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 12/06/2023

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 On 12/6/23 an on-site visit was conducted at Springbrook Center, for the purpose of complaint investigation ME#00045666. It was determined that Springbrook Center, is not in substantial compliance with 42 CFR Part 483, Subpart 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, 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);	F 584	Residents' personal clothing was placed in a covered cart and delivered. The shower chair in Saccarappa unit was cleaned. The edges, corners, and drain of the shower in Saccarappa unit were cleaned. The Administrator or designee will review storage and distribution of residents personal clothing and relocate additional identified uncovered items to a covered cart. The Housekeeping Manager or designee will review shower chairs and shower rooms for cleanliness and clean chairs and showers as indicated.	1/9/24

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

ADMINISTRATOR 12-22-23

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 §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 interviews, the facility failed to adequately provide housekeeping, laundry, and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 2 of 4 units observed (Wayside Gardens, Saccarappa House). Findings: 1. On 12/6/23 at 10:15 a.m., two surveyors observed a rolling rack with residents' personal laundry hanging uncovered in the common area of the Wayside Gardens unit. On 12/6/23 at 11:15 a.m., a surveyor discussed the finding with the Housekeeping Manager, who stated he/she was not in charge of residents' personal laundry but would let staff know. The Housekeeping Manager stated the laundry is transported to Massachusetts, where it is laundered by a contracted company and transported back to the facility. The resident's personal laundry is then delivered to residents by activities or central supply staff. 2. On 12/6/23 at 11:35 a.m., two surveyors	F 584	The Administrator or designee will provide education to the Central Supply Clerk on proper storage and distribution of personal clothing according to policy IC204 Linen Handling. The Housekeeping Manager or designee will provide education to housekeeping staff on policy ENV201 Cleaning: Resident and Patient areas. The Administrator or designee will audit storage and distribution of personal clothing weekly for four weeks then monthly for three months or until resolved to ensure it remains covered when stored and transported and report findings to the monthly QAPI meeting. The Housekeeping Manager or designee will audit shower chairs and shower rooms for cleanliness weekly for four weeks then monthly for three months or until resolved and repot findings at the	

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F 584	Continued From page 2 observed the shower room on the Saccarappa House unit. The edges and corners in the shower were noted to have a build-up of black, mildew-like material. The shower chair was observed with a build-up of brown material. An odor was noted emanating from the shower drain. On 12/6/23 at 12:20 p.m., the Nurse Manager of the Saccarappa House unit observed the shower room with a surveyor and confirmed the findings of the black, mildew like substance in the shower and the brown build-up on the shower chair. On 12/6/23 at 3:50 p.m., the surveyors discussed the above findings with the Administrator, the Director of Nursing, and the Nurse Manager of the Saccarappa House unit.	F 584		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	The care plans for resident #2 and resident #3 were updated to reflect residents' current needs and current physician orders. The Director or Nursing (DON) or designee will review care plans of residents who had falls with injury to ensure care plans have been revised to reflect residents' current needs and current physician orders.	1/9/24

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F 657	Continued From page 3 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise a care plan to reflect the current needs for 2 of 3 residents reviewed for falls with injuries (#2, #3). Findings: 1. A review of Resident #2's clinical record revealed that he/she sustained unwitnessed falls on 10/8/23 and 10/26/23, resulting in rib fractures. Resident #2's physician orders were noted to contain an order, dated 10/5/23, which stated "nonskid footwear for safety." The Minimum Data Set (MDS) 3.0, Admission Assessment, completed 10/11/23, noted under section J1900, Resident #2 experienced 1 fall with injury and 1 fall with no injury since admission. The care plan, with the most recent revision on 11/2/23, did not include the use of nonskid footwear, as ordered by the physician. 2. A review of Resident #3's clinical record revealed that he/she sustained an unwitnessed fall on 11/4/23, resulting in a fracture of the left distal fibula. A provider note, dated 11/16/23, stated "Seen by Ortho, significant swelling, stable fracture, recommend follow-up in additional 4 weeks. Continue nonweightbearing." A provider	F 657	The DON or designee will provide education to licensed nurses on implementing and documenting patient centered interventions according to individual risk factors in the patient's plan of care and adjust and document individualized intervention strategies as patient condition changes according to policies NSG215 Falls Management and OPS416 Person Centered Care Plan. The DON or designee will audit care plans of residents who had falls weekly for four weeks then monthly for three months or until resolved to ensure the care plan has been revised to reflect residents' current needs and current physician orders and report findings at the monthly QAPI meeting.	

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F 657	Continued From page 4 note, dated 11/29/23, stated "Seen by orthopedics. Patient fitted with a cam (controlled ankle motion) boot last week. Weight bearing as tolerated. Boot may be removed when he/she is in bed." The physician's orders were noted to contain the order, dated 11/29/23, "Weight bearing as tolerated on left lower extremity with the cam boot. Does not have to wear the boot when he/she is in bed." The MDS, Admission Assessment, completed 11/8/23, noted under section J1900, Resident #3 experienced 1 fall with injury since admission. The care plan, with the most recent revision on 12/3/23, noted a focus area, initiated on 11/23/23, of "Resident/Patient requires assistance/is dependent for mobility related to recent fracture. The focus area did not include any goals or interventions as required by physician orders. On 12/15/23 at 10:22 a.m., in a telephone interview, the surveyor discussed the findings with the Administrator. A review of the facility's policy, Falls Management, last revised 8/7/23, stated under "Practice Standards, 2. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. 2.1. Adjust and document individualized intervention strategies as patient condition changes."	F 657		