

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2025
NAME OF PROVIDER OR SUPPLIER Springbrook Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility failed to implement the care plan interventions for 1 of 7 residents reviewed for transfers using a mechanical lift. (Resident #7) Findings: Resident #7's Minimum Data Set 3.0, quarterly assessment dated [DATE], section GG functional abilities and goals revealed he/she was dependent on staff and required full assistance with transfers. The most recent Lift Transfer evaluation completed on 11/4/25 indicated the residents weight was 195 pounds and required a purple (medium) sling for use with the electric mechanical lift. The care plan and the corresponding Kardex (used by the Certified Nursing Assistant) revised on 11/7/25 include the nursing interventions of Provide resident/patient with dependent assist of 2 for transfers using a mechanical lift with medium (purple) full body sling based on manufacturers guide and nursing assessment. On 11/20/25 at 8:50 a.m., observation of Resident #7 in his/her wheelchair with a green (large) sling underneath his/her body. On 11/20/25 at 9:28 a.m., during an interview, Certified Nurses Aid (CNA) #5 stated the slings sizes that are to be used for each resident are on the iPad (system used for CNA Kardex and documentation) and the sling size goes by color of the edges, for example purple is medium. On 11/20/25 at 9:31 a.m., during an interview, CNA #3, stated the sling size is on the Kardex and we do it by color. That's how you know what size sling it is by the color on the edges. On 11/20/25 at 9:33 a.m., during an interview, CNA #1, stated the sling size is in the Kardex on the tablet, the edge of the sling is the size by color. On 11/20/25 at 10:24 a.m., during an interview, CNA #4 stated she knows which sling to use by the Kardex and the color is in the Kardex. She doesn't know what the sizes are, she just goes by the color the Kardex says. On 11/20/25 at 10:54 a.m., during an interview, CNA #6, stated she knows what size sling to use by the Kardex. The color of the lining on the outside depicts the size of the sling. The Kardex would say green large or purple medium. On 11/20/25 at 9:49 a.m., both the surveyor and the Regional Administrator observed Resident #7 in the dining room with a green (large) sling under him/her in the wheelchair. At this time, the care plan was reviewed with the Regional Administrator who confirmed Resident #7 was not in the correct sling as per his/her plan of care.</p>

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
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on record review and interviews, the facility failed to revise a care plan to reflect the correct size sling used for transfers with a mechanical lift for 1 of 3 residents reviewed for falls with major injury (#1). Findings: On 10/28/25, R1's clinical record was reviewed. The record indicated R1 was admitted to the facility in November, 2020. Diagnoses included: dementia, obesity, lymphedema, dorsalgia, muscle weakness, rheumatoid arthritis, limited mobility, and other morbidities. The Minimum Data Set (MDS) 3.0, Quarterly Assessment, dated 10/17/25, Section GG. Functional Abilities and Goals, revealed R1 was dependent on staff and required full assistance with bed mobility, transfers, and toileting. The care plan and corresponding Kardex (used by Certified Nursing Assistants), revised on 8/5/25, included the intervention to provide R1 with assist of 2 (staff), using a mechanical lift and a green full body sling for all transfers. Review of the Lift-Transfer Evaluation for R1, dated 9/18/25, indicated R1's weight was 239.2 pounds, and the height was 60 inches. The assessment indicated R1 required a blue (extra large) sling for use with the electric mechanical lift. On 10/28/25 at 4:00 p.m., in an interview with a surveyor, CNA2 stated R1 used a blue (extra large) sling. On 10/29/25 at 10:40 a.m., in a telephone interview with the Director of Nursing and Assistant Director of Nursing, a surveyor discussed that R1's care plan and Kardex indicated a green, size large, sling was to be used for transfers, but staff reported a blue sling was used when transferring R1. The Director of Nursing confirmed the care plan and Kardex for R1 had not been updated to reflect the change from a green to a blue sling. The Assistant Director of Nursing stated R1 met the manufacturer's requirements for the blue sling.</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Based on record review and interviews, the facility failed to ensure that sling straps were properly connected to a hanger bar before transferring a resident using an electric mechanical lift. This resulted in a resident falling from the lift sling onto floor during the transfer from bed to wheelchair and sustaining fractured ribs, lacerated spleen, and a fractured left arm, for 1 of 3 residents reviewed for falls with major injury (#1). Findings: On 10/27/25, the Division of Licensing and Certification received a report from the facility stating on 10/25/25 a nurse was preparing medications in front of R1's room when he/she heard a loud sound and upon turning around, R1 was found lying face down on the floor. Staff reported that the resident fell from the total lift during transfer from bed to wheelchair. When the resident was turned onto his/her back, it was observed that one of the sling loops had come off the lift hook, resulting in the fall. The nurse's assessment revealed a contusion of the left forehead and bleeding from the nose. R1 complained of pain and limited range of motion in both arms. Staff initiated first aid and called 911. R1 was transferred by ambulance to the hospital and was admitted to the trauma unit. On 10/28/25 at 11:15 a.m., in an interview with a surveyor, the Director of Nursing (DON) and the Administrator discussed the incident. The DON stated two Certified Nursing Assistants (CNAs) were transferring R1 from the bed to the wheelchair using a total lift. CNA1 pulled the lift out to position R1 for transfer into the wheelchair. CNA2 was holding onto R1 in the sling and guiding R1 into the chair. The DON stated R1 then rolled out of the sling and onto the floor. The nurse on duty was standing outside the room at the medication cart and heard the bang, turned to look and saw R1 on the floor. The first thing the nurse noticed was the loop was off of the swing bar on the electric lift. On 10/28/25 at 4:00 p.m., in an interview with a surveyor, CNA2 demonstrated how he/she assisted R1 with the transfer. The bed was to the left of the room, the lift facing towards the door. The wheelchair was facing toward the bed. R1 was facing toward the lift. CNA1 moved the lift while CNA2 guided the resident in the sling to position into the wheelchair. CNA2 was standing on the right side of the wheelchair. CNA2 stated both CNAs applied the sling for R1. During the lift, R1 suddenly flipped over from the sling and onto the floor. CNA2 stated R1 used a blue (extra large) sling and when the loops were attached to the hangar bar, green loops were applied on both sides of the head and black loops on both sides of the legs. The surveyor asked how CNA2 knows the loops are secured and how many times the loops are checked before a transfer takes place. CNA2 stated I do not know how many times I checked it. I just made sure it is safe. On 10/28/25, R1's clinical record was reviewed. The record indicated R1 was diagnosed with dementia, obesity, lymphedema, dorsalgia, muscle weakness, rheumatoid arthritis, limited mobility, and other morbidities. The Minimum Data Set (MDS) 3.0, Quarterly Assessment, dated 10/17/25, Section GG. Functional Abilities and Goals, revealed R1 was dependent on staff and required full assistance with bed mobility, transfers, and toileting. R1's care plan, revised on 8/5/25, included the intervention to provide R1 with assist of 2 (staff), using a mechanical lift and a green full body sling for all transfers. Review of the Lift-Transfer Evaluation for R1, dated 9/18/25, indicated R1's weight was 239.2 pounds, and the height was 60 inches, and required a blue (extra large) sling for use with the electric mechanical lift. A review of the hospital admission history and physical notes, dated 10/25/25, stated, R1's injuries included acute left rib fractures #8 and #9, displaced fractures of the distal radius and ulna with overlapping fracture segments, and splenic laceration with subcapsular hematoma. A review of the facility's Operation Competency Assessment for the Invacare Reliant 450 and 600 Full Body Lifts, noted under the section Operation of power lift, that staff Checks again that the sling straps are properly connected to hanger bar hooks before transfer. On 10/29/25 at 10:40 a.m., in a telephone interview with a surveyor, the DON confirmed the care plan and Kardex had not been updated to reflect the change from a green to a blue sling. During an interview, the surveyor asked what did staff do next before R1 was transferred to the wheelchair? CNA1 stated, We lift (him/her) up and open the legs of the Hoyer. The surveyor asked did staff double check straps before staff moved R1, to make sure everything was safe? CNA1 stated Not that day. On 10/29/25 at 11:30 a.m., in a telephone interview with a surveyor, the RN on duty at the time of the incident stated I was the one to fill out the incident report and I tried to determine the cause. The first thing I thought was the Hoyer pad must've been broken. On the upper left side of the sling, there was no break on the hooks. The sling was hanging down. I wondered how did he/she fall? I was asking questions of the CNAs and they said he/she jerked and moved and that caused the cradle to change balance. I was trying to check if that would loosen the hook on the cradle. It can open, but there's still some space. I know the upper left (loop) was completely off and hanging on the floor. It was hanging when I first came into the room. The other</p>		