STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 12/16/19 through 12/19/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WDXK11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 12/19/19. 2 of the 16 alligations were substantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 21 residents reviewed for MDS accuracy (Residents #6 and 24). Findings included: 1. Resident #6 was admitted to the facility on 5/31/18 with diagnoses that included non-Alzheimer's dementia and depression. A review of the quarterly MDS assessment dated 9/07/19 indicated the resident was not assessed for Brief Interview for Mental Status (BIMS). During an interview with Social Worker #2 on 12/18/19 at 12:59 PM, she revealed that she was responsible for completing BIMS assessment portion on the quarterly MDS assessment for	F 641	Springbrook Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Springbrook Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Springbrook Nursing and Rehabilitation reserves the right to refute any of the	1/6/20

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

Electronically Signed | 01/07/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 641	Continued From page 1 Resident #6. She stated it should have been done and she normally does them on time but had not done so for Resident #6. During an interview with Nurse #3 on 12/17/19 at 3:57 PM, she revealed that she had previously been the MDS Coordinator and was responsible for reviewing and ensuring the accuracy of Resident #6's quarterly MDS (dated 9/07/19) prior to submission. She stated the BIMS should have been done for Resident #6 and she did not know why it had not been done or why she had not noticed the inaccuracy prior to submission. During an interview with the Administrator on 12/18/19 at 4:13 PM, he stated the MDS for Resident #6 should have had a BIMS and he did not know why it had not been done. 2. Resident #24 was admitted to the facility on 10/05/2019 with diagnoses which included osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of the vertebra, sacral and sacrococcygeal region and congestive heart failure. The care plan dated 10/7/2019 revealed Resident #24 had an activity of daily living (ADL) and personal care deficit related to spinal paraplegia (is an impairment in motor or sensory function of the lower extremities caused by a spinal cord injury). A Minimum Data Set (MDS) dated 10/11/2019 revealed Resident #24 was cognitively intact and was independent with meals. The MDS further showed the resident required set up assistance with all other activities of daily living (ADL). The MDS coded the resident with no impairments of the lower extremities.	F 641	deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F641 Accuracy of Assessments On 12/19/19, the Social worker completed a Brief Interview for Mental Status (BIMS) and Resident Mood Interview for resident #6 with documentation in the electronic record. On 12/19/19, the MDS Coordinator completed a modification for Section G Functional Status for resident #24 to reflect impairment bilateral lower extremities. On 12/19/19, 100% audit of the most recent MDS assessment section C and section D for all residents to include resident #6 was completed by the MDS Coordinator to ensure all MDS□s assessments were completed accurately for cognition and mood status. The Social Worker will complete a BIMs and mood interview for any identified areas of concern during the audit. On 12/20/19, 100% audit of the most recent MDS assessment section G Functional Status was completed by the Unit Manager to include resident #24 to ensure the resident was coded correctly for functional status. All areas of concern	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 641	Continued From page 2 During an interview with the MDS Nurse on 12/18/2019 at 9:45 am, she stated the MDS dated 10/11/2019 was coded incorrectly for impairment of the lower extremities. The MDS Nurse further stated it was a data entry error and she was prepared to do a modification of the MDS. An interview with the Director of Nursing on 12/19/2019 at 11:00 am revealed the coding of Resident #24's MDS should have been coded to accurately reflect the lower extremity impairment. On 12/19/2019 at 1:30 pm during an interview with the Administrator, he stated it was obvious Resident #24 had an impairment of her lower extremities and the MDS Nurse should had checked the MDS before submitting it.	F 641	were addressed during the audit to include modification of MDS assessment. On 12/19/19 a 100% in-service was completed by the Facility Consultant with the MDS Coordinator, MDS nurse and Social Workers in regards to MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator, MDS nurse or Social Worker will be in-serviced by the Staff Facilitator during orientation in regards to MDS Assessments and Coding. 10% audit of all resident□s most recent MDS assessments, to include resident #6 and resident #24 will be completed by the unit manager and/or designee utilizing the MDS Accuracy Audit Tool. This audit will be completed weekly for four (4) weeks then monthly for one (1) month to ensure accurate and complete coding of the MDS assessment to include section C, D and section G. The unit manager and/or designee will address all areas of concern during the audit to include retraining of the MDS nurse and/or Social Worker and completing necessary assessment of the resident. The DON will review and initial the MDS Accuracy Audit Tool weekly for four (4) weeks and then monthly for one (1) month to ensure any areas of concerns were addressed. The DON will forward the results of MDS Accuracy Audit Tool to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 641	Continued From page 3	F 641	Assurance Performance Improvement Committee (QAPI) monthly for two (2) months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 656	Continued From page 4 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to utilize non-skid fall precaution mats on both sides of a resident's bed as indicated by the care plan for 1 of 4 residents reviewed for accidents. (Resident #9) Findings included: Resident #9 was admitted to the facility on 8/21/17. The resident's active diagnosis included dementia and difficulty walking. Resident #9's minimum data set assessment dated 9/21/19 revealed she was assessed as severely cognitively impaired. She required extensive assistance with bed mobility, locomotion on and off unit, dressing, eating, and personal hygiene. She was totally dependent on staff for transfers and toilet use. Resident #9's care plan dated 10/17/19 revealed the resident was care planned to be at risk for falls related to impaired mobility, history of falls, and an actual fall. The interventions included to place a non-skid mat on the floor on each side of	F 656	F656 Comprehensive Care Plan On 12/18/19, the assigned nursing aide placed fall mats on both sides of the bed for resident #9 per plan of care. On 12/18/19, Nursing Assistant #1 was immediately in-serviced by the unit manager with return demonstration on viewing care guide for safety interventions. On 12/20/19, the staff facilitator and unit managers completed a 100% audit of all residents at risks for falls to include resident #9 to ensure all safety interventions to include fall mats were in place per the plan of care. On 12/18/19, the unit manager initiated an in-service with return demonstration with nursing assistants (NA) to include NA #1 in regards to Viewing Care Guides with emphasis on viewing care guide for safety interventions. In-service was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 656	Continued From page 5 the resident's bed. During observation on 12/16/19 at 12:37 PM Resident #9 was in bed and had a non-skid mat on only the resident's left side of the bed. During observation on 12/16/19 at 3:48 PM Resident #9 was in bed and had a non-skid mat on only the resident's left side of the bed. During observation on 12/17/19 at 8:55 AM Resident #9 was in bed and had a non-skid mat only on the resident's left side of the bed. During observation on 12/17/19 at 12:47 PM Resident #9 was observed in bed and had a non-skid mat only on the resident's left side of the bed. During observation on 12/18/19 07:49 AM Resident #9 was observed in bed. There was still only a non-skid mat on the resident's left side of the bed. During an interview on 12/18/19 at 7:51 AM Nurse Aide #1, who was assigned to care for Resident #9 on 12/18/19, stated she was agency staff and had worked at the facility since October 2019. She further stated she was unaware of where nurse aides were able to find the care guides for residents and did not know Resident #9 needed a non-skid mat on both sides of the bed. During an interview on 12/18/19 at 7:55 AM Nurse #1 stated she believed care guides were either in resident closets or accessed through the tablets the nurse aides used. She stated she had access to the care guide through her own	F 656	on 1/6/20. All newly hired nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to Viewing Care Guides. 10 residents to include resident #9 will be observed by unit managers and/or designee weekly for four (4) weeks then monthly for one (1) month utilizing the Resident Care Audit Tool-Safety Interventions. This audit is to ensure all safety interventions were in place per the Care Plan/Care Guide. The unit managers and/or designee will address any concern identified during the audit to include placing appropriate safety intervention, updating care plan/care guide as indicated and re-training of staff. The Director of Nursing (DON) will review and initial the Resident Care Audit Tool-Safety Interventions weekly for four (4) weeks then monthly for one (1) month to ensure all areas of concern were addressed. The unit managers and/or designee will complete 10 staff observations weekly for four (4) weeks then monthly for one (1) month utilizing the Resident Care Audit Tool-Care Guides. This audit is to ensure the NA checked care guide prior to providing care to include ensuring all safety interventions are in place per the care plan/care guide. The unit managers and/or designee will address any concern identified during the audit to include re-training of staff. The Director of Nursing will review and initial the Resident Care Audit Tool-Care Guides weekly for (4) weeks then monthly for one (1) month to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 656	Continued From page 6 electronic documentation system. Upon review of Resident #9's care plan she stated the resident should have a fall mat on both sides of the bed. During an interview on 12/18/19 at 8:00 AM the Director of Nursing stated staff should be aware of how to access resident care guides. She further stated Resident #9 should have had a non-skid mat on each side of the bed according to the care guide and the care guide should have been followed by staff.	F 656	ensure all areas of concern were addressed. The Director of Nursing will forward the Resident Care Audit Tool-Care Guides and Resident Care Audit Tool-Safety Interventions to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Resident Care Audit Tool-Care Guides and Resident Care Audit Tool-Safety Interventions to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident, staff, and Nurse Practitioner interviews, and record reviews, the facility failed to follow the physician orders for 3 of 21 residents for daily weights (Resident #397), neurological checks (Resident #86), and discontinue indwelling catheter (Resident #96). Findings included: 1. Resident #397 was admitted to the facility on	F 658	F658 Services Provided Meet Professional Standards On 12/17/19, the unit manager clarified the order for daily weights for resident # 397. The nurse practitioner assessed resident #397 on 12/17/19 and discontinued the order as no longer clinically indicated. Monthly weight	1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 658	Continued From page 7 11/29/2019 with diagnoses which included chronic congestive heart failure. A physician's order dated 11/30/2019 revealed bumetanide tablet 2 milligrams, give 1 tablet by mouth one time a day for fluid retention. On 12/3/2019 daily weights were ordered. Further review of Resident #397's orders revealed a standing physician order for residents that were on daily weights. The order was to contact the physician if there was a 3 pound weight gain or loss which had occurred within one day, or if a 6 pound weight gain or loss had occurred in one week. A review of Resident #397's record revealed weights were taken on 11/30/2019 204 pounds (lbs.), 12/14/2019 225.0 lbs., and 12/16/2019 222.0 lbs. A care plan dated 12/2/2019 revealed a plan which focused on Resident #397's potential for or actual ineffective breathing pattern related to congestion heart failure with the intervention to weigh the resident as ordered. The Admission Minimum Data Set dated 12/5/2019 revealed Resident #397 was cognitively intact and had no shortness of breath, weight loss, or weight gain within the last month. The MDS showed the resident used a diuretic 6 days out of the 7 day look back period. The review of the Medication Administration Record (MAR) showed the order for daily weights were on the top of the MAR. During an interview on 12/18/2019 at 8:39 am with Nurse Aide #3, she stated Resident #397	F 658	monitoring was initiated per facility protocol. On 12/23/19, the facility nurse practitioner completed an assessment on resident #82 to ensure no neurological changes were identified. No new orders at this time. Resident #96 no longer resides in the facility. On 12/20/19, the unit managers initiated an audit of all weight monitoring orders for the past 30 days to include resident # 397 to ensure all weights were obtained per physician order. The unit managers will address all areas of concern identified during the audit to include obtaining weights as ordered by the physician and notification of the physician for any weight concerns identified during the audit. The audit was completed on 12/26/19. On 1/3/20, the director of nursing (DON) completed an audit of all resident incidents reports to include resident #82 for the past 14 days. This audit was to ensure that nurses completed neuro checks to include vital signs and neurological assessment for any incident involving suspected or unknown head trauma as directed by the physician. The unit managers and assigned hall nurse will address any concerns identified during the audit. On 12/20/19, the unit managers completed an audit of all residents with an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 658	Continued From page 8 had not received daily weights. NA #3 also stated when a resident was placed on daily weights the nurses would have the order on the Medication Administration Record (MAR) and would let the Nurse aides know when a resident needed a weight. She further stated the weights would be taken and the results given to the nurse and placed in the computer. An interview on 12/18/2019 at 9:00 am with Resident #397 revealed the staff did not weigh him daily and he was unaware that he was supposed to be weighed daily. The interview with the Dietician on 12/18/2019 at 2:06 pm revealed she did not monitor the daily weights. The dietician also stated the daily weights were monitored by the nurses. During a telephone interview with the Nurse Practitioner (NP) on 12/18/2019 at 3:10 pm, she revealed she expected the weights to be done as ordered. NP further stated the weights along with Resident #397's physical condition had to be assessed together. The NP also stated the resident had congestive heart failure and was on bumetanide. NP stated the bumetanide was regulated according to the weight gain or loss and Resident #397's physical changes such as breathing difficulties. The NP said the daily weights were changed on 12/17/2019 to weekly weights after she had assessed the resident. The NP indicated Resident #397's weight was not up, and the recorded weight did not correlate with the resident physical condition. She also stated it did not look like Resident #397's recorded weight was accurate. An interview with the Nurse #8 on 12/19/2019 at	F 658	indwelling Foley catheter to ensure residents have current orders for use and that no resident had an order to discontinue Foley that had not been completed. On 12/20/19, the Staff Facilitator initiated an in-service with nurses to include nurse #8, nurse #4 and agency nurses in regards to Physician□s Orders. Emphasis of the in-service included (1) completing weight monitoring as directed by the physician (2) completing neuro checks following suspected or unknown head trauma with complete neurological assessment and (3) following physician orders to include removal of Foley catheters. The in-service was completed on 1/6/20. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Physician□s Orders. An audit of 15 (fifteen) resident charts for new physician orders including residents #82 and #397 will be completed by the Unit Managers and/or designee to ensure orders to include but not limited to removal of Foley catheter, neuro checks and weight monitoring were completed per the physician□s order. This audit will be completed weekly for eight (8) weeks then monthly for one (1) month utilizing the Physician□s Orders Audit Tool. The unit managers and/or assigned hall nurse will address all areas of concern during the audit to include clarification of orders, assessment of the resident, notification of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 658	Continued From page 9 9:30 am revealed when the physician put the order in the computer, the order was then confirmed by the staff, and the order would show up on the MAR. The nurse that was assigned to Resident #397 for that day should have let the NA know that a weight was needed, and the results should have been placed in computer. An interview with the Director of Nursing (DON) on 12/19/2019 at 11:00 am revealed Resident #397 weights should have been obtained as ordered by the physician. The DON also stated there was no specific person assigned to monitor the daily weights and the assigned nurse was supposed to monitor the weight for that day. During an interview with the administrator on 12/19/2019 at 1:30 pm, he stated the weights were an order and it should have been done. 2. Resident #82 was admitted to the facility on 11/21/19 with diabetes mellitus and hypertension. Review of Resident #82'a nurse's note written by Nurse #4 dated 12/14/19 that indicated Resident #82 had an unwitnessed fall and when assessed had a knot on top of his head. Progress notes dated 12/13/19 at 6:30 PM, 12/13/19 at 7:30 PM, 12/13/19 at 8:30 PM, 12/13/19 at 9:30 PM, and 12/13/19 at 10:30 PM revealed neurological observations were conducted. The areas within the note for vital signs and level of consciousness were completed. The areas for pupil check, hand grasp and extremity movement were blank. Standing physician orders dated 11/21/19 revealed the neurological checks protocol for the facility was 15 minutes for 1 hour; then 30	F 658	physician of orders not completed as directed and/or re-education of staff. The Director of Nursing (DON) and/or Administrator will review and initial the Physician□s Orders Audit Tool weekly for eight (8) weeks then monthly for one (1) month to ensure all areas of concern were addressed. The Administrator will forward the Physician□s Orders Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will meet monthly for three (3) months and review the Physician□s Orders Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 658	Continued From page 10	F 658		

minutes for 2 hours; then hourly for 2 hours; then recheck in 9 hours for 72 hours.

An interview was conducted with Nurse #4 on 12/18/19 at 3:50 PM who stated Resident #82 had an unwitnessed fall on 12/13/19 and she was called down to his room by therapy staff. She indicated she completed neurological checks per facility protocol and relayed the information to the next nursing shift. Nurse #4 stated she did not notify the physician but understood one of the nursing supervisors had done so.

An interview was conducted with Nurse #3 on 12/18/19 at 3:56 PM who stated she spoke with Physician #1 regarding Resident #82 ' s unwitnessed fall on 12/13/19. She reported she was on the phone with him when the fall was discovered and made him aware at that time. Nurse #3 stated neurological checks should consist of vital signs, hand grips, cognition and speech. She continued she had reviewed the progress notes dated 12/13/19 labelled neurological observations and they should have included documentation regarding a pupil check, hand grasp, and extremity movement. Nurse #3 stated neurological checks should have been conducted every 9 hours for 72 hours according to the facility protocol.

An interview was conducted with Physician #1 on 12/18/19 at 12:15 PM who stated in the case of an unwitnessed fall he would expect neurological checks to be conducted for 24 hours. Physician #1 stated those checks should have included an assessment of motor strength, alertness and any changes in neurological baseline.

During an interview with Nurse Practitioner #1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 658	Continued From page 11	F 658		

12/18/19 at 3:10 PM she stated she would expect the facility to follow their protocol following an unwitnessed fall.

During an interview conducted with the Director of Nursing on 12/18/19 at 4:16 PM she indicated she was an agency nurse and was unsure of the facility protocol regarding neurological checks.

An interview was conducted with the Administrator on 12/19/19 at 12:30 PM he stated facility staff should follow the standing orders regarding neurological checks and he did not know why the orders were not followed after Resident #82 ' s unwitnessed fall on 12/13/19.
3. Resident #96 was admitted to the facility on 10/14/19 and discharged on 11/18/19 with diagnoses which included gastroesophageal reflux disease (GERD) and urinary retention.

Review of Resident #96's medical record revealed Nurse Practitioner (NP) #1 had written an order dated 11/01/19 that read, D/C (discontinue) indwelling urinary catheter on Sunday, 11/3/19.

Review of progress notes revealed a nurse's note written by Nurse #6 dated 11/05/19 that read in part catheter removed.

During an interview with Nurse #6 on 12/19/19 at 10:04 AM, she stated that on 11/05/19 Resident #96's daughter asked about the catheter being removed. When Nurse #6 looked at the resident's records, she found an order for the catheter to be removed on 11/03/19 which had not been done. Nurse #6 stated she removed the catheter on 11/05/19 and did not know why it had not been removed on 11/03/19 as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 658	Continued From page 12 During an interview with the facility Nurse Consultant on 12/19/19 at 10:37 AM, she stated she did not know why the catheter had not been removed as ordered. She further stated the staff who worked on that hall on 11/03/19 were agency staff and they had tried to reach them for interview but were unable to get in touch with them. During an interview with NP #1 on 12/18/19 at 3:05 PM, she stated the facility staff should follow her orders or contact her if they were unable to follow her orders. She further stated she was not notified that Resident #96's catheter had not been removed on 11/03/19 as ordered and she did not know why it had not been done. During an interview with the Administrator on 12/18/19 at 4:10 PM, he stated facility staff should follow the NP's orders or notify her if they were unable to follow them and he did not know why Resident #96's catheter had not been removed as ordered on 11/03/19.	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 758	Continued From page 13 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor an antipsychotic	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 758	Continued From page 14 medication and failed to have a stop date for an as needed psychotropic medication for 2 of 5 residents reviewed for unnecessary medications. (Resident #55, Resident #6) Findings included: 1. Resident #55 was admitted to the facility on 3/15/19. Her active diagnosis included anxiety disorder, psychosis, dementia, atrial fibrillation, hypertension, and cognitive communication deficit. Resident #55's order dated 6/24/19 revealed Resident #55 was ordered aripiprazole (an antipsychotic medication) 15 milligrams by mouth one time a day for behavior issues. The order start date was 6/25/19. Review of Resident #55's medication administration record from 6/2019 through 12/2019 revealed Resident #55 had received aripiprazole as ordered. Resident #55's minimum data set assessment dated 11/14/19 revealed she was assessed as severely cognitively impaired. She was assessed to have received an antipsychotic medication 7 days of the 7-day lookback period. Resident #55's Dyskinesia Identification System Condensed User Scale (DISCUS) assessment dated 12/6/19 revealed Nurse #2 documented Resident #55 was not receiving any antipsychotic medications. During an interview on 12/19/19 at 11:18 AM the Director of Nursing stated aripiprazole was an antipsychotic and Resident #55 had been	F 758	On 12/20/19, the Unit Manager completed an updated DISCUS assessment on resident #55 to reflect accurately antipsychotic medication use. There were no signs of Tardive Dyskinesia observed. On 12/18/19, the Unit Manager clarified the order for PRN Ativan for resident #6. The physician discontinued the order as no longer indicated. On 12/20/19, the Unit Manager completed an audit of all residents utilizing antipsychotic and/or anticholinergics to include resident #55. This audit is to ensure that a DISCUS assessment was completed timely with documentation of current medications and signs/symptoms of Tardive Dyskinesia. The Unit Managers, Assistant Director of Nursing and/or assigned hall nurse will address all areas of concern during the audit to include completing DISCUS assessment. On 12/20/19, the Unit Managers completed an audit of clarification of orders for all residents with PRN psychotropic medications for the past 30 days to include resident #6. This audit is to ensure all PRN psychotropic orders were transcribed per physician s order to include dose, frequency, route, indications for use and duration of use. The unit manager will address all areas of concern identified during the audit to include clarification of order and ensuring PRN orders are limited to the duration of 14 days unless otherwise indicated by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 758	Continued From page 15 receiving it since 6/25/19. She further stated the facility utilized the DISCUS screening to monitor antipsychotics and would be used for Resident #55 ' s aripiprazole. Upon review of the DISCUS screen perform on 12/6/19. She stated this was the first DISCUS performed on Resident #55 and concluded the staff member who performed the assessment should have captured the antipsychotic on the screening and not documented that Resident #55 was not receiving any antipsychotics and marked the questions not applicable. During an interview on 12/19/19 11:53 AM Nurse #2 stated she completed the DISCUS on 12/6/19. She further stated she did not identify aripiprazole as an antipsychotic and was why she documented Resident #55 was not on any antipsychotics and marked the questions as not applicable. 2. Resident #6 was admitted to the facility on 5/31/18 with diagnoses which included non-Alzheimer's dementia and depression. Review of Resident #6's medical record revealed a physician's order dated 11/12/19 that read, "Ativan 0.5 milligrams (mg) by mouth every 4 hours as needed for anxiety." agitation and received an order for Ativan. She further revealed she did not ask nor receive a medication frequency or duration for the Ativan during the telephone conversation with the doctor. During an interview with Physician #1 on 12/18/19 at 2:09 PM, he stated was contacted by Nurse #6 on 11/12/19 for Resident #6's agitation and he gave an order for Ativan. He stated he intended for the Ativan order to be a one-time dose and he believed it was a misunderstanding and he did	F 758	physician. On 12/20/19, the Staff Facilitator initiated an in-service with nurses to include nurse #2 in regards to DISCUS Assessments with emphasis on accurate completion and documentation of assessment of use of antipsychotic and/or anticholinergics medications and identification of symptoms related to Tardive Dyskinesia. In-service was completed on 1/6/20. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to DISCUS Assessments. On 12/20/19, the Staff Facilitator initiated an in-service with nurses to include nurse #6 in regards to Physician□s Orders. Emphasis of the in-service included (1) clarifying orders to ensure all medication orders include dose, frequency, route, indications for use and duration of use, (2) PRN psychotropic medications are limited to a 14-day use unless otherwise indicated by the physician. The in-service will be completed by 1/6/20. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Physician□s Orders. 10% audit of all residents utilizing antipsychotic and/or anticholinergics medications to include resident #55 will be completed by the MDS nurse weekly for four (4) weeks then monthly for one (1) month utilizing the DISCUS Audit Tool. This audit is to ensure DISCUS assessment was completed timely with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 758	Continued From page 16 not intend for the resident to receive Ativan on an as needed basis. A review of Resident #6's Medication Administration Records (MAR) revealed Resident #6 received one dose of Ativan on 11/12/19 and had not received any other doses but it was available on the MAR as a current physician's order. During an interview with the facility Nurse Consultant on 12/18/19 at 3:55 PM, she stated that Nurse #6 should have asked the physician for a frequency and duration of the Ativan and she did not know why she had not done so. During an interview with the Administrator on 12/18/19 at 4:10 PM, he stated the nurse should have verified the order with the physician to include a frequency and stop date and he did not know why she had not done so.	F 758	documentation of current medications and signs/symptoms of Tardive Dyskinesia. The Unit Managers and/or assigned hall nurse will address all areas of concern during the audit to include completing DISCUS assessment. The DON will review and initial the DISCUS Audit Tool weekly for four (4) weeks then monthly for one (1) month to ensure all areas of concern were addressed. 10% audit of all residents utilizing PRN psychotropic medications to include resident #6 will be completed by the MDS nurse weekly for four (4) weeks then monthly for one (1) month utilizing the PRN Psychotropic Medication Audit Tool. This audit is to ensure orders to ensure all PRN psychotropic medication orders include dose, frequency, route, indications for use and duration of use not to exceed 14 days unless otherwise indicated by the physician. The Unit Managers, Assistant Director of Nursing and/or assigned hall nurse will address all areas of concern during the audit to include completing clarification of orders when indicated. The DON will review and initial the PRN Psychotropic Medication Audit Tool weekly for four (4) weeks then monthly for one (1) month to ensure all areas of concern were addressed The DON will forward the results of the DISCUS Audit Tool and the PRN Psychotropic Medication Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 758	Continued From page 17	F 758	for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the DISCUS Audit Tool and the PRN Psychotropic Medication Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility staff failed to change gloves after they touched the handle of the refrigerator door and a beverage from the reach in refrigerator and before they plated ready to eat pancakes on residents ' meal trays during 1 of 3 meal service	F 812	F812 Food Procurement/Store/Prepare/Serve Sanitary On 12/18/19, dietary aide #1 (DA) was immediately in-serviced by the Assistant	1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 812	Continued From page 18 observations. The findings included: During the breakfast meal service on 12/18/19at 8:20 AM Dietary Aide (DA) #1 was observed placing food items on the residents ' plates. DA #1 was wearing gloves. She was observed to pick up the ready to eat pancakes with her gloved hand. She was then observed to walk away from the serving line to retrieve a beverage from the reach in refrigerator. DA #1 touched the reach in refrigerator door handle and the exterior of the beverage container while wearing the gloves. She then returned to the serving line and continued to plate the food items for the residents which included picking up the ready to eat pancakes while wearing the same pair of gloves. She did not change gloves during the meal service period. On 12/18/19 at 9:00 AM DA #1 stated she was certified in food safety. She added she should have changed gloves before touching the ready to eat pancakes again. During an interview with the Dietary Manager on 12/18/19 at 1:17 PM she stated DA #1 should have changed gloves after touching the refrigerator door handle and before she returned to the serving line and picked up the ready to eat pancakes.	F 812	Dietary Manager in regards to handwashing and changing gloves after completing each task. On 1/1/20, a 100% audit of all dietary aides to include dietary aide #1 was initiated by the Assistant Dietary Manager. This audit was to ensure all dietary aides utilized appropriate handwashing during meal prep and changed gloves after each task. Audit was completed on 1/3/20. On 12/18/19, an in-service was initiated by the Staff Facilitator with all dietary aides to include dietary aide #1 in regards to Gloves and Handwashing with emphasis on appropriate handwashing during meal prep and changed gloves after each task. In-service will be completed by 1/6/20. All newly hired dietary aides will be in-serviced during orientation by the Staff Facilitator in regards to Gloves and Handwashing. The Assistant Dietary Manager will observe five (5) dietary aides to include dietary aide #1 weekly for four (4) weeks then monthly for one (1) month utilizing the Dietary Audit Tool to ensure staff utilized appropriate handwashing during meal prep and changed gloves after each task. Assistant Dietary Manager will address all concerns identified during the audit to include re-education of staff. The Dietary Manager will review and initial the Dietary Audit Tool weekly for four (4) weeks then monthly for one (1) month. The Dietary Manager will forward the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 812	Continued From page 19	F 812	results of the Dietary Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly two (2) months and review the Dietary Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 20 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assess the residents for eligibility and ensure residents were offered the pneumococcal vaccinations upon admittance into the facility and offer annual influenza vaccine and for 5 of 5 residents reviewed for immunizations (Residents #40, #94, #17, #6, and #45). Findings included:	F 883	F883 Influenza and Pneumococcal Immunizations Resident received Pneumovax #13 in 2018 prior to admission to the facility. On 1/3/20, the Assistant Director of Nursing (ADON) obtained consent, educated resident/resident representative for resident #6 on pneumonia immunizations. Pneumovax #23 was administered on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 21	F 883		

The facility policy for Pneumococcal Immunization with the effective date of October 18, 2017 stated in part, "Residents will be offered the immunization upon admission, unless it is medically contraindicated ..." It further stated that "Upon consent, the pneumococcal vaccine (PCV13 or PPSV23) (Pneumococcal conjugate vaccine or pneumococcal polysaccharide vaccine) will be given according to the Centers for Disease Control and Prevention (CDC) and Advisory Committee for Immunization Practice (ACIP) recommendations."

The facility policy for Flu Immunization with the effective date of October 18, 2017 stated in part "Residents will be offered the flu vaccine annually from early October to March."

1. Resident #40, who was 73 years old, was admitted to the facility on 10/28/19 with diagnoses which included non-Alzheimer's dementia and diabetes. The admission Minimum Data Set (MDS) dated 11/03/19 revealed Resident #40 had moderately impaired cognition.

Record review of Resident #40's immunization information revealed no pneumococcal immunizations (PCV13 or PPSV23) had been documented as administered or refused.

Record review of Resident #40's immunization information revealed flu vaccine had been documented as "historical".

An interview with Nurse #3 on 12/17/19 at 4:07 PM revealed she had assumed the Infection Control position a couple of weeks ago and was aware the residents pneumococcal and flu vaccines had not been completed as they should 1/3/20.

Resident #94 received Pneumovax #13 in 2017 prior to admission to the facility. On 1/2/20, the Assistant Director of Nursing (ADON) obtained consent, educated resident/resident representative for resident #94 on pneumonia immunizations. Pneumovax #23 was administered on 1/2/20.

On 12/30/19, the assigned hall nurse obtained consent, educated resident/resident representative for resident #40 on pneumonia immunizations. Resident #40 received Pneumovax 23 on 12/30/19.

On 7/9/19, the Resident Representative (RR) for resident #17 declined consent for both Influenza and Pneumonia vaccines. On 12/30/19, the RR was educated on again on influenza and pneumonia vaccines but continued to decline immunizations.

On 1/4/20, the assigned nurse educated resident/resident representative for resident #45 on pneumonia vaccine. Resident/resident representative declined consent for Pneumovax vaccine.

On 12/18/19, 100% audit of all immunizations to include influenza and pneumonia #13 and #23 was completed by the Facility Consultant to ensure all immunizations were completed with appropriate documentation. The ADON, Unit Managers and assigned hall nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 22	F 883		

have been. She stated all residents should be offered the flu vaccine yearly and pneumococcal vaccines (PCV13 and PPSV23) should be offered on admission and she was aware this had not been done by the previous Infection Control Nurse. She further stated the prior Infection Control Nurse had given some of the annual flu vaccines in October but not all the residents had received the flu vaccine. Nurse #3 also stated they were in the process of auditing all resident flu and pneumococcal (PCV13 and PPSV23) immunization records to determine who needed the vaccines. Nurse #3 confirmed she did not know if Resident #40 had the pneumococcal vaccine or if it had been offered to her and she had not documentation either way. She also confirmed 'historical' meant the resident had had the flu vaccine prior to admission.

An interview with the facility Consultant on 12/18/19 at 8:55 AM revealed she was aware of a breakdown in the immunization process which had been discovered in November 2019. She further revealed all residents should have current pneumococcal (PCV13 and PPSV23) and flu vaccines and this was an issue they were working to resolve. The facility Consultant stated she did not know why the previous Infection Control Nurse had not been providing residents the pneumococcal vaccines.

An interview with the Administrator on 12/18/19 at 4:13 PM revealed he was aware of the flu and pneumococcal immunization 'challenges' and all residents should have their vaccines up-to-date.

2. Resident #94, who was 94 years old, was admitted to the facility on 6/06/18 with diagnoses which included depression and hypertension. The

will address all identified concerns to include obtaining consent, education of resident/RR on immunizations and providing immunizations as indicated.

On 12/18/19, an in-service was initiated by the Facility Consultant with the DON, ADON, Unit Managers and assigned hall nurse in regards to Immunizations with emphasis on obtaining consent, education of resident/resident representative, updating immunizations as indicated with appropriate and complete documentation, ensuring immunizations to include influenza and pneumonias are updated per facility protocol or annually. Staff must document any resident refusal in the electronic record. In-service was completed on 1/6/20. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Immunizations.

The ADON will review 15 (fifteen) resident influenza and pneumonia immunization records to include residents #6, #40, #17, #45 and #94 weekly for eight (8) weeks then monthly for one (1) month utilizing the Immunization Audit Tool to ensure all immunizations or refusal of immunizations have been updated per facility protocol. The ADON, unit manager and/or hall nurse will address all areas of concern identified during the audit to include but not limited to obtaining consent, education of resident and/or resident representative, providing immunization as indicated, obtaining history of immunization and/or documenting refusals in the electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 23 quarterly Minimum Data Set (MDS) dated 11/26/19 revealed Resident #94 had moderately impaired cognition. Record review of Resident #94's immunization information stated in part "Pneumovax Dose #1 Not Eligible" and no pneumococcal immunizations (PCV13 or PPSV23) had been documented as administered or refused. An interview with Nurse #3 on 12/17/19 at 4:07 PM revealed she had assumed the Infection Control position a couple of weeks ago and was aware the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) should be offered on admission and she was aware this had not been done by the previous Infection Control Nurse. Nurse #3 also stated they were in the process of auditing all resident flu and pneumococcal (PCV13 and PPSV23) immunization records to determine who needed the vaccines. Nurse #3 confirmed she did not know if Resident #94 had the pneumococcal vaccine or if it had been offered to her and she had not documentation either way. An interview with the facility Consultant on 12/18/19 at 8:55 AM revealed she was aware of a breakdown in the immunization process which had been discovered in November 2019. She further revealed all residents should have current pneumococcal (PCV13 and PPSV23) and flu vaccines and this was an issue they were working to resolve. The facility Consultant stated she did not know why the previous Infection Control Nurse had not been providing residents the pneumococcal vaccines. She also stated she did	F 883	record. The Director of Nursing will review and initial the Immunization Audit Tool weekly for eight (8) weeks then monthly for one (1) month to ensure all areas of concern were addressed. The DON will forward the Immunization Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will meet monthly for three (3) months and review the Immunization Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring The Administrator and Director of Nursing are responsible for ensuring completion of all audits, in-services and monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 24	F 883		

not know what "Not Eligible" meant and stated it could mean she had received prior to admission or refused or was otherwise not eligible but had no documentation to indicate what the "Not Eligible" documentation meant.

An interview with the Administrator on 12/18/19 at 4:13 PM revealed he was aware of the flu and pneumococcal immunization 'challenges' and all residents should have their vaccines up-to-date.

3. Resident #17, who was 79 years old, was admitted to the facility on 7/02/19 with diagnoses which included heart failure and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 10/09/19 revealed Resident #17 had severe cognitive impairment.

Record review of Resident #17's immunization information revealed no pneumococcal immunizations (PCV13 or PPSV23) had been documented as administered or refused.

Record review of Resident #17's immunization information revealed no flu vaccine had been documented as administered or refused.

An interview with Nurse #3 on 12/17/19 at 4:07 PM revealed she had assumed the Infection Control position a couple of weeks ago and was aware the residents' pneumococcal and flu vaccines had not been completed as they should have been. She stated all residents should be offered the flu vaccine yearly and pneumococcal vaccines (PCV13 and PPSV23) should be offered on admission and she was aware this had not been done by the previous Infection Control Nurse. She further stated the prior Infection Control Nurse had given some of the annual flu

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 25	F 883		

vaccines in October but not all the residents had received the flu vaccine. Nurse #3 also stated they were in the process of auditing all resident flu and pneumococcal (PCV13 and PPSV23) immunization records to determine who needed the vaccines. Nurse #3 confirmed she did not know if Resident #17 had the pneumococcal or flu vaccines or if they had been offered to her and she had not documentation either way.

An interview with the facility Consultant on 12/18/19 at 8:55 AM revealed she was aware of a breakdown in the immunization process which had been discovered in November 2019. She further revealed all residents should have current pneumococcal (PCV13 and PPSV23) and flu vaccines and this was an issue they were working to resolve. The facility Consultant stated she did not know why the previous Infection Control Nurse had not been providing residents the pneumococcal vaccines.

An interview with the Administrator on 12/18/19 at 4:13 PM revealed he was aware of the flu and pneumococcal immunization 'challenges' and all residents should have their vaccines up-to-date.

4. Resident #6, who was 81 years old, was admitted to the facility on 5/31/18 with diagnoses which included depression and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 9/07/19 had no Brief Interview for Mental Status (BIMS) related to cognition.

Record review of Resident #6's immunization information stated in part "Pneumovax Dose #1 Not Eligible" and no pneumococcal immunizations (PCV13 or PPSV23) had been documented as administered or refused.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 26	F 883		

An interview with Nurse #3 on 12/17/19 at 4:07 PM revealed she had assumed the Infection Control position a couple of weeks ago and was aware the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) should be offered on admission and she was aware this had not been done by the previous Infection Control Nurse. Nurse #3 also stated they were in the process of auditing all resident flu and pneumococcal (PCV13 and PPSV23) immunization records to determine who needed the vaccines. Nurse #3 confirmed she did not know if Resident #94 had the pneumococcal vaccine or if it had been offered to her and she had not documentation either way.

An interview with the facility Consultant on 12/18/19 at 8:55 AM revealed she was aware of a breakdown in the immunization process which had been discovered in November 2019. She further revealed all residents should have current pneumococcal (PCV13 and PPSV23) and flu vaccines and this was an issue they were working to resolve. The facility Consultant stated she did not know why the previous Infection Control Nurse had not been providing residents the pneumococcal vaccines. She also stated she did not know what "Not Eligible" meant and stated it could mean she had received prior to admission or refused or was otherwise not eligible but had no documentation to indicate what the "Not Eligible" documentation meant.

An interview with the Administrator on 12/18/19 at 4:13 PM revealed he was aware of the flu and pneumococcal immunization 'challenges' and all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 27	F 883		

residents should have their vaccines up-to-date.

5. Resident #45, who was 83 years old, was admitted to the facility on 5/31/18 with diagnoses which included non-Alzheimer's dementia and diabetes. The quarterly Minimum Data Set (MDS) dated 11/03/19 revealed Resident #45 was cognitively intact.

Record review of Resident #45's immunization information stated in part "Pneumovax Dose #1 Not Eligible" and no pneumococcal immunizations (PCV13 or PPSV23) had been documented as administered or refused.

An interview with Nurse #3 on 12/17/19 at 4:07 PM revealed she had assumed the Infection Control position a couple of weeks ago and was aware the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) should be offered on admission and she was aware this had not been done by the previous Infection Control Nurse. Nurse #3 also stated they were in the process of auditing all resident flu and pneumococcal (PCV13 and PPSV23) immunization records to determine who needed the vaccines. Nurse #3 confirmed she did not know if Resident #94 had the pneumococcal vaccine or if it had been offered to her and she had not documentation either way.

An interview with the facility Consultant on 12/18/19 at 8:55 AM revealed she was aware of a breakdown in the immunization process which had been discovered in November 2019. She further revealed all residents should have current pneumococcal (PCV13 and PPSV23) and flu

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(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 883	Continued From page 28 vaccines and this was an issue they were working to resolve. The facility Consultant stated she did not know why the previous Infection Control Nurse had not been providing residents the pneumococcal vaccines. She also stated she did not know what "Not Eligible" meant and stated it could mean she had received prior to admission or refused or was otherwise not eligible but had no documentation to indicate what the "Not Eligible" documentation meant. An interview with the Administrator on 12/18/19 at 4:13 PM revealed he was aware of the flu and pneumococcal immunization 'challenges' and all residents should have their vaccines up-to-date.	F 883		