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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springbrook Center	300 Spring St Westbrook, ME 04092

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the complaint intake form, clinical record reviews, interviews, and facility policy, the facility failed to identify the appropriate resident when passing medications resulting the CNA-M admisistering medications to the incorrect resident that resulted in a resident being transported to an Acute Care Emergency Department and later admitted to the hospital critical care unit for monitoring and treatment of low blood pressure. (Resident #1) Findings: The Division of Licensing and Certification received an Adult Protective Services (APS) complaint that indicated on 5/8/25, at 9:20 a.m., Resident #1 received another resident's medications which resulted in a hypotensive episode. Resident #1 was transported to the emergency room and subsequently admitted to the critical care unit (CCU). A review of nursing documentation dated 5/8/25 at 9:33 a.m., stated, [Med tech] approached me [Nurse] and stated that she gave the meds of [room [ROOM NUMBER]B to room [ROOM NUMBER]A]. On assessment, patient appears to be stable and no complaints. Vital signs were taken immediately and stable. Reported incident immediately to [Doctor] and [Nurse Practice educator]. He/she was reevaluated by MD immediately. A review of the physician note dated 5/8/25, signed at 11:18 a.m., stated, I was asked to see [Resident #1] acutely as [he/she] received the wrong medications on morning pass. Meds taken at 09:20 this morning incorrectly received: Amlodipine 10 mg (milligram), Aspirin 81 mg, Calcium carbonate 500 mg, Clonidine 0.3 mg, Furosemide 80 mg, Losartan 100 mg, Metoprolol tartrate 100 mg, Nephro-Vite 0.8 mg, Omeprazole 20 mg, Prednisone 30 mg, Sertraline 100 mg, Sevelamer 800 mg . My greatest concern is for [his/her] blood pressure, having received amlodipine 10/clonidine 0.3/losartan 100/metoprolol 100 as well as furosemide 80 (but [he/she] usually takes torsemide 10 mg daily). Blood pressure checks every 15 minutes through 8 PM . As such, we will have a low threshold for sending to ER, but currently with a strong BP (Blood Pressure) and safe to continue to monitor here with frequent checks. A nursing note dated 5/8/25 at 1:57 p.m., stated, [Resident #1] was transferred to hospital for abnormal Vital Signs. (continued on next page)

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.

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

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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springbrook Center	300 Spring St Westbrook, ME 04092

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On 5/12/25 at 1:08 p.m., during an interview with Certified Nurse's Assistant - Medication Aide (CNA-M) #2, she stated she had grabbed the medication cards from the slot labeled 6A (indicating the medications were for the resident in room [ROOM NUMBER] bed A). She then opened up the Medication Administration Record for the name on the card and began preparing the medications. She then entered the room and asked the resident in 6A if he/she was [the name on the medication cards]. The resident stated he/she was that name and was given the medications. When the CNA-M #2 returned to the cart, she realized she had given resident in room [ROOM NUMBER]A resident in room [ROOM NUMBER]B's medications. She immediately notified the nurse. At this time, the CNA-M #2 confirmed she failed to identify the resident using the picture and the identification bracelet he/she had on. The facilities Identification of Patient policy and procedure revised on 10/15/24 states, Purpose: To identify a method of patient identification. Practice Standards: Staff will use at least two patient identifiers to verify patient identity while being evaluated or prior to undergoing procedures/treatments. The facilities Medication Administration General Guidelines policy and procedure revised on 1/25 states, Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include: Check identification band, Check photograph attached to medical record, Verify resident identification with another nursing care center personnel. Note: the residence room number or physical location is not used as an identifier. On 5/12/25 at 4:20 p.m., during the exit interview with the Market Clinical Advisor, Administrator, Administrator in Training, and the Director of Nursing, the above failure to identify the resident prior to administering medications, failure to follow basic principles of medication administration safety and the facilities own policy on resident identification resulting in Resident #1 being admitted to the CCU was confirmed. On 5/12/25 Resident #1 remained at the hospital being treated for receiving the wrong medications.