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 01/18/2024

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 1/18/2024, an unannounced on-site visit was conducted at Springbrook Center for the purpose of an investigation of complaints #ME00046090 & #ME00046096. 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 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. (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;	F 842		

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

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 842	Continued From page 1 (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. §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 record reviews and interviews, the	F 842		

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F 842	Continued From page 2 facility failed to ensure that the clinical records were complete and contained accurate documentation for 1 of 1 sampled residents (#1). Findings: On 1/18/2024, during review of Resident #1 clinical record, it was discovered in the providers documentation of their visit on 12/11/2023, that the resident left the facility post 911 call made by the residents case manager because [redacted] "was not getting the medical care [redacted] needed". The medical record lacked documentation of the resident's condition other than the provider's note. In addition, the medical record lacked documentation that the resident left the facility on 12/11/2023, and that the resident returned to the facility on 12/12/2023. On 1/18/2024 at 12:15 p.m,. in an interview with the Director of Nursing, he stated that any resident who needed to be taken from the facility as a result of a 911 call, no matter who made it, needed documentation in the clinical record as to their condition. He agreed that Resident #1's record lacked any documentation of condition or the fact that [redacted] left the facility. He also agreed that on 12/12/2023, when the resident returned to the facility, the record lacked documentation of [redacted] return or mention of [redacted] condition on returning. On 1/18/2024, the above information was confirmed with the Director of Nursing and the Administrator at 12:30 p.m.	F 842		