sheetrock exposed around the toilet. -Resident Room 7- The bathroom wall had water damage. The floor had dirt/debris around the base of the toilet. Saccarappa Unit: -Resident Room 8 - the entrance door had a missing piece from the door. -Resident Room 10 - the area under the window sill was open to the outside. Mayflower Unit: -Resident Room 2- the entrance door had approximately a 5 feet piece of laminate peeling off with a large chipped area. -The 3rd floor common area had two stained ceiling tiles. -The 3rd floor clean utility room had dirt/debris and trash on the floor. King Unit: -Resident Room 1 - the wall is gouged. the resident bathroom wall cove base near the toilet was loose/peeling. -Resident Room 6 - the door was chipped/gouged. -Resident Room 7 - the bathroom wall to the left after entering the room was gouged. -Resident Room 8 - the entrance door was missing a piece of laminate from the door -The unit kitchenette counter was missing multiple areas of laminate on the counter.	F 584		

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	A care plan was initiated in the area of oxygen for Resident #17, #56, #72, and #310. A care plan was initiated in the area of CPAP for Resident #17. Care plans were implemented in the areas of eating, communication, and toileting for Resident #53. The Director of Nursing (DON) or designee will review care plans of residents with current oxygen orders and develop additional identified missing care plans in the area of oxygen. The DON or designee will review residents care planned for assistance with eating, communication, and toileting to ensure areas are being implemented. The DON or designee will provide education to direct care staff on policy OPS416 Person Centered Care Plan and NSG200 Activities of Daily Living (ADL).	9/2/24

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F 656	Continued From page 4 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to develop care plans in the area of oxygen therapy for 4 of 5 residents reviewed for respiratory care (#17, #56, #72 and #310). In addition, the facility failed to implement a care plan in the area of Activities of Daily Living (ADL), nutrition and incontinence for 1 of 2 residents reviewed for ADL's (#53). Findings: 1. On 7/15/24 at 9:30 a.m., a surveyor observed oxygen equipment at Resident #17's bedside. A Review of Resident #17's Electronic Medical Record (EMR) found orders dated 4/8/24 for Oxygen therapy and Continuous positive airway pressure (CPAP) therapy. A review of Resident #17's care plan failed to include a focus, goal or intervention in the area of oxygen or CPAP therapy. 2. On 7/15/24 at 9:35 a.m,. a surveyor reviewed Resident #56's EMR showed orders dated 7/17/24 for oxygen therapy. A review of Resident #56's care plan did not include a focus, goal or intervention in the area of oxygen therapy. 3. On 7/15/24 at 9:45 a.m., a surveyor observed Resident #72 with a nasal cannula for oxygen	F 656	The DON or designee will audit care plans of residents with current oxygen orders weekly for four weeks then monthly for three months or until resolved to ensure care plans in the area of oxygen are developed and report findings at the monthly QAPI meeting. The DON or designee will audit ADL care in the areas of eating, communication, and toileting weekly for four weeks then monthly for three or until resolved to ensure assistance is provided per the care plan and report findings at the monthly QAPI meeting.	

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F 656	Continued From page 5 therapy. A surveyor reviewed Resident #72's EMR and found an order dated 5/5/23 for oxygen therapy. Resident #72's care plan did not include a focus, goal or intervention in the area of oxygen therapy. 4. On 7/15/24 at 10:00 a.m., a surveyor observed Resident #310 with a nasal cannula for oxygen therapy during an interview. Resident #310's EMR found an order dated 7/14/24 for oxygen therapy. A review of Resident #310's care plan did not include a focus, goal or intervention in the area of oxygen therapy. On 7/17/24 at 1:50 p.m. a surveyor discussed the above findings with the Market Quality Specialist. 5. Resident #53's most recent ADL care plan revised on 3/14/23 states, "resident requires assistance/is dependent of ADL care", with instruction for nursing to, "Lip plate for all meals", "resident has limited vision to the left- please provide assist as needed as patient is not able to scan or see to the left", resident with limited vision and attention to left, approach resident from right side" and Provide resident/patient with set-up assist for self feeding and supervision and cues- This includes putting utensils in hand or problem solving with resident for eating", The most recent Nutritional risk care plan last revised on 6/28/24 instructs nursing to, "encourage resident to chew and swallow each bite" and the most recent incontinence care plan last revised on 4/14/22 instructs nursing to, "routine toileting, individualized schedule: 2 hours using toilet". On 7/15/24 from 12:24 p.m. to 12:48 p.m., observation of Resident #53 sleeping in a Broda	F 656		

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F 656	Continued From page 6 chair at the dining room table with an uneaten lunch served on regular plate in front of him/her. At 12:37 p.m., observation of a certified nursing assistant (CNA) approach the table and then walked away, with no resident contact. At 12:45 p.m., while the resident was sleeping, the CNA removed the uneaten lunch tray, and left a slice of watermelon. At 12:48 p.m., while the resident was still sleeping, the CNA discarded the uneaten slice of watermelon. At no time did the CNA attempt to wake up the resident or assist him/her with eating. On 7/16/24 from 8:10 a.m. to 11:52 a.m., the surveyor observed the following: Resident #53 was sleeping in the Broda chair sitting at the dining room table with his/her right side against the wall. In his/her lap is an empty cup. While the resident slept, a CNA approached the resident from the left side and removed the cup from his/her lap and walked away. Then, at 9:13 a.m., while the resident slept, the CNA again approached the resident from the left side and removed the uneaten breakfast, served on regular plate, leaving the chocolate milk and blueberry muffin in front of him/her. At 11:24 a.m., the CNA again, approached the resident from the left side and discarded the uneaten blueberry muffin, leaving the chocolate milk. At 11:52 a.m., lunch was delivered to Resident #53 from the left side, usign a regular plate.During this time of 3 hours and 42 mins, the CNA continued to approach the resident from the left side, did not attempt to wake up the residen up to assist with his/her meal or offer toileting. On 7/17/24 at 8:11 a.m., during an interview with the Administrator, the above concerns were discussed.	F 656		

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and interviews the facility failed to provide Activities of Daily Living (ADL) care in the area of showers/bathing for 1 of 33 residents reviewed (#18), and in the area of nutrition for 1 of 2 sampled residents during 2 of 5 days of survey. (#53). Findings: 1. On 7/15/24 at 11:44 a.m., in an interview with a surveyor, Resident #18 stated "a couple weeks ago (she) did not get her weekly shower, due on Sundays, for 2 weeks until her family said something to staff." A review of the clinical record for Resident #18 revealed diagnoses that included multiple sclerosis and an above the knee amputation of the left leg. The quarterly Minimum Data Set 3.0 (MDS) assessment, completed on 7/6/24, indicated Resident #18 required partial to moderate assistance for showering/bathing. The current care plan stated Resident #18 required extensive 1-person assistance for bathing, and a total mechanical lift, with 2-person assistance to transfer to a shower. A review of Certified Nursing Assistant (CNA)	F 677	Resident #18 was provided a shower. Resident #53 is receiving assistance with eating per the care plan. The DON or designee will review tub/shower documentation to ensure showers are offered/ provided on a regular basis to all residents. The DON or designee will review residents care planned for assistance with eating to ensure it is being provided per the care plan. The DON or designee will provide education to direct care staff on policy NSG200 Activities of Daily Living. The DON or designee will audit tub/shower documentation weekly for four weeks then monthly for three months or until resolved to ensure showers are offered/ provided on a regular basis and report findings at the monthly QAPI meeting.	9/2/24

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F 677	Continued From page 8 documentation noted Resident #18 received one shower in the month of June, on 6/23/24. There was no documentation from staff stating Resident #18 refused weekly showers. On 7/18/24 at 11:10 a.m., in an interview with the Market Clinical Advisor and the Administrator, the surveyor discussed that staff documentation indicated Resident #18 received only one shower in June. 2. Resident #53's ,Quarterly Minimum Data Set 3.0 dated 6/30/24, under section GG0130A Eating states, "resident requires supervision or touching assistance - helper provides verbal cues or touching/steadying assistance as resident completes activity". The most recent ADL care plan revised on 3/14/23 states, resident requires assistance/is dependent of ADL care, with instructions for nursing to, "Provide resident/patient with set-up assist for self feeding and supervision and cues- This includes putting utensils in hand or problem solving with resident for eating." On 7/15/24 at 9:41 a.m., observation of Resident #53 sleeping in a Broda chair at the dining room table with a cup of chocolate milk in front of him/her. At 12:24 p.m., observation of Resident #53 sleeping at the dining room table with an untouched lunch tray in front of him/her and the cup of chocolate milk on the side of the tray. At 12:37 p.m., observation of a certified nursing assistant (CNA) approach the table and then walked away, with no resident contact. At 12:45 p.m., while the resident was sleeping, the CNA removed the uneaten lunch tray, and left a slice	F 677	The DON or designee will audit ADL care in the area of eating weekly for four weeks then monthly for three months to ensure assistance is provided per the care plan and report findings at the monthly QAPI meeting.	

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F 677	Continued From page 9 of watermelon. At 12:48 p.m., while the resident was still sleeping, the CNA discarded the uneaten slice of watermelon. At no time did the CNA attempt to wake up the resident or assist him/her with eating. On 7/15/24 at 12:52 p.m., during an interview with the Licensed Practical Nurse (LPN) Manager, the above was discussed. The LPN manager stated Resident #53 typically does not feed oneself and needs assistance. On 7/15/24 at 3:53 p.m., during an interview, Resident #53's guardian stated, she wondered about Resident #53's eating and if his/her behaviors occur because he/she is hungry. On 7/16/24 from 8:10 a.m. to 11:52 a.m., the surveyor observed the following: Resident #53 was sleeping in the Broda chair sitting at the dining room table with his/her right side against the wall. In his/her lap is an empty cup. A breakfast tray in front of him/her contained chocolate milk, a banana, a blueberry muffin, scrambled eggs and a bowl of cereal. While the resident slept, a CNA removed the cup from his/her lap and walked away. Then, at 9:13 a.m., while the resident slept, the CNA removed the uneaten breakfast and left the chocolate milk and blueberry muffin in front of him/her. At 11:24 a.m., while Resident #53 slept, a wandering resident was observed moving Resident #53's chair back away from the table. The CNA redirected the wandering resident and placed Resident #53 back at the table, then discarded the uneaten blueberry muffin, leaving the chocolate milk. At 11:52 a.m., lunch was delivered to Resident #53. During this time, the CNA did not attempt to wake up Resident #53 or assist with his/her meal.	F 677		

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F 677	Continued From page 10 On 7/17/24 at 8:11 a.m., during an interview with the Administrator, the above concerns were discussed.	F 677		
F 684 SS=D	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 policy review, clinical record review, observations and interviews, the facility failed to notify the provider and obtained orders for 1 of 6 residents reviewed for respiratory care (#33) and 1 of 6 residents reviewed for pressure ulcers (#48). In addition, the facility failed to assess a resident after an unwitnessed fall and complete neurological assessments as per facility policy for 1 of 3 residents reviewed for falls (#407). 1. On 7/15/24 at 11:05 a.m., a surveyor observed Resident #33 asleep in his/her bed on the Wayside Unit. The surveyor observed oxygen delivered at 3.5 liters/minute via nasal cannula with 2 oxygen tubes connected to the wall unit and only 1 tube connected to Resident #33. At 11:14 a.m., the surveyor discussed with the charge nurse that the oxygen was running but one tube was not connected to the resident. The charge nurse stated the extra tube was to be	F 684	The oxygen order for Resident #33 was clarified with the physician. Physician notification was made and a order was obtained for the wound for Resident #48. The Director of Nursing (DON) or designee will review residents on oxygen to ensure orders are clarified, administered per the order, and the amount of oxygen in use is documented with saturation levels. The DON or designee will review residents with wounds to ensure the physician was notified and orders were obtained. The DON or designee will ensure neurological checks are completed fully for all unwitnessed falls/ falls with injuries to the head.	9/2/24

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F 684	Continued From page 11 used with the nebulizer and then proceeded to turn that oxygen tube off. Resident #33 awoke and asked what the oxygen was set at. The charge nurse stated 3.5 liters. Resident #33 asked for the oxygen to be turned up to 4 liters and the charge nurse complied. A review of Resident #33's clinical record noted a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). A physician order, dated 10/5/23, was noted for Oxygen at 3 liters/minute via nasal cannula continuously. Another order, dated 1/26/24, stated "Oxygen 2.5 liters via nasal cannula to keep Oxygen Saturation greater than 90-94%." Review of a provider visit on 5/10/24, noted "Stage 3 Severe COPD, O2 (oxygen) dependent, 3.5 liters, closer to usual baseline following treatment for exacerbation/pneumonia last month. Continue O2 nasal cannula." Review of nursing progress notes revealed a note dated 6/27/24 at 6:41 a.m., which stated "Resident who had episode of shortness of breath and chest xray was negative, this a.m., his/her O2 (saturation) was around 87-88, 89, 90 on 5 liters (of) oxygen. Will share with other nurses and sbar (communication) with provider." A review of the July Treatment Administration Record noted Resident #33's oxygen saturation was checked every shift but did not indicate how much oxygen the resident was receiving at the time. On 7/17/24 at 9:20 a.m., the surveyor asked the charge nurse on the Wayside Unit to clarify Resident #33's oxygen order. The charge nurse	F 684	The DON or designee will provide education to licensed nurses on the Pulse Oximetry Procedure, and policies: NSG122 Change in Condition: Notification of, NSG204 Neurological Evaluation, and NSG236 Skin Integrity and Wound Management. The DON or designee will audit residents on oxygen, residents with new wounds, and residents with unwitnessed falls/falls with injuries to the head weekly for four weeks then monthly for three months or until resolved to ensure oxygen orders are clarified, administered per the order, and the amount of oxygen in use is documented with saturation levels; physician notification is made and orders obtained for new wounds; and neurological checks are completed after a fall and report findings at the monthly QAPI meeting.	

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F 684	Continued From page 12 reviewed the electronic record and stated the current order was 2.5 liters (per minute). The surveyor noted there were 2 orders, and the charge nurse confirmed both orders were in effect. He/she stated the order from 10/5/23 should have been discontinued. In addition, the charge nurse confirmed that documentation for the amount of oxygen being delivered should be included when oxygen saturation levels are checked. The surveyor asked if the charge nurse remembered turning Resident #33's oxygen up to 4 liters when he was asked to on 7/15/24. The nurse confirmed he/she had turned up the oxygen and stated Resident #33 "had been at 4 liters for a couple of months and was getting 3.5 liters before that. It looks like 4 liters is his/her baseline already. We need to see if that's where he/she is at and let the provider know." On 7/17/24 at 9:45 a.m., the surveyor discussed the findings with the Market Clinical Advisor, who reviewed the provider orders and confirmed there were 2 oxygen orders in effect and no documentation of the amount of oxygen in use when the saturation level is obtained. 2. On 7/16/24, review of the clinical record for Resident #48 revealed documentation, dated 7/15/24, of a wound on the bilateral gluteal folds that was described as measuring 9.0 centimeters (cm) in length by 5.5 cm in width, and was erythemic and excoriated. There was no documentation of steps taken by staff to address the wound. On 7/17/24 at 9:15 a.m., in an interview with the Wayside Unit charge nurse, a surveyor asked	F 684		

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F 684	Continued From page 13 what type of wound Resident #48 had on the gluteal folds. The charge nurse reviewed the electronic medical record and stated Resident #48's wound was moisture associated skin damage. The surveyor asked what type of treatment would be used. The charge nurse stated "I would use Z-guard and combine it with miconazole." The surveyor asked if there was an order for this treatment. The charge nurse stated he/she had left a message regarding the wound for the nurse on the facility's skin care team. The charge nurse confirmed the provider had not been notified and no order had been obtained since the wound assessment was completed on 7/15/24. On 7/17/24 at 9:45 a.m., the surveyor discussed the finding with the Market Clinical Advisor and the Administrator. The Administrator confirmed the facility's process would be if a nurse found a new wound, the provider would be called, and an order obtained.	F 684		

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F 684	Continued From page 14	F 684		

3. Review of Resident #407's clinical record revealed "Progress Note" dated 7/29/23 stating "At approximately 0025 (12:25 a.m.) nursing staff including this nurse heard someone call out and a clash of noises coming from patient room. This nurse and other staff quickly responded and found resident on the floor laying supine, Resident said [he/she] lost balance on [his/her] way out from the bathroom and fell onto [his/her] bottom ... Vital signs were WNL (within normal limits), neuros were baseline ... Will continue to monitor."

Review of Resident #407's entire clinical record lacked evidence of continued neurological monitoring or "Neurological Evaluation Flow Sheet" for fall occurring 7/29/23.

On 7/15/24 at 1:26 p.m. during an interview, the Administrator was unable to provide evidence of continued neurological monitoring following the resident's fall on 7/29/23.

Review of policy titled "Falls Management" last reviewed 3/15/24 states, " ... 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 ... "

Review of policy titled "Neurological Evaluation Flow Sheet" states " ... Evaluate every 15 minutes for first 2 hours after final evaluation ...After first 2 hours completed above, evaluate every 30minutes for 2 hours, after first 4 hours completed above, evaluate every hour for 4 hours ..."

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F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that staff maintained the appropriate competency and skill required to provide tracheostomy care for 1 of 2 residents with tracheostomies on the Wayside	F 726	The Wayside unit charge nurse was provided education on the Tracheostomy Care Procedure and Tracheostomy Suctioning Procedure. All residents requiring tracheostomy care have the potential to be affected by this deficient practice. The DON or designee will provide education to licensed nurses on the Tracheostomy Care Procedure and Tracheostomy Suctioning Procedure. The DON or designee will observe tracheostomy care and suctioning weekly for four weeks then monthly for three months or until resolved to ensure licensed staff maintain the appropriate competency and skill and report findings at the monthly QAPI meeting.	9/2/24

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F 726	Continued From page 16 Unit (#48). Finding: On 7/15/24 at 10:47 a.m., a surveyor observed a personal protective equipment station and signage advising Enhanced Barrier Precautions were required at the entrance of Resident #48's room The surveyor observed Resident #48 lying in bed, receiving oxygen via a tracheostomy. A review of Resident #48's clinical record revealed diagnoses including anoxic brain injury, seizure disorder, chronic respiratory failure with hypoxia, and developmental delay. The record revealed a history of drug resistant organisms in Resident #48's sputum: Methicillin Resistant Staphylococcus Aureus (MRSA) and Pseudomonas Aeruginosa. The quarterly Minimum Data Assessment (MDS) 3.0, completed 6/11/24, indicated Resident #48 is dependent upon staff for all ADLs and is nonverbal, requires suctioning, has a tracheostomy and receives oxygen. The current care plan includes appropriate interventions to address Resident #48's needs. Provider orders, signed 6/26/24, include tracheostomy care twice daily and as needed, suctioning twice daily and as needed, change the inner cannula of the tracheostomy every day shift and as needed. On 7/16/24, the surveyor requested to observe the Wayside Unit charge nurse perform tracheostomy care for Resident #48. At 12:30 p.m., the surveyor observed the Nurse Practice Educator (NPE) was present for the observation.	F 726		

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F 726	Continued From page 17 The charge nurse stated he/she had asked the NPE to be present as he/she did not feel competent doing the procedure. During the procedure, the NPE coached and prompted the charge nurse for next steps using a check off sheet. At one point, Resident #48 appeared to have labored breathing with audible rhonchi and copious white secretions draining from the tracheostomy. The charge nurse began using a Yankauer suction around the outside edge of the tracheostomy. The surveyor asked the charge nurse if he/she was going to perform deep suction. The charge nurse then proceeded to provide deep suction. Afterwards, Resident #48 was observed to be calm and relaxed, with unlabored respirations. At approximately 1:30 p.m., the surveyor asked the charge nurse if he/she had received training on performing tracheostomy care. The nurse stated it had been about 3 years ago but he/she was usually assigned on the upstairs unit, and did not feel competent to do the care when the surveyor asked to observe. The surveyor asked what did the nurse do when Resident #48 requires deep suctioning? The nurse stated he/she calls an upstairs unit and requests another nurse come down to perform the procedure. The surveyor stated that on 7/15/24, the charge nurse had signed Resident #48's treatment administration record and indicated he/she had performed tracheostomy care and deep suctioning. The charge nurse stated he/she had the nurse who was going off duty perform the suctioning and he/she "did all the other things" and signed off the tasks. On 7/17/24 at 2:00 p.m., a review of the facility assessment, last revised 1/22/24, noted the	F 726		

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F 726	Continued From page 18 facility stated it provides care for respiratory treatments including suctioning, tracheostomy care, ventilator or respirator. This includes policies and procedures to provide "specialized respiratory care for tracheostomy or ventilator." The surveyor reviewed the procedures for tracheostomy care and suctioning, dated 7/15/21. On 7/17/24 at 2:50 p.m., the surveyor discussed the findings with the Administrator, who stated licensed nurses are required to complete a combination of online trainings and attend an annual skills fair where annual competencies are tested. On 7/17/24 at 3:00 p.m., in an interview with the surveyor, the Marketing Clinical Advisor, confirmed the last skills fair and competency testing for tracheostomy care and suctioning, that the charge nurse on the Wayside Unit completed was 9/29/22.	F 726		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	The events occurred in the past and cannot be corrected. All residents have the potential to be affected by this deficient practice. The DON or designee will provide education to licensed nurses and medication technicians on policy 4.1 Medication Storage.	9/2/24

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F 761	Continued From page 19 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews the facility failed to ensure that medications were stored properly by having an unlocked, unattended medication cart on 1 of 7 resident units in the facility. In addition, the facility failed by leaving a resident's medications unattended at a bedside, allowing residents and unauthorized persons access to medications. (#33) (Saccarappa House Unit, Wayside Unit). Findings: 1. On 7/15/24 at 9:42 a.m., two surveyors observed the unlocked and unattended medication cart in the hallway on Saccarappa House Unit. At 9:46 a.m., the Certified Medication Technician returned to the unlocked medication cart and began to prepare a resident's medication. On 7/17/24 at 11:27 a.m., the above finding was discussed with the Administrator and the Market Clinical Advisor. 2. On 7/15/24 at 11:05 a.m., a surveyor observed Resident #33 asleep in bed. A cup of pills was observed on the overbed table next to Resident	F 761	The DON or designee will audit medication carts and resident rooms weekly for four weeks then monthly for three months or until resolved to ensure medications are stored properly and are not accessible to residents and unauthorized persons and report findings at the monthly QAPI meeting.	

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F 761	Continued From page 20 #33. At 11:14 a.m., the Wayside Unit charge nurse confirmed he/she had left the pills next to Resident #33, "who must have forgotten to take them." On 7/15/24 at 1:15 p.m., the surveyor discussed the finding with the Market Clinical Advisor.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 791	Resident #29 had a dental referral scheduled. The DON or designee will review physician's orders for dental referrals to ensure all referrals have been processed. The DON or designee will provide education to Nurse Managers on policy OPS160 Dental Services. The DON or designee will audit physician's orders for dental referrals weekly for four weeks then monthly for three months or until resolved to ensure all referrals have been processed and report findings at the monthly QAPI meeting.	9/2/24

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F 791	Continued From page 21 led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to follow through with a physician's order for a dental referral for 1 of 43 sampled residents (#29). Finding: Resident #29's clinical record contained a physician's order dated 3/18/23 instructing staff to refer the resident to a dentist for gingivitis and a cleaning. Resident #29's clinical record lacked evidence of any follow up with the dental referral. In an interview with the surveyor on 7/17/24 at 11:06 a.m. the Marketing Clinical Advisor confirmed that Resident #29's dental referral had not been scheduled.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842	The documentation for eating on 7/15/24 lunch meal and 7/16/24 breakfast meal for Resident #53 was struck out.	9/2/24

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F 842	Continued From page 22 (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(i) Medical records. §483.70(i)(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(i)(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 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.	F 842	All residents have the potential to be affected by this deficient practice. The DON or designee will provide education to direct care staff on policy OPS402 Clinical Record: Charting and Documentation The DON or designee will observe meal consumption and audit subsequent documentation weekly for four weeks then monthly for three months or until resolved to ensure that clinical records are complete and contain accurate information and report findings at the monthly QAPI meeting.	

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F 842	Continued From page 23 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(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(i)(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 interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 2 residents reviewed for Activities of Daily Living (ADL) (#53). Finding: On 7/15/24 lunch meal and on 7/16/24 breakfast meal, Resident #53 was observed sleeping through both of the meals with no cueing provided by staff and did not consume any of the food or fluids provided. Review of the certified	F 842		

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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 842	Continued From page 24 nursing aid documentation for 7/15/24 lunch and 7/16/24 breakfast states the amount eaten my mouth was 50%. The documentation for eating: self-performance for 7/15/24 lunch states resident was supervision with encouragement or cueing, and the lunch on 7/16/24 the documentation states resident was independent with no help or staff oversight at any time. On 7/17/24 at 8:11 a.m., during an interview with the Administrator, the above concerns were discussed.	F 842		