DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			SURVEY	
		IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			PLETED
							С
345569			B. WING			07	/27/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGR	ROOK NURSING & REH	ABILITATION CENTER		1	95 SPRINGBROOK AVENUE		
SPININGE		ADIENTATION CENTER		C	CLAYTON, NC 27520		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG					DEFICIENCY)		
F 000	INITIAL COMMENTS		F	000			
1 000			•				
	No deficiencies cited	as a result of complaint					
	investigation of 07/27						
F 431	483.45(b)(2)(3)(g)(h)		F	431			8/14/17
SS=D	LABEL/STORE DRU		•				0, 1 , 11
00 5							
	The facility must prov						
	drugs and biologicals to its residents, or obtain						
	them under an agreement described in						
	§483.70(g) of this part. The facility may permit						
	unlicensed personnel to administer drugs if State						
	law permits, but only under the general supervision of a licensed nurse.						
	supervision of a licen	seu nuise.					
	(a) Procedures. A fac	cility must provide					
		ces (including procedures					
		ate acquiring, receiving,					
		nistering of all drugs and					
	biologicals) to meet the	ne needs of each resident.					
	(b) Somioo Consultat	ion. The facility must					
(b) Service Consultation. The facility must employ or obtain the services of a licensed							
	pharmacist who						
	<b>.</b>						
	(2) Establishes a syst	tem of records of receipt and					
		rolled drugs in sufficient					
	detail to enable an ac	curate reconciliation; and					
	(3) Determines that d that an account of all	rug records are in order and					
	maintained and perio	•					
	(g) Labeling of Drugs	and Biologicals.					
		s used in the facility must be					
		e with currently accepted					
	professional principle						
	appropriate accessor						
	instructions, and the	expiration date when					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

Electronically Signed

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.

08/14/2017

		ND HUMAN SERVICES				FORM	D: 09/19/2017 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345569			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING _				C 27/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	SI	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			95 SPRINGBROOK AVENUE LAYTON, NC 27520		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		3E	(X5) COMPLETION DATE
F 431	Continued From page applicable. (h) Storage of Drugs		F4	431			
	the facility must store locked compartments	all drugs and biologicals in s under proper temperature only authorized personnel to					
	permanently affixed of controlled drugs lister Comprehensive Drug Control Act of 1976 a abuse, except when the package drug distribut quantity stored is min	provide separately locked, compartments for storage of d in Schedule II of the Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can					
	by: Based on observatio facility failed to date a of two medication sto	☐ is not met as evidenced on and staff interview, the an opened medication in one orage rooms and failed to edication on one of four			F 431 483.45 (b)(2)(3)(g)(h) Drug Records, Label/Store Drugs and Biologicals The bottle containing the milk of magnesia that was expired and the via Purified Protein Derivative (PPD, a tes	st for	
	shared by the 100,20 checked for expired r contained one vial of (PPD, a test for tuber vial were dated 16 No opened with no date. On 7/27/2017 at 10:0 on the 500 - 600 hall	AM, the medication room 0, 300 and 400 halls was medications. The refrigerator Purified Protein Derivative roulosis). The box and the ovember 2018. The vial was 00 AM, the medication cart was checked. A bottle ognesia had an expiration			tuberculosis) that was opened but not dated, were discarded by the director of nursing on 7/27/17. A 100% audit was completed on 7/27/15 by the Director of Nursing of all medication rooms to include the medication room shared by 100, 200, 3 and 400 halls and medication carts to include the 500 and 600 hall carts, in t facility, to ensure all med rooms and medication carts did not have any	of 17 300,	

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	-	ID HUMAN SERVICES				FC	ED: 09/19/2017 RM APPROVED NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345569		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST A. BUILDING			(X3) DATE SURVEY COMPLETED C 07/27/2017	
		B. WING					
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	SPRINGBROOK NURSING & REHABILITATION CENTER			195 SP CLAYT			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			D BE	(X5) COMPLETION DATE
F 431		7/2017 at 10:45 AM, the ated her expectation was ad when opened, and	F 4	me mill that rec Pro- con the A 1 on upp can me wa Nu 08, will De me op and me dui Me 600 inc 100 mc for inc by and X's the nu the	edications that were expired to include of magnesia and/or any medica at were opened and not dated that quired an open date to include Pu- betein Derivative. No further areas incern were noted during the audi- e Director of Nursing. 100% in-service to all licensed nu- dating medications that require of on opening and checking medica- rts and medication rooms for exp edications, and discarding approp- is initiated on 7/27/17 by the Dire- rrsing (DON) and will be complete (14/17. All newly hired licensed nu- l be in-serviced by the Staff evelopment Coordinator SDC on e- edications that require dating upo- ening and checking medication c d medication rooms for expired edications, and discarding approp- ring orientation. edication Carts to include the 500 0 hall carts and Medication Room e- dude the medication room shared 0, 200, 300, and 400 halls, will be onitored using a QI audit tool for edication Carts and Medication R Expired/Undated medications to edication Carts 1 month. The licer rses will be immediately re-traine e ADON, RN QI nurse and/or the OC nurses for any identified areas	ations ations ations ations of t by rses dating tion ired oriately, ctor of ed on ourses dating n arts oriately, and hs to d by e ooms vials, nurse a week eks nsed d by LPN	

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTU	PLE CONSTRUCTION		10. 0938-039 TE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345569			A. BUILDIN		COMPLETED	
		B. WING		C 07/27/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE	
				195 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & RE	HABILITATION CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 431 Continued From page 3		ge 3	F 43	<ul> <li>concern. The DON will revie the Medication cart/Expired QI Tool for completion and to areas of concerns were add X's 8 weeks and then month month.</li> <li>The Director of Nursing will results of the Medication car medications QI Tool to the E Committee monthly x 3 mon Executive QI committee will review the Medication cart a rooms/expired medications of monthly X's 3 months to det and trend to include continue frequency.</li> </ul>	medications o ensure all ressed weekly aly X's 1 forward the t/Expired fixecutive QI ths. The meet to nd med QI tool ermine issues	

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