PRINTED: 08/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345569		B. WING	B. WING		C <b>07/12/2018</b>		
NAME OF PROVIDER OR SUPPLIER  SPRINGBROOK NURSING & REHABILITATION CENTER				195 S	EET ADDRESS, CITY, STATE, ZIP CODE SPRINGBROOK AVENUE YTON, NC 27520	1 077	12/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	complaint investigation	cited as a result of the on on 7/13/2018. Event I/D 00135223.NC00137460.					
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)-		F	F 690			8/2/18
	resident who is continuadmission receives somaintain continence of condition is or become not possible to maintain \$483.25(e)(2)For a reincontinence, based of comprehensive assessensure that— (i) A resident who entindwelling catheter is	cility must ensure that ment of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's esment, the facility must ers the facility without an not catheterized unless the					
	catheterization was n (ii) A resident who entindwelling catheter or is assessed for removas possible unless the demonstrates that cathand (iii) A resident who is receives appropriate to	ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary;  incontinent of bladder treatment and services to nfections and to restore					
	§483.25(e)(3) For a reincontinence, based comprehensive asses						
ADODATODY	DIDECTORIC OD DDOVIDEDIO	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u></u>		TITI F		(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/26/2018

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.

**Electronically Signed** 

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
345569			B. WING		0	C <b>7/12/2018</b>	
NAME OF PROVIDER OR SUPPLIER  SPRINGBROOK NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 195 SPRINGBROOK AVENUE CLAYTON, NC 27520		1712/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	receives appropriarestore as much in possible. This REQUIREME by: Based on observaresident, family an failed to remove the catheter drainage collection bag to a prevented urine from approximately 8 here reviewed for urina.  Findings included: Record review reviewed for urina. Findings included: Record review reviewed for urina. Findings included: Record review reviewed for urina. Findings included: Record review reviewed for urina. Findings included: Record review review reviewed for urina. Findings included: Review of the faction for the faction of the Cardian for the Cardian fo	dent who is incontinent of bowel atte treatment and services to formal bowel function as a city is not met as evidenced ation, record review and a staff interview the facility are end cap from a urinary bag when changing from a leg regular drainage bag, which om draining in the bag for burs for 1 of 1 residents by catheters (Resident #62).  The dinimum Data Set (MDS) dated and Resident #62 was cognitively a limited to extensive assistance for all his activities of daily living. The dinimum Data Set (CAA) are a Assessment (CAA) are a Assessment (CAA) are a trisk for urinary tract rinary retention and the catheter. The CAA indicated the eplanned.	F	F 690 Bowel/Bladder Incontinence UTI CFR(s):486.25€(1)-(3)  The process that led to this that the facility failed to remove cap from a urinary catheter when changing from a leg or to a regular drainage bag, we prevented urine from draining for approximately 8 hours for residents reviewed for urina (Resident #62).  Upon assessment on 07/12/approximately 5:00am, the resident #62 opened the cat resident #62. The Resident (RR) was present and award cap removal.  On 7/12/18 the physician was examined resident #62 with orders.  A 100% audit was complete by the Treatment Nurse and Improvement (QI) Nurse of a with catheters to ensure cati were in the appropriate position.	deficiency is ove the end drainage bag ollection bag which ag in the bag or 1 of 1 ary catheters  /18 at nurse for theter cap for representative e of catheter  as notified and no new  ad on 7/12/18 d Quality all patients theter caps ition.		
		d a focus of an altered pattern		A 100% in-service was initia			

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			A. BUILDING			C 07/12/2018		
	<b>345569</b> B. WING							
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
CDDINGD		THA BILLITATION CENTED		19	95 SPRINGBROOK AVENUE			
SPRINGB	ROOK NURSING & RI	EHABILITATION CENTER		С	LAYTON, NC 27520			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 690	Continued From pa	age 2	F	690				
	-	he interventions included the		000	to be conducted by the DON, Assistant	,		
		free from complications form			Director of Nursing (ADON), Staff			
		ary catheter and to maintain a			Facilitator, Treatment Nurse, and/or QI			
		stem with an unobstructed			Nurse with all licensed personnel to			
	urine flow.				educate staff that facility practice would	l be		
				for nurses only to change catheter				
	An interview was c	onducted with Resident #62 on			systems. Furthermore, in-servicing will			
		AM. The resident's family			educate that the entire system should t	ре		
		ng the resident. The resident			changed unless otherwise indicated to			
		y catheter leg bag was			lessen the likelihood of cap error.			
	changed by Nursin			In-servicing will be completed on				
		g the night before at  OPM. The resident stated he			07/27/18. All newly hired licensed personnel will be in-serviced by the Sta	off		
	woke up around 5:			Facilitator in orientation in regards to	111			
		ent indicated he did not			facility practice for nurses only to change	ae		
		in. The resident further			catheter systems, and that the entire	,-		
		re times the catheter tubing			system should be changed if possible t	ю.		
	would become clos	gged and would have to be			lessen the likelihood of cap error.			
	irrigated. The resid	lent stated he called for the						
	nurse and she imm	nediately came to the room. He			25% audit of Catheter System			
		her of how he felt and she			Replacement will be monitored using a			
		eter tubing and the collection			Catheter Systems Replacement QI Too			
	•	e disconnected the collection			ensure cap position, and compliance w			
	bag, removed the l			new facility practice by the ADON, Unit				
	tubing and reconne reported when the			Manager, and QI nurses 3 times a wee X's 4 weeks, then weekly X's 4 weeks	ĸ			
	reconnected the ur			then monthly X's 1 month. The license	d			
				personnel will be immediately re-traine				
	the collection bag. The resident stated there were no further issues with the catheter. The resident removed the privacy cover form the urinary collection bag and approximately 200 milliliters of clear yellow urine was observed in the bag.				by the auditor for any identified areas of			
					concern. The DON will review and initia			
					the Catheter Systems Replacement QI	ĺ		
					Tool for completion to ensure all areas	of		
					concerns were addressed weekly X's 8	}		
		conducted on 7/12/2018 at 3:16			weeks and monthly X's 1 month.			
		ssistant (NA) #1. NA #1						
		the NA who changed the			The Executive QI committee will meet	.О		
		g bag to the large drainage bag			review the Catheter Systems			
		n 7/11/2018. NA #1 reported			Replacement QI tool monthly X's 3	ta		
	i sne was unsure of	the exact time but thought it			months to determine issues and trend	.U		

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		IDENTIFICATION NUMBED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	345569 B. WING				C 07/12/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		07/12/2016	
	10 112 11 011 001 1 21211			195 SPRINGBROOK AVENUE			
SPRINGB	ROOK NURSING & REH	IABILITATION CENTER		CLAYTON, NC 27520			
				· ·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE	
F 690	Continued From pag	e 3	F6	90			
	wanted to return to be asked to have the sire switched out to the lareturned to bed. NA urine from the small the small bag and recollection bag which assisted the resident resident's family menthe drainage bag was he did not recall if the large bag tubing who urinary catheter tubic checked on the residence was completing assignment. NA #1 in the collection bag since she emptied the bag after 8:00 PM pri	NA #1 reported the resident and from his wheelchair and mall urinary drainage bag arge collection bag before he #1 indicated she emptied the drainage leg bag, removed placed the bag with the large was in the room and to bed. The NA indicated the mber was in the room when s changed. The NA stated here was a blue cap on the en she attached it to the ng. The NA reported she dent around 10:30 PM when her last round on her ndicated there was no urine at that time. NA #1 stated he urine from the small legior to attaching the large was no need for concern. NA to notify the nurse.		include continued moni	toring frequency.		
	7/12/2018 at 3:50 Pf was the nurse on du 11PM to 7AM shift for the resident called for stated he felt his blaindicated the resider knew when there we The nurse stated shot o see if his urine was was no urine in the of stated she checked when she disconnected drainage system she was on the tubing. Since the state of	nducted with Nurse #1 on M. Nurse #1 confirmed she ty for the Resident #62 on the or 7/11/2018. Nurse #1 stated or her around 5:00 AM and dder was full. Nurse #1 at was alert and oriented and are issues with his bladder. As assessed the collection bag is normal and noticed there collection bag. The nurse the tubing for patency and ted the tubing form the enoticed the blue end cap he stated she removed the et tubing and the urine began					

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F 690 Continued From page 4 to flow in the collection bag. The nurse stated she assessed the resident's vital signs and they were normal. The nurse stated the resident reported the feeling of pressure was gone and he had no other issues during the shift. The nurse stated the catheter drained approximately 600 milliliters of clear urine after the cap was on the tubing when she assessed the resident to the Director of Nursing (DON) prior to leaving the facility that morning.  An interview was conducted with the Director of Nursing (DON) on 7/12/2018 at 4:12 PM. The DON stated she was notified of the issue with the drainage collection bag that morning. The DON stated the expectation was for proper care be provided by all staff with indwelling urinary catheters and the tubing to ensure the tubing was patent and draining urine.  F 695 SS=D F 695 SS=D F 695 Respiratory/Tracheostomy Care and Suctioning tracheostomy care and tracheal suctioning.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345569		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
SPRINGBROOK NURSING & REHABILITATION CENTER  (X4) ID PREFIX TAG  CONTINUED FROM INC. 27520  FROM INC. 27520  CONTINUED FROM INC.			B. WING		_	
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 690  Continued From page 4 to flow in the collection bag. The nurse stated she assessed the resident's vital signs and they were normal. The nurse stated the resident reported the feeling of pressure was gone and he had no other issues during the shift. The nurse stated the catheter drained approximately 600 milliliters of clear urine after the cap was removed. The nurse stated she assessed the resident to the Director of Nursing (DON) prior to leaving the facility that morning.  An interview was conducted with the Director of Nursing (DON) on 7/12/2018 at 4:12 PM. The DON stated she was notified of the issue with the drainage collection bag that morning. The DON stated the expectation was for proper care be provided by all staff with indwelling urinary catheters and the tubing to ensure the tubing was patent and draining urine.  F 695  SS=D  S483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	NAME OF PROVIDER OR SUPPLIER				195 SPRINGBROOK AVENUE	1 011122010
to flow in the collection bag. The nurse stated she assessed the resident's vital signs and they were normal. The nurse stated the resident reported the feeling of pressure was gone and he had no other issues during the shift. The nurse stated the catheter drained approximately 600 milliliters of clear urine after the cap was removed. The nurse stated she reported the end cap was on the tubing when she assessed the resident to the Director of Nursing (DON) prior to leaving the facility that morning.  An interview was conducted with the Director of Nursing (DON) on 7/12/2018 at 4:12 PM. The DON stated she was notified of the issue with the drainage collection bag that morning. The DON stated the expectation was for proper care be provided by all staff with indwelling urinary catheters and the tubing to ensure the tubing was patent and draining urine.  F 695 SS=D Respiratory/Tracheostomy Care and Suctioning \$483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.  This REQUIREMENT is not met as evidenced by:  Based on observation, resident and staff interviews and record review, the facility failed to provide respiratory care by not labeling or dating  The facility must ensure that a resident who needs respiratory care, including tracheostomy care and such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.  This REQUIREMENT is not met as evidenced by:  Based on observation, resident and staff interviews and record review, the facility failed to provide respiratory care by not labeling or dating	F 695	to flow in the collection assessed the resider normal. The nurse state feeling of pressure other issues during the catheter drained approclear urine after the content of tubing when she associated she reported the tubing when she associated she reported the stated she reported the tubing when she associated she reported the tubing when she associated she was drainage (DON) on 7/DON stated she was drainage collection be stated the expectation provided by all staff to catheters and the tubing patent and draining to the catheters and the tubing at the state of the state of the state of the catheters and the tubing at the state of the sta	on bag. The nurse stated she nt's vital signs and they were ated the resident reported re was gone and he had no he shift. The nurse stated the roximately 600 milliliters of cap was removed. The nurse he end cap was on the essed the resident to the DON) prior to leaving the notified of the issue with the ag that morning. The DON in was for proper care be with indwelling urinary bing to ensure the tubing was urine.  In the state of the issue with the agency of the issue with the agency of the issue with the agency of the issue with indwelling urinary bing to ensure the tubing was urine.  In the state of the issue with the agency of the issue with indwelling urinary bing to ensure the tubing was urine.  In the state of the issue with the agency of the such professional standards of the issue with individual tracheal suctioning. In the state of the issue with individual tracheal suctioning. It is not met as evidenced into goals and preferences, abpart.  In is not met as evidenced in the facility failed to the individual to th		F 695 Respiratory/ Tracheostomy Care and	8/2/18

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						С	
345569			B. WING _			07/	12/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SDDINGDI	ROOK NURSING & REH	ARII ITATION CENTER		1	95 SPRINGBROOK AVENUE		
SPRINGE	ROOK NUKSING & REH	ABILITATION CENTER		C	CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		
F 695	F 695 Continued From page 5		F 6	695			
F 695	reviewed for respirator Findings included: A review of the medic #62 was admitted 5/1 which included respir retention and aftercar replacement surgery. The admission Minim 5/25/2018 noted Resintact and had no ber of care. The MDS not extensive assistance Living (ADLs) with the totwo persons. The care plan dated a potential for ineffectiv respiratory failure. The maintained through noincluded oxygen there insufficient breathing. Order noted for oxygen minute via nasal cannon 7/11/2018 at 11:00 made of Resident #62 use and tubing conneconcentrator. There we the tubing. Resident #62 use and the tubing was An observation was an AM of Resident #62 utubing was connected a label and date. The had not been change On 7/13/2018 at 10:5 ambulating in the hall Upon entering the root the floor without a date.	cal record revealed Resident 8/2018 with diagnoses atory failure, urinary re following joint refollowing and had no rejection reformed Resident #62 needed for all Activities of Daily rephysical assistance of one reformed in a focus of reformed	F	695	The process that led to this deficiency that the facility failed to provide respira care by not labeling or dating the oxyge tubing for one of one residents reviewe for respiratory care (Resident #62).  The oxygen tubing for patient #62 that was undated was discarded and replace with new tubing and dated on 7/13/18.  A 100% audit was completed on 7/13/18.  A 100% audit was completed on 7/13/18 by the Treatment Nurse and Quality Improvement (QI) Nurse for all patients using Oxygen to include resident #62 to ensure all tubing was accurately labeled and less than or equal to 7 days old. A areas of concern were addressed at the time.  A 100% in-service with all licensed nurwas initiated on 7/13/18 by the DON in regards to the requirements of dating Oxygen tubing and replacing tubing greater than 7 days old. In-service will completed by 07/27/18. All newly hired licensed nurses will be in-serviced by the Staff Facilitator in regards to the requirements of replacing and dating oxygen tubing every 7 days during orientation.  25% audit of all oxygen tubing to include oxygen tubing for resident #62 will be completed by the Assistant Director of Nursing (ADON), Unit Manager, and Quality tool to ensure all tubing is accura	tory en ed ed 8 6 6 6 d ny at be the	
	ambulating in the hall Upon entering the roo the floor without a dat In an interview on 7/1	way without his oxygen. om, the tubing was laying in	completed by the Assistant Director of ut his oxygen.  Ding was laying in nother tubing.  11:00 AM, the  completed by the Assistant Director of Nursing (ADON), Unit Manager, and QI nurses utilizing the Oxygen Tubing QI audit tool to ensure all tubing is accurately labeled and less than or equal to 7 days				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
345569			B. WING_			C 07/12/2018	
NAME OF P	ROVIDER OR SUPPLIER	040000	1	STREET ADDRESS, CITY, STATE, ZIP CODE	l	07/12/2018	
				195 SPRINGBROOK AVENUE			
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	changed weekly by the dated at that time. And the company of the D of the oxygen tubing of inspecting the tubing no date on the tubing On 7/13/2018 at 11:30 clerk was interviewed document when the twas changed. She statook the list of resider around and changed In an interview on 7/1 DON stated her expe	ne central supply clerk and nobservation was made, in ON, in Resident #62's room, coiled on the floor. After the DON stated there was and stated she did not ubing on residents' oxygen ated every Wednesday she ats on oxygen and went	F 6	weekly X's 4 weeks then month month. The licensed nurses wi immediately re-trained by the a any identified areas of concern will review and initial the Oxyge QI Tool for completion to ensur of concerns were addressed w weeks and monthly X's 1 monto The Executive QI committee w review the Oxygen tubing QI to X's 3 months to determine issuterend to include continued monfrequency.	Il be nuditor for . The DON en Tubing e all areas eekly X's 8 h. ill meet to ool monthly es and		