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 02/28/2024

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 On 2/28/2024, an unannounced on-site visit was conducted at Springbrook Center in Westbrook to investigate complaints #ME00045174, #ME00046047, #ME00046323, #ME00046350, #ME00046360, #ME00046443, #ME00046551, and #ME00046553. It was determined that Springbrook Center was not in compliance with 42 CFR 483, Sub-part B-Requirements for Long Term Care Facilities	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

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

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F 607	Continued From page 1	F 607		

§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to follow the facility policy and failed to document adequate interventions taken to protect resident (Resident #7) from abuse following a resident-to-resident altercation for 1 of 2 residents reviewed for abuse allegations.

Findings:

On 2/13/24 at 12:40 p.m., Department of Licensing and Certification received a facility reported incident of abuse between two residents that took place at 2/12/24 at approximately 9:00 p.m. Resident #5 was found with his/her hands around Resident #7's neck and Resident #7 was screaming. They were immediately separated. A scratch was discovered on Resident #7's neck.

On 2/28/24 at 12:12 p.m., during an interview with the Unit Director, discussed the documentation in the medical records for Resident #5 and Resident #7 does not show that the residents involved in the altercation had adequate supervision following the altercation, per facility policy. A room change did not occur until 4 days following the incident. No documentation of additional safety checks before this room change occurred were located.

Review of the Genesis Healthcare Policy OPS300 Abuse Prohibition last revised 10/24/22 states the following:
6.3 If the suspected abuse is patient-to-patient,

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F 607	Continued From page 2 the patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed. 6.3.1 The center will provide adequate supervision when the risk of patient-to-patient altercation is suspected. On 2/28/24 at 1:00 p.m., during an interview with the DON and Administrator, it was discussed that while both residents have cognitive impairments, a reasonable person would not feel safe sleeping in the same room following the described altercation and the documentation does not show additional supervision following the altercation.	F 607		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide an environment free of accident hazards and supervision for 2 out 3 floors observed for accident hazards. Findings: 1. On 2/28/24 at 9:20 a.m., a surveyor and an Administrator in Training(AIT) observed a	F 689		

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F 689	Continued From page 3 resident on Lincoln Unit in Room 05 who exited their bathroom with a walker and had difficulty maneuvering around a commode being stored along the wall that was blocking the pathway back into his/her room. The resident was not assisted at any point by staff during our observation. 2. 0n 2/28/24 at 9:25 a.m., a surveyor and an AIT observed an empty wheelchair against the wall in Lincoln Unit Room 04. The footrests were raised and sticking out creating a potential tripping hazard in the direct pathway into the room for anyone entering or leaving the room. 3. On 2/28/24 at 11:10 a.m., a surveyor observed on the second floor, 5 walkers blocking access to the handrail in front of the physical therapy room. When I brought this to the attention of staff at the nursing station, they were not removed. On 2/28/24 at 1:00 p.m., the above findings were discussed with the Administrator, Director of Nursing and the Administrator in Training, who confirmed the above findings were hazards.	F 689		