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 07/19/2024

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

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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 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).	F 684		

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

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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 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."

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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 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

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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 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.

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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

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F 684	Continued From page 5 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 ..."	F 684		