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 08/20/2021

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 08/16/21 through 08/20/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5U4G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/16/21 through 08/20/21. Event ID# 5U4G11. 14 of the 30 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		9/28/21

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

Electronically Signed | 09/10/2021

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 08/20/2021

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to maintain a dignified dining experience by referring to residents (Residents # 20, 36, 62, 74, and 141) who needed assistance with meals as "feeders" during 2 of 3 dining observations. The findings included: 1. On 8/18/21 at 6:32 PM Nurse #9 was observed in the dining area. There were 4 trays one of the tables. The trays observed on the table were identified as Resident #20, # 62, #74 and #36. There was one resident seated in the dining area. Nurse #9 called loudly down the 500 hall to another staff member the trays left on the table were for the "feeders." She stated this phrase a total of 3 times. She then walked with one tray into a resident's room.	F 550	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 deficiencies on this Statement 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 08/20/2021

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 550	Continued From page 2 On 8/18/21 at 6:35 PM Nurse #9 returned to the dining area. She stated the 3 remaining trays (for Residents #20, 62, and 36) on the table in dining area were for the resident's who needed assistance with eating, but she usually called them "feeders". She added Resident #74 was a "feeder" too. She said it was a dignity concern to refer to those residents as "feeders". On 8/16/21 at 2:41 PM the Director of Nursing (DON) stated the word "feeder" should not be used. She said the staff member should have asked if a resident needed assistance with meals. She said the term "feeder" was a dignity concern for residents and should not be used. 2. Resident #141 was admitted to the facility on 8/13/21. Resident #141's care plan dated 8/16/21 revealed he was care planned for activities of daily living care. The interventions included to provide set up and assistance with meals as needed. During observation on 8/16/21 at 1:53 PM Nurse Aide #1 was entering Resident #141 room and turned to Nurse Aide #2 who was approximately 10 feet away and on the hall. Nurse Aide #1 asked if Resident #141 was "a feeder". There was another resident on hall about 20 feet away. During an interview on 8/16/21 at 1:54 PM Nurse Aide #2 stated when the staff spoke to each other they called residents "feeders" who needed assistance with meals, and she had never been told not to call residents "feeders". She concluded "feeders" was what they always called those residents in the facility. During an interview on 8/16/21 at 2:33 PM Nurse	F 550	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 On 8/16/21, the Director of Nursing in-serviced nursing assistant (NA) # 1 in regard to Dignity with emphasis on not referring to residents requiring feeding assistance as Feeder. Nurse #9 no longer employed by the facility. On 8/23/21, the Assistant Director of Nursing initiated interviews with all alert and oriented residents in regards to Dignity. This interview was to identify any resident who felt they were not treated with dignity or respect. There were no additional concerns identified during the interviews. On 8/31/21, the facility initiated 100% questionnaires with all nurse and nursing assistants to include nursing assistant #1. This questionnaire is to validate staff knowledge and understanding of not using inappropriate labels to include referring to residents requiring feeding assistance as Feeder. The Administrative Nurse, ADON and or Human Resource Coordinator will address all concerns identified during the questionnaires 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 08/20/2021

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 550	Continued From page 3 Aide #1 stated she used the term feeder to describe residents who needed assistance with meals. She stated it was a term she had always used to describe those residents but understood that it could be a dignity concern and would use another term to describe those residents in the future. During an interview on 8/16/21 at 2:41 PM the Director of Nursing stated the term "feeder" was not a term to be used by staff and they should have asked if Resident #141 needed assistance with meals. She concluded the term "feeder" was a dignity issue for residents and was not to be used.	F 550	include education of staff. The questionnaires will be completed by 9/28/21. On 8/16/21, the Director of Nursing (DON) initiated an in-service with all nurses and nursing assistants in regards to Non-Labeling. Emphasis was on not using inappropriate labels to include referring to residents requiring feeding assistance as Feeder. In-service will be completed by 9/28/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Non-Labeling. The Administrative nurses will complete 10 resident care audits with nurses and nursing assistants to include NA #1 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audit Tool-Dignity During Meals. This audit is to ensure staff are treating residents with dignity and respect by not using inappropriate labels to include referring to residents requiring feeding assistance as Feeder. The Administrative Nurse will address all concerns identified during the audit to include re-education of staff. The Director of Nursing (DON) will review the Resident Care Audit Tool-Dignity During Meals weekly x 4 weeks then monthly x 1 month to ensue all concerns were addressed. The DON will present the findings of the Resident Care Audit Tool-Dignity During Meals to the Executive Quality Assurance Performance Improvement (QAPI)	

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 08/20/2021

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 550	Continued From page 4	F 550	committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audit Tool-Dignity During Meals to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review the facility failed to provide a wheelchair to accommodate the need for 1 of 1 residents (Resident #82) reviewed for positioning and mobility. Finding included: Resident #82 was readmitted to the facility on 7/19/2021 with diagnoses that included pressure ulcer of the left buttock stage 4. The Quarterly Minimum Data Set (MDS) dated 7/25/2021 revealed Resident #82 was cognitively intact. It indicated she required extensive to total assistance with bed mobility and transfers. It indicated a wheelchair was used as a mobility device.	F 558	Resident # 82 no longer resides in the facility. On 8/31/21, the Therapy Director and Director of Nursing initiated an audit of all residents requiring a wheelchair for positioning and mobility. This audit is to ensure all residents identified were supplied a wheelchair and the wheelchair was the appropriate size for resident needs. The Therapy Director and Director of Nursing will address all concerns identified during the audit to include providing the appropriate wheelchair when indicated. The audit will be completed by 9/28/21. On 9/9/21, the Director of Nursing initiated an audit of all residents with orders to Get out of bed. This audit is to ensure staff are following physician orders to get resident	9/28/21

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 08/20/2021

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 558	Continued From page 5 The Physician order dated 7/21/2021 revealed Resident #82 should be up in wheelchair daily on day shift. A nursing note dated 7/21/2021 revealed the nurse was unable to find an available large wheelchair for Resident #82 to get up in. It indicated the nurse contacted the therapy department and was informed therapy did not have an available large wheelchair. A care plan reviewed on 7/28/2021 focused on activities of daily living. The interventions included mechanical lift for transfers and one person assistance for bed mobility. Observation on 8/16/2021 at 10:17 am and 2:00 pm revealed Resident #82 was in the bed resting with her eyes closed. Another observation on 8/17/2021 at 9:30 am and 3:00 pm revealed Resident #82 was in the bed with her eyes open. During an interview with Resident #82 on 8/18/2021 at 10:00 am she said she would like to sit up in a chair, but she needed a large wheelchair to sit in. Resident #82 stated she have been told by the Nurse Aides (NA) the facility did not have an available large wheelchair for her to sit in. The Resident was unable to provide specific NA names. An interview with NA #3 on 8/18/2021 at 1:00 pm revealed she was recently informed Resident #82 needed to be out of the bed daily and in a wheelchair. NA #3 said the nurses would tell the NAs of any changes to the Resident's care. The NA stated she did not offer to assist Resident #82	F 558	out of bed. The Administrative nurses and/or therapy staff will address all concerns identified during the audit to include getting residents out of bed or notifying the physician if resident unable to get out of bed as recommended for further instructions/orders. The audit will be completed by 9/28/21. On 9/9/21, the Director of Nursing initiated an in-service with all nurses and nursing assistants in regards Equipment Needs with emphasis on notification of Assistant Director of Nursing, Director of Nursing and/or Therapy staff if appropriate equipment to include wheelchair is not available. In-service will be completed by 9/28/21. All newly hired nursing and nursing assistants will be in-serviced during orientation in regards to Equipment Needs. 10% of all residents who require wheelchair for positioning or mobility will be completed by the Administrative nurse weekly x 4 weeks then monthly x 1 month utilizing Equipment Audit Tool. The Administrative nurses will address all concerns identified during the audit to include ensuring the resident has an appropriate wheelchair for positioning and mobility. The Director of Nursing will review the Equipment Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the Equipment Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review 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 08/20/2021

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 558	Continued From page 6 out of the bed because the facility did not have a large wheelchair for her to sit in. She further stated if there was a chair for Resident #82 she was never told about it. During an interview with Medication Technician (Med Tech) #1 on 8/18/2021 at 2:00 pm she stated she did not know Resident #82 was supposed to get out of the bed daily to a wheelchair. Med Tech #1 stated she would check with the therapy department to see if they had a wheelchair that Resident #82 could use. An observation on 8/18/2021 at 4:00 pm revealed Resident #82 was sitting beside her bed in a geri-chair. During an interview with the Director of Nursing on 8/19/2021 at 11:28 am she stated the nurses should have been aware of the order for Resident #82 to get out of bed to a wheelchair daily. She then stated if there was no wheelchair available the nurses should have contacted the therapy department. An interview with the Administrator on 8/20/2021 at 10:25 am revealed staff should have notified someone that Resident #82 did not have a wheelchair, and someone could have rented one for her.	F 558	Equipment 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		9/28/21

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 08/20/2021

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 561	Continued From page 7 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide showers according to the residents' preference for 2 of 4 residents reviewed for choices (Residents #28 & #54). The findings included: 1. Resident #28 was admitted to the facility on 8/12/20. His diagnoses included congestive heart failure, paraplegia, and diabetes. The quarterly minimum data set dated 6/12/21 revealed Resident #28 was cognitively intact. He required extensive assistance for activities of	F 561	On 8/28/21, a shower was offered and provided to resident # 28. On 8/31/21, a shower was offered and provided to resident # 54. On 9/1/21, the Administrative nurses initiated an audit of showers for all residents to include resident # 28 and resident #54 for the past 7 days This audit is to identify any resident who was not offered a shower per facility protocol during review period or who is not documented as refusing a shower. All areas of concern will be immediately addressed by the assigned hall nurses	

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 08/20/2021

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 561	Continued From page 8 daily living except he required total assistance with bathing. Item number 3 on a grievance submitted on 3/17/21 revealed Resident #28 "prefers showers". The investigation section revealed the former administrator discussed the grievance with Resident #28 and he again said he prefers showers and "that was shared with the nurse and aide on 3/18/21." A review of the care plan revealed the daily and activity preference updated 4/2/21 read "Prefers showers (not a bed bath) preferable on 3rd shift if possible." On 8/16/21 at 10:22 AM Resident #28 stated he was not getting showers. He said he should receive a shower two times per week. Resident #28 said the last time he had a shower was last Wednesday (8/11/21). He stated he was scheduled to receive a shower on Wednesdays and Saturdays in the mornings. A review of the shower documentation for Resident #28 revealed from 7/1/21 through 8/17/21 he received a shower on 7/3/21, 7/14/21, 7/17/21, 7/28/21 and 8/11/21. On 8/19/21 at 2:40 PM Nurse Aide (NA) #8 stated she would give a partial or full bath when short staffed. NA # 8 added they don't have time to give showers unless the resident can stand and walk. The Director of Nursing (DON) was interviewed on 8/19/21 at 2:33 PM. The DON stated all residents should have their choice of receiving a bed bath or a shower and if the resident refused it	F 561	and nursing assistants to include offering and providing resident with a shower or documenting resident refusal of shower with notification of RR of refusal if indicated. Audit will be completed by 9/28/21. On 8/18/21, the Administrative nurses initiated a Resident Preference Questionnaire with all alert and oriented residents to include resident # 28 and resident #54 in regards to preference for showers/nail care. The assigned nurse, Assistant Director of Nursing (ADON) and/or Minimum Data Set (MDS) nurse will address all concerns identified during the audit to include providing shower/bath/ADL care per resident preference and updating all care plans to reflect resident preference for shower/bed bath/ADL care. Audit will be completed by 9/28/21. On 9/2/21, the Director of Nursing updated the shower schedule to accommodate resident preference. On 9/1/21, the Director of Nursing initiated an in-service was with all nurses and nursing assistants in regards to (1) Resident Preferences with emphasis on resident right to make choices about aspects of life to include but not limited to shower preference, wake/sleep times, and meal preferences (2) Resident Showers/ADL. In-services will be completed by 9/28/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Resident Preferences and Resident Showers/ADL. 10 resident care audits to include resident	

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 08/20/2021

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 561	Continued From page 9 should be documented. On 8/20/21 at 10:50 AM the Administrator said the facility had enough staff. She was not aware the showers were not being provided. 2. Resident #54 was admitted to the facility on 10/29/19. His diagnoses included diabetes and heart failure. The significant change minimum data set (MDS) dated 7/7/21 revealed Resident #54 was cognitively intact. He required limited to extensive assistance with activities of daily living. He needed physical help with part of bathing. Resident #54's care plan revised on 2/20/20 revealed a bathing preference of showers. The care guide stated to honor resident's preferences on a daily basis. During an interview on 8/16/21 at 11:14 am Resident #54 stated he was not getting showers. He said the last time he had a shower was 2 weeks ago on Tuesday (8/3/21). Resident #54 said he was scheduled to have a shower two times per week, but the nursing aides (NAs) say they don't have enough help. He said he was scheduled to have his showers during the evening shift (3:00 PM - 11:00 PM) on Tuesdays and Thursdays. A review of the shower documentation from 7/1/21 through 8/17/21 for Resident #54 revealed he received a shower on 7/7/21, 7/13/21, 7/16/21, 7/20/21, 7/29/21, 8/3/21 & 8/8/21. On 8/19/21 at 2:40 PM Nurse Aide (NA) #4 stated she would give a partial or full bath when short staffed. NA #4 added they don't have time to give	F 561	#28 and resident #54 will be completed weekly x 4 weeks then monthly x 1 month. This audit is to ensure all residents are offered/provided appropriate ADL care to include but not limited to shower per resident preference and/or facility protocol, utilizing the Resident Care ADL Audit Tool. Any areas of identified concern will be addressed by the hall nurse and nursing assistant to include providing resident care per preference, updating care plan/care guide of resident preference, notification of the resident representative of care refusals and/or additional staff training. The DON will initial the Resident Care ADL Audit Tool weekly x 4 weeks, then monthly for one month to ensure all areas of concern were addressed. The Director of Nursing will forward the Resident Care ADL Audit Tool 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 ADL 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 08/20/2021

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 561	Continued From page 10 showers because frequently she was the only NA assigned to that hall. The Director of Nursing (DON) was interviewed on 8/19/21 at 2:33 PM. The DON stated all residents should have their choice of receiving a bed bath or a shower and if the resident refused it should be documented. On 8/20/21 at 10:50 AM the Administrator said the facility had enough staff. She was not aware the showers were not being provided.	F 561		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		9/28/21

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 08/20/2021

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 585	Continued From page 11	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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 08/20/2021

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 585	Continued From page 12 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review the facility failed to complete a grievance for 1 of 1 resident reviewed for grievances (Resident #142). Findings included: Resident #142 was admitted to the facility on 8/12/21. Her active diagnoses included displaced	F 585	On 8/16/21, the Admission staff completed a grievance form and initiated an investigation for resident # 142. Grievance investigation was completed and letter of resolution mailed to the resident representative on 8/20/21 On 9/1/21, the Social Worker initiated questionnaires with all alert and oriented residents to include resident #142 in	

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 08/20/2021

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 585	Continued From page 13 intertrochanteric fracture of left femur, chronic obstructive pulmonary disease, and chronic kidney disease. Resident #142's care plan dated 8/13/21 revealed she was care planned to require assistance with activities of daily living and personal care due to physical impairment related to left hip fracture. The interventions included to provide one-person physical assistance with toileting for safety. During an interview on 8/16/21 at 11:20 AM Resident #142 stated a nurse aide that worked with her on 8/15/21 told her she would not assist her with urination. She further stated she just reported the concern to Nurse #1 who told her she would discuss the concern with management. During an interview on 8/16/21 at 11:30 AM Nurse #1 stated she was waiting for the Director of Nursing to not be busy to ask her to go speak with Resident #142 about the concern she voiced that morning. During a follow up interview on 8/20/21 at 8:08 AM Nurse #1 stated she spoke to the Assistant Director of Nursing on 8/16/21 and she believed the Assistant Director of Nursing spoke to the Director of Nursing about the concern of dignity with a nurse aide and how she spoke to Resident #142. During an interview on 8/20/21 at 8:18 AM the Director of Nursing stated she was unaware of any concerns with Resident #142. She stated she would make a grievance. During an interview on 8/20/21 at 8:25 AM the	F 585	regards to grievances. This questionnaire was to identify any resident with a concern that not addressed by staff. The Social Worker, Assistant Director of Nursing, and/or Nurse Liaison will address all concerns identified during the audit to include completion of grievance investigation, grievance summary follow up with the resident or resident representative. Questionnaires will be completed by 9/28/21. On 8/31/21, the Director of Nursing initiated an in-service with all staff to include nurse #1 in regards Grievance Guidance with emphasis on reporting all concerns to the Supervisor at the time the concern is expressed. In-service will be completed by 9/28/21. All newly hired staff will be in-serviced during orientation in regards to the Grievance Guidance. The Social Worker will interview all alert and oriented residents to include resident #142 weekly x 4 weeks then monthly x 1 month utilizing the Grievance Resolution Interviews. This interview is to ensure resident concerns were addressed timely by staff. The Social Worker, assigned nurse, Assistant Director of Nursing (ADON), Dietary Manager, Therapy Manager or Housekeeping Manager will address all concerns identified during the audit to include completion of grievance investigation, grievance summary follow up with the resident or resident representative notification, completion of the grievance log and/or additional staff training. The Administrator and/or Director of Nursing (DON) will review all Grievance Resolution Interviews weekly x 4 weeks	

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 08/20/2021

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 585	Continued From page 14 Assistant Director of Nursing stated she vaguely remembered Nurse #1 did speak to her about a resident who shared concern with a staff member speaking rudely to a resident. She could not remember exactly what was said and who the resident was, just that it was brought to her by Nurse #1. She stated she did not complete a grievance and she could not remember if she spoke to the Director of Nursing that Monday. During a follow up interview on 8/20/21 at 9:15 AM the Director of Nursing stated when a grievance is brought to the facility's attention a grievance should be completed immediately and anyone could complete the grievance form in the facility and would give the completed grievance to the Director of Nursing or other administrative staff if she was not available. She stated once a concern was brought to the facility's attention it should be immediately documented on a grievance form and the investigation should begin. She concluded the facility should attempt to complete the grievance in 3 business days. During an interview on 8/20/21 at 9:50 AM the Administrator stated in morning meetings any concerns that come up are discussed and a grievance audit is completed in the conference room. She further stated any staff member could file a grievance and grievances were to be documented on a grievance form immediately upon the concern being received by the facility. She further stated the grievance form should have been completed but with everything going on with state in the building, the grievance must have fallen through the cracks.	F 585	then monthly x 1 month to ensure concerns were addressed. The Administrator will forward the Grievance Resolution Interviews to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Grievance Resolution Interviews 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/28/21

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 08/20/2021

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 15 §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 staff interviews and record review the facility failed to accurately code the hospice status of a resident for 1 of 2 residents reviewed for hospice care and failed to accurately document weight for 1 of 4 residents reviewed for nutrition (Resident #143 and Resident #78). Findings included: 1. Resident #143 was admitted to the facility on 6/2/2020. His active diagnoses included Parkinson's disease, coronary arterial disease, hypertension, dementia, and depression. Resident #143 s hospice admission documentation revealed he was admitted to hospice on 11/20/2020. Resident #143's quarterly minimum data set assessment dated 3/3/21 revealed he was assessed as severely cognitively impaired. He was coded as not receiving hospice care while a resident in the facility. Resident #143's care plan dated 3/24/21 revealed he was care planned for hospice care. The interventions included to consult with hospice and physician regarding pain management as needed, encourage and assist with feeding as needed, encourage to eat and let eat at own pace; weight loss anticipated due to hospice and end of life care, notify hospice and physician of significant changes, and provide medication as	F 641	On 8/17/21, The Minimum Data Set (MDS) nurse completed a significant correction to prior comprehensive assessment for Resident # 78, to reflect accurate coding for resident weight. On 8/17/21, The Minimum Data Set (MDS) nurse completed a significant correction to prior comprehensive assessment for Resident # 143, to reflect accurate coding for resident on hospice. On 9/1/21, The MDS Consultant completed an audit of section K for all residents most current Minimum Data Set (MDS) assessment to ensure all MDS assessments completed are coded accurately for weights. The MDS nurse completed modifications for all concerns identified during the audit. On 9/1/21, The MDS Consultant completed an audit of section O for all residents most current Minimum Data Set (MDS) assessment to ensure all MDS assessments completed are coded accurately for residents on hospice. There were no additional concerns identified. On 8/18/21, a 100% in-service was initiated by the MDS Consultant with the MDS Coordinator, MDS Nurse, DON, Administrator and Dietary Manager/Registered Dietician in regards to MDS Assessments and Coding per the Resident Assessment Instrument (RAI)	

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 08/20/2021

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 16 per physician orders and monitor for effectiveness. During an interview on 8/17/21 at 1:18 PM MDS Nurse #1 stated the 3/3/21 minimum data set assessment for Resident #143 was incorrect, and he was on hospice care at that time. He was admitted to hospice on 11/20/2020. During an interview on 8/17/21 at 1:22 PM the Administrator stated the minimum data set assessments should accurately reflect the hospice status of residents. 2. Resident #78 was admitted to the facility on 07/16/2021 with a diagnosis of multiple fractures after a motor vehicle accident. A physician's order for Resident #78 dated 07/16/2021 indicated to weigh Resident #78 on admission. The admission minimum date set assessment (MDS) for Resident #78 dated 07/22/2021 indicated he was 69 inches in height and weighed 069 pounds (lbs). A dietary progress note for Resident #78 dated 07/23/2021 at 4:25 PM written by the registered dietician (RD) indicated Resident #78 was unable to be weighed since his admission to the facility due to his injuries. During an interview on 08/17/2021 at 2:26 PM the RD stated she entered the weight of 069 lbs for Resident #78 on the MDS dated 07/22/2021. She went on to say this was an error as there had been no weight available for Resident #78 since his admission to the facility. During an interview on 08/18/2021 at 11:55 AM	F 641	Manual with emphasis on completing assessment accurately and completely. In-service will be completed by 9/28/21. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Director of Nursing during orientation in regards to MDS Assessments and Coding 10% audit of all resident□s most recent MDS assessments section K, and O will be completed by the Director of Nursing utilizing the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment to include section K for weights and section O for residents on hospice. The MDS Coordinator and DON will address all areas of concern identified during the audit to include retraining of the MDS nurse and completing necessary assessment of the resident. The Administrator will review and initial the MDS Accuracy Tool weekly x 4 weeks to ensure any areas of concerns were addressed The DON will forward the results of MDS Accuracy Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the MDS Accuracy 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 08/20/2021

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 17 MDS Nurse #2 stated the weight of 069 lbs entered by the RD on Resident #78's MDS dated 07/22/2021 had been an error. She further indicated no weight had been available for Resident #78 since his admission to the facility and a dash should have been entered instead. During an interview on 08/18/2021 at 4:01 PM the Administrator stated the MDS should be completed accurately. She went on to say this had been a case of human error.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident for a Preadmission Screening and Resident Review	F 644	On 8/19/21, resident #34 was referred for evaluation of PASRR. New PASRR level received on 8/23/21 at a Level II.	9/28/21

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 08/20/2021

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 644	Continued From page 18 (PASARR) re-screening when the resident had a new diagnosis for mental illness (Resident #34) for 1 of 1 resident reviewed for PASARR. The findings included: Review of the clinical record for Resident #34 revealed a PASARR screening dated 1/29/18 and was a PASARR level 1. Resident #34 was admitted to the facility on 9/30/20 and did not have a psychiatric diagnosis. The Admission Minimum Data Set (MDS) Assessment dated 10/6/20 revealed the resident was cognitively intact and did not have a psychiatric diagnosis or a level 2 PASARR. Review of the clinical record revealed a new diagnosis of brief psychotic disorder on 1/12/21. A diagnosis of hallucinations was added on 1/15/21 and post-traumatic stress disorder (PTSD) on 1/18/21. A Significant Change Minimum Data Assessment (MDS) dated 1/19/21 revealed the resident did not have a level 2 PASARR. There were new diagnoses added of psychotic disorder and post-traumatic stress disorder. A Quarterly MDS Assessment dated 6/28/21 revealed the resident was cognitively intact and received an antipsychotic medication for 7 days during the look back period and received antipsychotics on a routine basis only. The resident's active care plan last reviewed on 7/13/21 revealed the following: Use of psychotropic drugs with the potential for side effects. Receives antipsychotic medication.	F 644	On 8/30/21, the Facility Consultant initiated an audit of diagnosis for all residents with a Level I PASRR. This audit is to identify any resident with a newly added Level II PASRR qualifying diagnosis to ensure resident assessed for need to re-submit PASRR for evaluation. The Social Worker and/or Admission Director will address all concerns identified during the audit to include submission of Level II PASRR evaluation/re-evaluation. Audit will be completed by 9/28/21. On 8/30/21, an in-service on Level II PASRRs was initiated by the Administrator with the Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing with emphasis on referral for evaluation/re-evaluation of PASRR following changes in mental health status or newly Level II qualifying diagnosis. In-service will be completed by 9/28/21. All newly hired Social Worker, Minimum Data Set Nurse (MDS), and Director of Nursing will be in-serviced during orientation on PASRRs in regards to referral for re-evaluation following changes in mental health status. 100% of all resident with a newly added Level II PASRR qualifying diagnosis and/or behaviors to include resident #34 will be reviewed by the Minimum Data Set Nurse (MDS) and/or Administrative nurses week x 4 weeks then monthly x 1 month utilizing the PASARR Audit Tool. This audit is to ensure any newly written PASRR qualifying diagnosis or behaviors is reviewed to determine the need for re-submission of PASRR information. 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 08/20/2021

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 644	Continued From page 19 Medications as ordered. The care plan also noted the resident had visual hallucinations and to stay with the resident when the resident started to hallucinate and provide reality orientation without confrontation. An interview was conducted with Social Worker (SW) #1 on 8/18/21 at 3:56 PM. The SW stated the resident had a family member to passed away and she started to see a dead family member so they obtained a psychiatry consult. The SW further stated that urinary tract infections would bring on hallucinations and at this time the resident had improved. The SW confirmed the resident's last PASARR screening was on 1/29/18. On 8/19/21 at 8:27 AM, SW #1 stated that due to the new diagnosis of hallucinations and PTSD, a new PASARR screening should have been done. On 8/20/21 at 8:58 AM, the Administrator stated in an interview that it was her expectation that a rescreening for PASARR would have been done for Resident #34 with the new psychiatric diagnosis.	F 644	Unit Manager, Social Worker and/or MDS nurse will address all concerns identified during the audit to include completing a new PASRR review. The Director of Nursing (DON) will review and initial the PASARR Audit Tool weekly for 4 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The DON will forward the results of PASARR Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the PASARR 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 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		9/28/21

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 08/20/2021

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 657	Continued From page 20 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to have a quarterly care plan meeting for 2 of 3 residents reviewed for care plan meetings (Resident #54 and Resident #5). The findings included: 1. Resident #54 was admitted to the facility on 10/29/19. His diagnoses included diabetes and heart failure. A record review revealed a care plan meeting note by a previous social worked dated 8/11/20 which read met with resident today to review care plan. The significant change minimum data set (MDS) dated 7/7/21 revealed Resident #54 was cognitively intact. He required limited to extensive	F 657	On 8/31/21, the Social Worker rescheduled care plan meeting for resident # 5 and mailed a letter of invite to resident # 5 representative. The care plan meeting was held on 8/31/21. On 9/8/21, the Social Worker rescheduled care plan meeting for resident # 54 and mailed a letter of invite to resident # 54 representative. The care plan meeting was held on 9/9/21. On 8/27/21, the Social Worker reviewed all care plans completed in the past 30 days. This audit is to ensure the resident representative was invited to attend scheduled comprehensive care plan meetings. The Social Worker will review care plan by phone, mailed a copy of the care plan and/or reschedule care plan meeting for any resident/ resident	

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 08/20/2021

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 657	Continued From page 21	F 657		

assistance with activities of daily living. He needed physical help with part of bathing.

During an interview with Resident #54 on 8/16/21 at 11:22 AM he stated he did not remember participating in the development or review of his plan of care.

A review of the electronic medical record revealed Resident #54 had quarterly MDS assessments dated 1/26/21, 4/26/21 & 6/12/21. He also had the significant change MDS dated 7/7/21.

On 8/19/21 at 3:24 PM Social Worker (SW) #1 stated if a care plan meeting was conducted it would be documented in the electronic medical record. SW #1 said a care plan meeting should be conducted every 90 days (quarterly). SW #1 said Resident #54 was alert and oriented, so he knows what is going on with himself. SW #1 reviewed Resident #54's medical record and stated there were no care plan meeting with Resident #54 since the first of this year so the care plan meetings with Resident #54 must have been missed.

During an interview on 8/18/21 at 11:01 AM the Administrator stated care plan meetings should be held on admission and quarterly for all residents.

2. Resident #5 was admitted to the facility on 3/23/21.

Resident #5's minimum data set assessment dated 7/30/21 revealed she was assessed as cognitively intact. She had no behaviors and required supervision with bed mobility, transfers, walking in room and corridor, locomotion on unit, dressing, eating, toilet use, and personal hygiene.

representative not invited with documentation in the clinical record. Audit will be completed by 9/28/21.
On 8/23/21, the Administrator initiated an in-service with the Social Workers to include Social Worker #1, DON and MDS nurses in regards to Comprehensive Care Plans. Emphasis is on written invitation of resident and/or resident representative with documentation of invitation mailed and response of resident and/or resident representative in the electronic record. All newly hired Social Workers, DON and MDS nurses will be in-serviced during orientation in regards to Comprehensive Care Plans. In-service will be completed by 9/28/21.
The Assistant Director of Nursing and/or Administrative nurse will review progress notes for all resident care plan to include resident #5 and resident #54 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure the Social Worker mailed a written invitation to the resident and/or resident representative for all care plan meetings with documentation of invitation mailed and response of the resident and/or resident representative in the electronic record. The Medical Records Director and/or Admission Staff will address all concerns identified during the audit to include re-scheduling care plan meeting if indicated and education of staff. The Administrator and/or DON will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.
The Director of Nursing 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 08/20/2021

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 657	Continued From page 22 Her active diagnoses included diabetes mellitus, heart failure, hypertension, hyperlipidemia, depression, and overactive bladder. Resident #5's chart revealed there was no documentation of a care plan meeting for Resident #5. During an interview on 8/16/21 at 12:11 PM Resident #5 stated she did not know of any care plan meetings in the facility and had never been invited to a care plan meeting. During an interview 8/18/21 at 10:53 AM Social Worker #1 stated Resident #5 had not had a care plan meeting since her admission on 3/23/21. He further stated residents which included Resident #5 should have care plan meetings quarterly and Resident #5 had not had one. He concluded the social worker who was responsible for doing care plan meetings with the 800 hall was no longer at the facility and they were playing catch up with care plan meetings for a few residents. During an interview on 8/18/21 at 11:01 AM the Administrator stated she was not aware Resident #5 had not had a care plan meeting. She concluded care plan meetings should be held on admission and quarterly for all residents.	F 657	Care Plan Audit Tool 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 Care Plan 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		9/28/21

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 08/20/2021

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 677	Continued From page 23 Based on record review, resident and staff interviews, the facility failed to provide showers or bed baths for 1 of 2 residents who were dependent on staff for assistance with activities of daily living (Resident #60). Findings included: Resident #60 was admitted to the facility on 1/08/21 with diagnoses that included hemiplegia and hypertension. The quarterly Minimum Data Set (MDS) dated 7/17/21 indicated Resident #60 was cognitively intact and was coded as extensive assistance or total dependence for activities of daily living (ADL) except independent for eating. The MDS noted no rejection of care or behavior symptoms. The admission MDS dated 1/14/21 listed a resident response of 'Very Important" when asked about being able to choose between a bed bath, tub bath, sponge bath or shower. Resident #60's care plan revised on 7/30/21 had a focus of activities of daily living with an intervention for bathing as dependent on staff. Review of the facility's shower schedule posted at the Nurses' station revealed that Resident #60's room and bed number were scheduled to receive showers on Monday and Thursdays during the hours of 3:00 PM and 11:00 PM. Review of Resident #60's bathing reports provided by the facility for the period of 6/20/21 through 8/16/21 revealed there were no documented showers. Further review revealed no bed baths for 7/01, 7/02, 7/03, 7/04, 7/07, 7/08,	F 677	On 9/2/21, resident # 60 was offered a shower but declined. A full bed bath was provided per resident preference. On 9/1/21, the Administrative nurses initiated an audit of showers for all residents to include resident #60 for the past 7 days This audit is to identify any resident who was not offered a shower per facility protocol during review period or who is not documented as refusing a shower. All areas of concern will be immediately addressed by the assigned hall nurses and nursing assistants to include offering and providing resident with a shower or documenting resident refusal of shower with notification of RR of refusal if indicated. Audit will be completed by 9/28/21. On 8/18/21, the Administrative nurses initiated a Resident Preference Questionnaire was with all alert and oriented residents to include resident #60 in regards to preference for showers/nail care. The assigned nurse, Assistant Director of Nursing (ADON) and/or Minimum Data Set (MDS) nurse will address all concerns identified during the audit to include providing shower/bath/ADL care per resident preference and updating all care plans to reflect resident preference for shower/bed bath/ADL care. Audit will be completed by 9/28/21. On 9/1/21, the Director of Nursing initiated an in-service was with all nurses and nursing assistants to include nursing assistant #4 and nursing assistant #6 in regards to (1) Resident Preferences with emphasis on resident right to make	

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 08/20/2021

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 677	Continued From page 24 7/10, 7/17, 7/19, 7/20, 7/22, 7/26, 7/29, 7/30, 7/31, 8/04, 8/11, 8/12, and 8/14. Review of Resident #60's progress notes revealed no refusals for showers. An interview on 8/19/21 at 9:42 AM with Resident #60 revealed he had not received a shower since he was admitted to the facility. He stated sometimes he would not get a bed bath for several days. He stated he had never been offered a shower and that he had never refused any ADL care. He stated he had complained to the previous Director of Nursing about his lack of ADL care and did not know why he had never been offered a shower or received daily bed baths. An interview on 8/19/21 at 3:22 PM with Nursing Assistant (NA) #4 revealed she worked 3:00 PM to 11:00 PM and was often assigned to work on Resident #60's hall. She stated she had given him a bed bath but had never given him a shower. She stated his care plan stated he was dependent on staff and to her that meant he did not get a shower. An interview on 8/19/21 at 3:42 PM with NA #6 revealed she worked 3:00 PM to 11:00 PM and sometimes was assigned to work on Resident #60's hall. She stated she had given Resident #60 a bed bath but had never given him a shower. She also stated he had never refused any ADL care when she was caring for him. NA #6 stated there was a resident shower schedule at the Nurses' station with days of the week, shifts, and resident room numbers to determine when a resident was supposed to have a shower. She confirmed Resident #60's scheduled shower	F 677	choices about aspects of life to include but not limited to shower preference (2) Resident Showers/ADL. In-services will be completed by 9/28/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Resident Preferences and Resident Showers/ADL. 10 resident care audits to include resident #60 will be completed weekly x 4 weeks then monthly x 1 month. This audit is to ensure all residents are offered/provided appropriate ADL care to include but not limited to shower, nail care, and removal of facial hair per resident preference and/or facility protocol, utilizing the Resident Care ADL Audit Tool. Any areas of identified concern will be addressed by the hall nurse and nursing assistant to include providing resident care per preference, updating care plan/care guide of resident preference, notification of the resident representative of care refusals and/or additional staff training. The Director of Nursing (DON) will initial the Resident Care ADL Audit Tool weekly x 4 weeks, then monthly for one month to ensure all areas of concern were addressed. The Director of Nursing will forward the Resident Care ADL Audit Tool 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 ADL Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for	

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 08/20/2021

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 677	Continued From page 25 days were Monday and Thursday during second shift. An interview on 8/19/21 at 2:33 PM with the Director of Nursing (DON) revealed she believed all residents should have a shower if they wanted and she did not know why Resident #60 had not received a shower. An interview on 8/20/21 at 9:26 AM with the Administrator revealed she expected all residents to be offered a shower or bath and did not know why Resident #60 had not received a shower.	F 677	further and / or frequency of monitoring.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff, family, and physician interviews, and record review the facility failed to transcribe orders accurately to the electronic medical record and have medications available as ordered for 1 of 7 residents for medication regimen review (Resident #143). Findings included: Resident #143 was admitted to the facility on 6/2/2020. His active diagnoses included	F 684	Resident #143 no longer resides in the facility. On 8/30/21, the DON completed an audit of the current Hospice Plan of Care Orders to the residents medication administration record (MAR). This audit is to ensure that all Hospice orders were transcribed correctly to the MAR, medications were available and being administered per physician order. The assigned nurse will address all concerns	9/28/21

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 08/20/2021

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 684	Continued From page 26 Parkinson's disease, coronary arterial disease, hypertension, dementia, and depression. Resident #143's minimum data set assessment dated 3/3/21 revealed he was assessed as severely cognitively impaired. He had no behaviors and required extensive assistance with bed mobility, eating, toilet use, and personal hygiene. He was totally dependent on staff for transfers and dressing. He received and antidepressant and opioid 7 days of the 7 day lookback period. Resident #143's care plan dated 3/24/21 revealed he was care planned for hospice care. The interventions included to consult with hospice and physician regarding pain management as needed and provide medication as per physician orders and monitor for effectiveness. Resident #143's hospice admission documentation revealed he was admitted to hospice on 11/20/2020. Resident #143's admission orders from hospice dated 11/20/2020 revealed he was ordered Levsin 0.125 milligrams every hour sublingually as needed for secretions. He was also ordered Ativan 0.5 milligrams by mouth, under tongue, or rectally every 4 hours as needed for anxiety or agitation. Resident #143's orders revealed he was ordered on 11/26/2020 Ativan 0.5 milligrams by mouth every 4 hours as needed for anxiety. This order was discontinued on 12/6/2020. On 12/6/2020 he was ordered Ativan 0.5 milligrams by mouth every 4 hours as needed for anxiety. This was discontinued on 1/5/21. Ativan was not reordered	F 684	identified during the audit to include updating the MAR and notification of the physician if indicated for order clarification. On 9/1/21, the Director of Nursing (DON) initiated an in-service with all nurses in regards to Hospice Orders with emphasis the process for transcribing orders for residents on hospice. In-service will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation in regards to Hospice Orders. The Administrative Nurse will monitor all orders for residents receiving hospice weekly x 4 weeks then monthly x 1 month utilizing the Hospice Audit Tool. This audit is to ensure that all hospice orders were transcribed correctly to the MAR and being administered per physician order. The Administrative Nurse will address all concerns identified during the audit to include updating the MAR, notification of the physician if indicated for order clarification and/or re-education of the nurse. The DON will review the Hospice Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the Hospice Audit Tool 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 Hospice 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 08/20/2021

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 684	Continued From page 27	F 684		

again until 5/20/21 when it was ordered as Ativan 0.5 milligrams give 1 tablet by mouth every 4 hours as needed for anxiety or agitation rectally or under tongue.

Resident #143's orders revealed he was not ordered Levsin until 5/20/21 when he was ordered Levsin 0.125 milligrams every hour sublingually as needed for secretions.

A nursing note dated 5/20/2021 at 4:05 PM revealed Nurse #2 documented Resident #143's condition was declining. The responsible party was at bedside and requested Ativan, however no order was visible on Resident #143's medication administration record. Hospice was contacted and the nurse was waiting for a return call.

A nursing note dated 5/20/2021 at 10:01 PM revealed Nurse #3 spoke with the hospice nurse and was faxed orders for a comfort care kit. The orders were verified with the physician. Resident #143 was resting with eyes closed and oxygen via mask and receiving morphine as ordered. Daughter remains at bedside and informed of any updates or changes. Ativan was not given to the resident at that time.

A review of the Medication Administration Record for November 2020 through May 2021 revealed he did not receive any doses of Ativan or Levsin.

During an interview on 8/18/21 at 8:53 AM the Director of Nursing stated once a resident goes on hospice, hospice directs the care. The orders for Resident #143 were to be taken from hospice, verified by staff, and entered into their electronic system. She stated MDS Nurse #1 was the staff member she believed should have entered 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 08/20/2021

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 684	Continued From page 28	F 684		

orders into the electronic system for Resident #143 as she was working on the floor at that time and was not a Minimum Data Set nurse at that time. She stated once Resident #143 was admitted to hospice on 11/20/2020 he was ordered Ativan 0.5 milligrams by mouth, sublingually, or rectally every 4 hours. She further stated this order was transcribed to their system as Ativan 0.5 milligrams by mouth every four hours and did not capture the other ways the medication could be given. She further stated due to as needed psychotropic meds requiring a stop date, they were rewriting the order for Ativan every 30 days and on 1/5/21 it was not reordered in their electronic system and she did not know why. She further stated it was her expectation that hospice orders were correctly transcribed onto their electron system. The Director of Nursing continued to state when the responsible party was requesting Ativan from Nurse #2 on 5/20/21 there was a current order from hospice for Ativan but Nurse #2 was agency and did not know to look at hospice orders and did not provide the medication and instead contacted hospice at 4 PM when the medication was requested. The order was not confirmed by hospice until 10 PM with Nurse #3 who received the order and entered it in the system correctly however it was not given. The Director of Nursing stated when Resident #143 went on hospice, he was also ordered Levsin 0.125 milligrams every hour sublingually as needed for secretions on 11/20/2020. She stated this order was not transcribed to the electron orders and medication administration record until 5/20/21 when the family was requesting medications and the hospice nurse was called to verify orders for the medications. This order should have been transcribed to their electronic system as well and

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 08/20/2021

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 684	Continued From page 29	F 684		

she was unsure as to why it was not done. The Director of Nursing stated during her time with the resident around his death she assessed him on 5/15/21 and there was no issue with secretions and comfort. He was having difficulty swallowing; however, which made it important to have secretion medication ordered and have Ativan ordered to be given sublingually or rectally.

During an interview on 8/18/21 at 9:33 AM Nurse #2 stated she was told by the facility when hospice took over a resident, hospice supplied the medications that were needed. She inquired with a unit manager, and could not remember which manager it was, about Ativan as it was not ordered on the medication administration record. The unit manager told her to contact hospice. She stated she left a message and she never received the order from hospice before she left that shift so she did not give the medication. Nurse #2 stated Resident #143 was working hard for respirations and keeping his oxygen saturation up so the family felt the Ativan would help relax him. She stated he was on oxygen which helped him relax and morphine was being given every hour which also aided in his comfort and he did not appear in any immediate distress or issues with secretions according to her nursing judgement at the time the family was requesting Ativan. The family just wanted to ensure he was comfortable and had Ativan available to him if needed.

During an interview on 8/18/21 at 11:35 AM Physician #1 stated hospice orders were the orders to be followed once a resident was on hospice. He concluded he did not believe any harm came from not having Levsin and Ativan ordered for Resident #143; however, staff were 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 08/20/2021

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 684	Continued From page 30	F 684		

accurately transcribe orders from hospice to the electronic medical record and provide hospice medications as ordered.

During an interview on 8/18/21 at 12:34 PM the Executive Director of the Hospice Company stated Resident #143 was being followed by Hospice Nurse #1 in the facility. She stated Resident #143 was ordered Levsin 0.125 milligrams every hour sublingually as needed for secretions and was ordered Ativan 0.5 milligrams by mouth, under the tongue, or rectally every 4 hours as needed for anxiety or agitation. She further stated these orders were not discontinued until his death on 5/21/21. The hospice company operated under the understanding that the orders they implemented were being followed by the facility and were available to the resident unless notified otherwise by the facility. She concluded the facility did not inform the hospice company the orders for Ativan and Levsin were not being implemented so they had assumed the orders were in place.

During an interview on 8/18/21 at 3:44 PM Nurse #3 stated Nurse #2 spoke to her the evening before Resident #143 died about the family requesting Ativan. She stated if her note was around 4 PM then that was when the nurse spoke to her about the Ativan the family was requesting. She stated she looked with the nurse in the facility's medication administration record and electronic chart for Resident #143 and did not see any orders for Ativan. She was not aware of any separate orders from hospice available in the facility for Resident #143. The nurse stated she informed Nurse #2 there were no orders for Ativan and the nurse would contact hospice for order clarification. The nurse stated she called

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 08/20/2021

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 684	Continued From page 31	F 684		

Hospice about the orders and the hospice nurse informed her the orders should be in the chart. She again looked and did not find any orders from hospice and she clarified again with hospice who finally did resend the orders. She stated she got the new orders when her note was placed so if the note was at 10 PM, then that was when she got the new orders for Ativan and Levsin. She stated she then faxed the orders to the pharmacy who in turn faxed the orders to a local pharmacy where she could go pick the order up for the resident. She concluded by the time she had the medication available to give to the resident in the facility, he had passed away.

During an interview on 8/18/21 at 4:18 PM Resident #143's family member stated the resident was struggling to breath the afternoon and evening of 5/20/21 and his respirations were very loud and very wet. He was getting his ordered morphine on her request ever hour. She concluded she felt the Ativan and Levsin would have made his passing more comfortable, but it was unavailable to him at the time he needed it even though it had been ordered by hospice ever since his admission to hospice in November of 2020.

During an interview on 8/19/21 at 8:25 AM Detective #1 stated he had opened an investigation into Resident #143 on 12/13/20. He further stated on 5/26/21 he spoke with Hospice Nurse #1 and the hospice nurse informed him she had been assigned to Resident #143 since January of 2021. She informed him during a visit around 5/12/21 she was informed the facility did not receive Resident #143's orders which included Ativan and Levsin. Hospice Nurse #1 sent the orders again on 5/12/21, 5/13/21, and

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 08/20/2021

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 684	Continued From page 32	F 684		

5/17/21. The hospice nurse also personally delivered the orders to the facility on 5/18/21 but no name was given as to which staff she supplied the orders to. Each time she sent the orders she was later told the orders were never received. The hospice nurse informed Detective #1 she did not believe this was true as the facility was administering morphine as directed by hospice but not the other medications.

During an interview on 8/19/21 at 9:34 AM MDS Nurse #1 stated when residents go on hospice, the hospice nurse comes out to the facility and evaluates the resident. Hospice then admits the resident and writes a list of medications and faxes the medications over within the next day as a comfort kit. She stated the staff then put the order into their electronic system and verify the orders. She concluded she did not remember putting in Resident #143's hospice orders into the system and she was unsure why the orders for Ativan and Levsin did not make it into his electronic records and were not available for him.

During an interview on 8/19/21 at 9:48 AM Nurse #4 stated she did care for Resident #143 when he passed away the evening of 5/20/21 through the early morning of 5/21/21. She further stated Resident #143 had a family member at the bedside but did not recall the family every asking her for Ativan or Levsin. She stated she was administering Resident #143's morphine as needed every hour per request and during change of shift, Nurse #2 did tell her that Nurse #3 was getting some medications that were just ordered for the resident from hospice. She stated Nurse #3 had taken over acquiring those medications and she did not recall if the medications arrived prior to Resident #143

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 08/20/2021

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 684	Continued From page 33 passing. She stated during her assessments of Resident #143 up until his death he did not have any signs of distress or issues with secretions. Hospice Nurse #1 no longer worked at the hospice company and was not available for interview.	F 684		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		9/28/21

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 08/20/2021

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 726	Continued From page 34 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to validate the Nursing Assistant skills competency for 2 of 2 Nursing Assistant Trainees (NAT) reviewed for competency (NAT #1 and NAT #2). Findings included: 1. NAT #1 was hired by the facility on 6/08/21. An interview on 8/17/21 at 1:44 PM with NAT #1 revealed she was frequently assigned to the 600 hall and was expected to provide activities of daily living (ADL) care for residents which included showers and nail care. She stated she had not been asked to demonstrate ADL skills competency with Nurse #3. An interview on 8/18/21 at 3:35 PM with Nurse #3 revealed she was responsible for ensuring the ADL's skills competency of NAT #1. She stated that NAT #1 was hired to perform ADL care for the residents and function in a Nursing Assistant (NA) capacity. She stated she spent 1 day with them and went over policies and verbally discussed ADL care. She stated she did not have NAT #1 demonstrate skills competency for any ADL care which included showers and nails care. Nurse #3 stated they were supposed to work with a preceptor for 2 weeks to complete their training. 2. NAT #2 was hired by the facility on 6/15/21. An interview on 8/18/21 at 3:07 PM with NAT #2 revealed she was assigned the 600 hall and was	F 726	On 8/26/21, the Administrative Nurses initiated return demonstrations with all nursing assistant trainees (NAT) to include NAT #2 in regard to showers/baths, nail care to include feet, catheter care and skin observations to ensure staff knowledge and competency. The Administrative Nurses will address all areas of concern identified during the audit to include education of staff. Return demonstrations will be completed by 9/28/21. NAT #1 no longer employed by the facility. On 9/1/1, the Director of Nursing initiated an in-service with all nursing assistant trainees to include NAT #2 in regard to ADL Care with emphasis on showers/baths, nail care to include feet, catheter care and skin observations. In-service will be completed by 9/28/21. All newly hired nursing assistants trainees will be in-serviced during orientation in regards to ADL care. The Administrative nurses will complete 10 resident care observations with nursing assistants to include NAT #2 weekly x 4 weeks then monthly x 1 month utilizing the Resident Care ADL Audit Tool. Observations are to ensure staff demonstrate competency for providing ADL care to include but not limited to showers/baths, nail care to include feet, catheter care and skin observations. Observations will include all shifts. The Administrative nurses will address 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 08/20/2021

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 726	Continued From page 35 expected to provide activities of daily living (ADL) care for residents which included showers and nail care. She stated she had not been asked to demonstrate ADL skills competency with Nurse #3. An interview on 8/18/21 at 3:35 PM with Nurse #3 revealed she was responsible for ensuring the ADL's skills competency of NAT #2. She stated that NAT #2 was hired to perform ADL care for the residents and function in a Nursing Assistant (NA) capacity. She stated she spent 1 day with them and went over policies and verbally discussed ADL care. She stated she did not have NAT #2 demonstrate skills competency for any ADL care which included showers and nails care. Nurse #3 stated they were supposed to work with a preceptor for 2 weeks to complete their training.	F 726	areas of concern identified during the audit to include re-education of staff. The DON will review the Resident Care ADL Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will forward the Resident Care ADL Audit Tool 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 ADL 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 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to arrange a follow-up urology appointment for 1 of 4 residents reviewed for urinary catheters (Resident #78). Findings included: Resident #78 was admitted to the facility on 07/16/2021 with diagnoses including multiple fractures after a motor vehicle accident and urinary retention.	F 745	On 8/18/21, resident #78 was seen for a follow up appointment with Urology. On 9/1/21, the Director of Nursing initiated an audit of current resident orders for appointments to include admission and consult orders. This audit is to ensure residents went to their appointments and if proper notification was completed with documentation in the medical records if the appointment was missed or cancelled. The Assistant Director of Nursing	9/28/21

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 08/20/2021

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 745	Continued From page 36 The admission minimum data set (MDS) assessment for Resident #78 dated 07/22/2021 indicated he was moderately impaired for daily decision making. It further indicated he had an indwelling urinary catheter. The hospital discharge summary for Resident #78 dated 07/16/2021 revealed he should follow-up with a urologist in 2 weeks. Review of the medical record revealed there was no evidence of a follow-up urology appointment for Resident #78 since his admission to the facility. In an interview on 08/17/2021 at 4:22 PM the medical records director (MRD) indicated the facility transporter (FT) was responsible for arranging resident's follow-up appointments. She stated when the facility received a new admission, she went through the paperwork to locate the discharge summary. The MRD went on to say she highlighted any follow-up appointments on this document and gave the information to the FT. She further indicated she recalled giving Resident #78's information to the FT when Resident #78 was admitted to the facility. She stated the FT should have made Resident #78's follow-up urology appointment. In an interview on 08/17/2021 at 4:31 PM the FT indicated he could find no record of having made a follow-up urology appointment for Resident #78 since his admission to the facility. In a follow-up interview on 08/18/2021 at 3:10 PM the FT stated he did not know why he had not made any urology follow-up appointment for Resident #78. He stated maybe Resident #78's paperwork had	F 745	(ADON), Director of Nursing (DON), Appointment Scheduler and/or Administrative Nurse will address all areas of concern identified during the audit to include ensuring appointments were re-scheduled if missed with notification of the physician and resident representative. On 9/9/21, the Director of Nursing initiated an in-service with the transportation staff in regards to Scheduling Appointments. Emphasis of in-service was scheduling/confirming appointments, rescheduling appointments with cancellations, arranging and confirming transportation, notification of resident/resident representative and physician of appointments and/or appointment changes with documentation in the electronic record. In-service will be completed by 9/28/21. All newly hired transportation staff will be in-serviced during orientation in regards to Scheduling Appointments. On 9/9/21, the Director of Nursing initiated an in-service with all nurses in regards to Appointments. Emphasis is on ensuring the nurse reviews all discharge summaries, consultation forms and orders for appointments and updating transportation staff for scheduling. In-service will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation in regards to Appointments. 10% of all admission and consult orders for appointments to include resident #78 will be reviewed by the Administrative Nurse weekly x 4 weeks then monthly x 1	

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 08/20/2021

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 745	Continued From page 37 gotten lost. In an interview on 08/18/2021 at 12:31 PM Physician #1 stated if Resident #78 had a recommended urology follow-up appointment after his discharge from the hospital, Resident #78 should have had this appointment arranged. He further indicated he did not think Resident #78's urology follow-up was a high priority. In an interview on 08/18/2021 at 4:01 PM the Administrator stated if Resident #78 had a follow-up urology appointment recommended on his hospital discharge summary, the FT should have arranged that appointment.	F 745	month utilizing the Consultant Tracking Tool. This audit is to ensure all referrals/orders for follow up appointment was scheduled and the resident representative was notified of all scheduled, missed and/or cancelled appointments with documentation in the clinical records. The Administrator or Director of Nursing will review and initial the Consultant Tracking Tool weekly x 4 weeks to ensure all areas of concern were addressed appropriately. The DON will forward the Consultant Tracking Tool to the Executive QA Committee monthly x 1 month. The Executive QA Committee will review the Consultant Tracking Tool monthly x 1 month to determine trends and / or issues that may need further interventions put into place and the need for further and / or frequency of monitoring.	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		9/28/21

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 08/20/2021

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 756	Continued From page 38 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews the facility failed to act on 3 of 3 pharmacist's recommendations for 1 of 7 residents whose medications were reviewed (Resident #34). The findings included: Resident #34 was admitted to the facility on 9/30/20 and did not have a diagnosis of a psychotic disorder on admission to the facility. Review of the clinical record revealed the resident was admitted to the facility on 9/30/20 and did not	F 756	On 8/17/21, the assigned nurse completed the Dyskinesia Identification System Condensed User Scale (DISCUS) assessment for resident #34 per pharmacy recommendation and facility protocol. On 8/17/21, the Director of Nursing initiated an audit of all pharmacy recommendations for the past two months to ensure all recommendations to include recommendations for DISCUS monitoring were completed per recommendation and physician□s approval. The Assistant Director of Nursing, Administrative 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 08/20/2021

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 756	Continued From page 39 have a psychiatric diagnosis upon admission to the facility. A baseline DISCUS (Dyskinesia Identification System Condensed User Scale) was conducted on 9/30/20 with a score of 0. A DISCUS is a test done to detect involuntary movements that can be caused by antipsychotic medications. There were no further DISCUS tests found on the resident's clinical record. The Admission Minimum Data Set (MDS) Assessment dated 10/6/20 revealed the resident did not receive antipsychotic medication. Review of the clinical record revealed a new diagnosis of brief psychotic disorder on 1/12/21, hallucinations on 1/15/21 and post-traumatic stress disorder (PTSD) on 1/18/21. Review of a facility document titled "Antipsychotic Tracking excluding other psychoactives" noted an order dated 3/10/21 for Seroquel 25 milligrams (mg) once daily for hallucinations related to brief psychotic disorder and 50 mg every night at bedtime for hallucinations related to brief psychotic disorder. A Quarterly MDS Assessment dated 3/30/21 noted the resident received an antipsychotic for 7 days during the look back period. The MDS noted the antipsychotic was received on a routine basis only. A psychiatry consult dated 4/13/21 noted the resident still received Seroquel. A Quarterly MDS dated 6/28/21 revealed the resident was cognitively intact and had a psychotic disorder. The MDS noted the resident received an antipsychotic medication for 7 days	F 756	and assigned hall nurse will address all concerns identified during the audit to include completing DISCUS assessment and/or notification of the physician when indicated. Audit will be completed by 9/28/21. On 8/18/21, the Administrative nurse initiated an audit of all resident DISCUS to include resident #34 to ensure a DISCUS was completed per facility protocol and pharmacy recommendation. The Administrative nurse and hall nurse will address all areas of concern identified during the audit. Audit will be completed by 9/28/21. On 9/1/21, the Administrator in-serviced the Director of Nursing and Assistant Director of Nursing in regards to completion of pharmacy recommendations with emphasis on notifying the physician of the recommendation, following the physician□s order for all approved recommendations and completion of DISCUS assessment per pharmacy/facility protocol. Pharmacy recommendations will be forward to the physician for review following each consultant visit. In-service will be completed by 9/28/21. On 9/1/21, the Director of Nursing initiated an in-service with all nurses in regards to DISCUS Monitoring for antipsychotic medication use. Emphasis on completing assessment timely, accurately and per pharmacy recommendation. In-service will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation in regards to DISCUS Monitor.	

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 08/20/2021

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 756	Continued From page 40 during the look back period. The MDS noted the antipsychotic was received on a routine basis only. The resident's active care plan last reviewed on 7/13/21 revealed the following: The resident used psychotropic drugs with the potential for side effects and received antipsychotic medications. The interventions included to give medications per orders, DISCUS per protocol, evaluate effectiveness and side effects of medications for possible reduction or elimination of psychotropic medication and observe for signs of tremor. Review of the current physician's orders revealed an order for Seroquel 50mg every night at bedtime. Review of the pharmacist recommendations revealed the pharmacist requested a DISCUS on 3/17/21, 5/12/21 and 7/16/21. On 8/18/21 at 8:36 AM the Administrator and the Director of Nursing (DON) provided a completed DISCUS dated 8/17/21. The DON stated she was not sure how the previous DON did the DISCUS but stated she gave a list of the ones that needed to be done to the nurses on the unit and they were responsible for completing the DISCUS and they were to be done every 6 months. The Administrator stated the DISCUS was missed due to a switch over in DONs. On 10/20/21 at 10:44 AM, Pharmacist #1 stated in an interview he had requested a DISCUS be done on 3/17/21, 5/12/21 and 7/16/21. The Pharmacist stated he had observed the resident during visits and had seen no involuntary movements in the resident.	F 756	10% audit of all pharmacy recommendations to include recommendations for DISCUS monitoring will be completed by the Assistant Director of Nursing monthly x 2 months utilizing the Pharmacy Recommendation Audit Tool. This audit is to ensure all recommendations to include recommendations for DISCUS monitoring were completed per pharmacy and facility protocol and/or physician□s orders. The ADON and/or DON will address all concerns identified during the audit to include notification of the physician of recommendations, initiating orders per physician orders and completion of DISCUS monitoring per facility and pharmacy protocol. The DON will review and initial the Pharmacy Recommendation Audit Tool monthly x 2 months to ensure all areas of concern were addressed. The DON will present the findings of the Pharmacy Recommendation Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Pharmacy Recommendation Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further 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 08/20/2021

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 756	Continued From page 41 The Administrator stated in an interview on 8/20/21 at 8:56 AM that it was her expectation that a DISCUS be completed every 6 months for residents on antipsychotic medications.	F 756		
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 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	F 758		9/28/21

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 08/20/2021

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 42 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 physician and staff interview, and record review the facility failed to obtain a stop date for an as needed (PRN) psychotropic medication for 1 of 7 Residents (Resident #33) and to complete a Dyskinesia Identification System Condensed User Scale (DISCUS) (Resident #34) for 1 of 7 Residents reviewed for unnecessary medications. Finding included: 1. Resident #33 was admitted to the facility on 5/22/2021 with diagnoses that included anxiety disorder. A physician's order dated 7/6/2021 revealed ativan 0.5 milligram (mg) one tablet every 8 hours as needed for anxiety. There was no end date to the medication order. A significant change Minimum Data Set (MDS) dated 7/11/2021 revealed Resident #33 was	F 758	On 8/18/2021, the Director of Nursing clarified the stop date for the PRN antianxiety medication order for resident #33. The order was updated in the electronic record. On 8/17/21, the assigned nurse completed the Dyskinesia Identification System Condensed User Scale (DISCUS) assessment for resident #34 per pharmacy recommendation and facility protocol. On 9/8/2021, the Director of Nursing initiated an audit of all PRN psychotropic medication orders. This audit is to ensure all PRN psychotropic orders have appropriate stop dates per pharmacy and facility guidelines. The assigned hall nurse will address all concerns identified during the audit to include clarifying orders with the physician as indicated to include stop dates. Audit will be completed by 9/28/21.	

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 08/20/2021

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 43 severely cognitively impaired. It indicated the Resident had no mood changes or behaviors within the 7 day look back assessment period. The MDS revealed Resident #33 received an antianxiety medication once during the assessment period. The care plan revised on 7/15/2021 focused on the use of a psychotropic medication with the potential for side effects. The interventions included administer psychotropic medication as ordered, observe for signs of tremors, and pharmacy review of medications monthly. The pharmacy review dated 7/15/2021 recommended to discontinue the ativan order or document the rationale for the need for ativan beyond 14 days. During an interview with Nurse #1 on 8/16/2021 at 4:00 pm she stated Resident #33 did not need a stop date for the ativan because she had behaviors documented in the progress notes. Nurse #1 stated she did not know the PRN ativan needed a stop date. She stated the recommendations were given to the assigned nurse and the nurse would page the physician. She then stated a copy of the recommendation would be faxed to the physician so he would have something to look at. During an interview with Physician #1 on 8/18/2021 at 1:20 pm he stated he was not aware the ativan order needed a stop date. He further stated he had received a recommendation from the pharmacy about the PRN ativan on 8/18/2021, agreed with the recommendation, and signed it.	F 758	On 8/18/21, the Administrative nurse initiated an audit of all resident DISCUS to include resident #34 to ensure a DISCUS was completed per facility protocol and pharmacy recommendation. The Administrative nurse and hall nurse will address all areas of concern identified during the audit. Audit will be completed by 9/28/21. On 9/9/21, the Director of Nursing initiated an in-service with all nurses in regards to PRN Psychotropic Medications with emphasis on ensuring medications have appropriate stop dates per pharmacy and facility protocol or physician documentation for continued use past the recommended stop orders. On 9/9/21, the Director of Nursing initiated an in-service with all nurses in regards to DISCUS Monitoring for antipsychotic medication use. Emphasis on completing assessment timely, accurately and per pharmacy recommendation. In-services will be completed by 9/28/21. All newly hired nurses will be in-serviced during orientation in regards to PRN Psychotropic Medications and DISCUS Monitor. The Administrative Nurses will review all newly written physician orders for PRN psychotropic medications to include orders for resident #33 utilizing the PRN Psychotropic Medication Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure all PRN psychotropic orders have appropriate stop states per pharmacy and facility guidelines or physician documentation for continued use past the recommended stop orders.	

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 08/20/2021

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 44 An interview with Pharmacist #1 on 8/18/2021 at 4:15 pm revealed he had completed a recommendation concerning the PRN ativan order on 7/15/2021. He stated he was able to determine if the physician had seen the recommendation by looking for new orders for Resident #33. He said the recommendations are loaded onto the server and sent to the Director of Nursing (DON). The Pharmacist stated the current ativan order did not have a stop date. The interview with the Director of Nursing on 8/19/2021 at 11:28 am revealed she was aware Resident #33's order for PRN ativan needed a stop date. She stated when the order was transcribed the nurse should have noted there was not a stop date for the PRN ativan order and contacted the physician for clarification. The DON stated she received the recommendations from Pharmacist #1 via computer on the same day of the consultation and then would print off the recommendations. She stated she would then give the recommendation to the nurse on the Resident's assigned hall for the physician or Nurse Practitioner to review. She stated sometimes the Physician would wait on a psychotropic medication recommendation to let the psychiatrist review it. 2. Resident #34 was admitted to the facility on 9/30/20 and did not have a diagnosis of a psychotic disorder on admission to the facility. Review of the clinical record revealed the resident was admitted to the facility on 9/30/20 and did not have a psychiatric diagnosis upon admission to the facility. A baseline DISCUS (Dyskinesia Identification System Condensed User Scale) was conducted on 9/30/20 with a score of 0. A DISCUS is a test done to detect involuntary	F 758	The assigned hall nurse will address all concerns identified during the audit to include clarifying orders with the physician as indicated to include stop dates. The Minimum Data Set Nurse (MDS) will audit all resident DISCUS assessments to include assessment for resident #34 weekly x 4 weeks then monthly x 1 month utilizing the DISCUS Audit Tool. This audit is to ensure DISCUS assessment is completed accurately, timely and per pharmacy guidelines/recommendations. The ADON and/or Administrative nurse will address all concerns identified during the audit to include completion of DISCUS per pharmacy guidelines, notification of the physician when indicated and education of the nurse. The DON will review the PRN Psychotropic Medication Audit Tool and the DISCUS Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will forward the PRN Psychotropic Medication Audit Tool and the DISCUS Audit Tool 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 PRN Psychotropic Medication Audit Tool and the DISCUS 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 08/20/2021

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 45	F 758		

movements that can be caused by antipsychotic medications. There were no further DISCUS tests found on the resident's clinical record.

The Admission Minimum Data Set (MDS) Assessment dated 10/6/20 revealed the resident did not receive antipsychotic medication.

Review of the clinical record revealed a new diagnosis of brief psychotic disorder on 1/12/21, hallucinations on 1/15/21 and post-traumatic stress disorder (PTSD) on 1/18/21.

Review of a facility document titled "Antipsychotic Tracking excluding other psychoactive" noted an order dated 3/10/21 for Seroquel 25 milligrams (mg) once daily for hallucinations related to brief psychotic disorder and 50 mg every night at bedtime for hallucinations related to brief psychotic disorder.

A Quarterly MDS Assessment dated 3/30/21 noted the resident received an antipsychotic for 7 days on a routine basis only during the look back period.

A psychiatry consult dated 4/13/21 noted the resident still received Seroquel.

A Quarterly MDS dated 6/28/21 revealed the resident was cognitively intact and had a psychotic disorder. The MDS noted the resident received an antipsychotic medication on a routine basis for 7 days during the look back period.

The resident's active care plan last reviewed on 7/13/21 revealed the following: The resident used psychotropic drugs with the potential for side effects. Receiving antipsychotic medications.

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 08/20/2021

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 46 Medications per orders. DISCUS per protocol. Evaluate effectiveness and side effects of medications for possible reduction or elimination of psychotropic medication. Observe for signs of tremor Review of the current physician's monthly orders revealed an order for Seroquel 50mg every night at bedtime. Review of the record revealed pharmacist #1 requested a DISCUS on 3/17/21, 5/12/21 and 7/16/21. On 8/18/21 at 8:36 AM the Administrator and the Director of Nursing (DON) provided a completed DISCUS dated 8/17/21. The DON stated the nurses on the hall were responsible to see that the DISCUS was completed and they were to be done every 6 months. The Administrator stated the DISCUS was missed due to a switch over in DONs. The Administrator stated in an interview on 8/20/21 at 8:56 AM that it was her expectation that a DISCUS be completed every 6 months for residents on antipsychotic medications.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		9/28/21

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 08/20/2021

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 761	Continued From page 47 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure an unattended medication cart for 1 of 5 carts (700 and 800 hall cart) and to remove loose unsecured pills in 4 of 5 (500 hall, 700 and 800 hall, 100 and 200 hall, and 300 and 400 hall) medication carts reviewed for medication storage. Findings included: 1. A continuous observation for 20 minutes on 8/19/2021 at 8:00 am revealed Nurse #5 removed medications for Resident #57 from the medication cart and shut the drawer. She walked down the hall into Resident #57's room and left the medication cart unlocked. She did not have a view of the medication cart from inside the room. A 30-milliliter medication cup with crushed medications and pudding were observed to be left uncovered on top of the medication cart. A	F 761	On 8/18/21, the DON in-serviced nurse #5 in regards to Storage of Medications with emphasis on locking medication cart when not in direct supervision of the nurse or medication aide and not storing medications on top of cart. On 9/2/21, 100% audit of all medication carts was completed by the Administrative Nurses to ensure all carts were locked when not in direct supervision of the nurse and/or medication aide and that all loose pills/non-labeled medications were discarded per facility protocol. The hall nurse and Administrative nurse will address all concerns identified during the audit. On 9/9/21, the Director of Nursing initiated an in-service with all nurses and medication aides in regards to Medications Storage with emphasis 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 08/20/2021

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 761	Continued From page 48 Resident was sitting in a wheelchair across from the cart and an outside transportation employee was standing beside the Resident while the cart was unlocked and unattended. During an interview with Nurse #5 on 8/19/2020 at 8:25 am she stated she had left the medication cart unlocked because it was always unlocked when she came to work. She said she would just leave it unlocked during the day at times. Nurse #5 stated that she was aware the medication cart should have been locked while it was unattended. She stated she intended to throw away the medications that were left on top of the medication cart and just had not trashed it yet. An interview with the Director of Nursing on 8/19/2021 at 11:28 am revealed the nurses had been educated on keeping the medication carts locked when unattended. She stated Nurse #5 should have locked the medication cart before she walked away to give the medications. During an interview with the Administrator on 8/20/2021 at 10:25 am she stated the nurses were responsible for keeping their medications carts locked when it were unattended. She then stated the nurses have been educated on keeping the carts lock. She said Nurse #5 should not have left medications on top of the medication cart. The Administrator further stated Nurse #5 should have locked the medication cart before she stepped away from it. 2. On 8/18/2021 at 2:35 pm an inspection was conducted of the 500-hall medication cart. Nine loose pills of various colors and sizes were observed in several drawers. Two pills were in the stock medication drawer and 7 pills were in	F 761	securing medication cart when not directly supervised by assigned nurse or medication aide, not storing medications on top of the cart and ensuring all loose pills or non-labeled medications are discarded per facility protocol. In-service will be completed by 9/28/21. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation in regards to Medications Storage. The Administrative Nurses will complete audits of all medication carts weekly x 4 weeks then monthly x 1 month utilizing the Medication Cart Audit Tool. This audit is to ensure all carts are locked when not in direct supervision of the nurse and/or medication aide, no medications are stored on top of the medication cart and that all loose pills/non-labeled medications were discarded per facility protocol. The Administrative nurse will address all concerns identified during the audit to include re-education of staff, securing medication carts and discarding loose non-labeled medications. The DON will review the Medication Cart Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed. The Director of Nursing will forward the Medication Cart Audit Tool 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 Medication Cart Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and	

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 08/20/2021

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 761	Continued From page 49 drawers where the resident's medications were stored. During an interview with the Medication Technician (Med Tech) #2 on 8/18/2021 at 2:32 pm she stated personally she was not responsible for the loose pills. She said she understood that it was the Nurse Manager's responsible to keep the medication cart checked. On 8/18/2021 at 2:44 pm an inspection was conducted of the 700 and 800 hall medication cart. Six loose pills of various colors and sizes were observed to be in the drawers where the resident's medications were stored. During an interview with the Medication Technician (Med Tech) #1 on 8/18/2021 at 2:53 pm she stated a pill package could have gotten stuck in the drawer. She said when the drawer was pulled out, the package could have torn and dropped the pill in the cart. She stated the nurses would usually check the medication cart on the third shift. On 8/18/2021 at 3:20 pm an inspection was conducted of the 100 and 200 hall medication cart. Eleven loose pills with various size and colors were observed to be in the drawers where the resident's medications were stored. An interview with Nurse #7 on 8/18/2021 at 3:30 pm revealed she did not know what kind of pills were loose in the drawers were right off hand. She stated the nurses were responsible for checking the medication carts for loose pills and expired medications. On 8/18/2021 at 3:42 pm an inspection was	F 761	/ 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 08/20/2021

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 761	Continued From page 50	F 761		

conducted of the 300 and 400 hall medication cart. Two loose pills with a different size and color were observed to be in the drawers where the resident's medications were stored.

During an interview with Nurse #8 on 8/18/2021 at 3:50 pm she stated all nurses were responsible for keeping the medication carts clean and those pills were missed during the cart cleaning.

An interview with the Director of Nursing (DON) on 8/19/2021 at 11:28 am revealed the nurses were responsible for keeping the medication carts clean. She stated the nurses should be doing an audit on the carts. The DON said loose pills should not have been left in the medication carts.
2. During observation on 8/19/21 at 3:36 PM Nurse #5 was observed to leave the 700 and 800 Hall Medication Cart unlocked and unattended and entered a resident room and closed the door. A resident was observed to pass the medication cart at 3:37 PM. At 3:39 PM Nurse #5 returned to the medication cart. At 3:54 PM Nurse #5 was observed to again leave the 700 Hall and 800 Hall Medication Cart unlocked and unattended, enter a resident's room, and close the door. A resident was in the common area near the medication cart. Nurse #5 returned to the cart at 3:56 PM.

During an interview on 8/19/21 at 3:56 PM Nurse #5 stated medication carts were to be locked when left unattended. She concluded she had no reason she did not lock the 700 Hall and 800 Hall Medication cart when she left it unattended.

During an interview on 8/19/21 at 4:04 PM the Director of Nursing stated she had just in-serviced Nurse #5 this morning about medication storage and safety. Nurse #5 had

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 08/20/2021

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 761	Continued From page 51 signed the in-service, acknowledged her mistake that morning leaving her medication cart unlocked, and verbalized understanding of the education. She stated the nurse should have locked the 700 and 800 Hall Medication Cart before leaving it unattended this afternoon.	F 761		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to have sufficient dietary staff with competencies to carry out meal preparation and service for 79 of 79 residents who received meal trays. The findings included: This tag is cross-referenced to F 804. Based on	F 802	On 8/17/21, the Dietary Consultant suspended meal service delivery from the community-dining kitchen and meal service delivery initiated from the main kitchen area. On 9/10/2021, the facility posted open dietary positions on job site in effort to increase dietary staffing.	9/28/21

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 08/20/2021

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 802	Continued From page 52 interviews with residents (Resident #28, #290, #54, #68) and staff, review of grievances (Resident #45), resident council minutes and a test tray the facility failed to provide food that was at an appetizing temperature for 4 of 4 residents reviewed for food palatability. This had the potential to affect all the residents in the facility. The facility assessment dated April 2021 indicated the Food and Nutrition Services staff should include 1 corporate dietary consultant, 1 contracted registered dietitian, 1 dietary manager, 1 assistant dietary manager, 2-4 cooks, 4-6 dietary aids. A review of the dietary staff schedule revealed on 8/16/21 there was one person assigned as cook and one dietary aide for the morning shift. There was one cook and one aide for the evening shift. On 8/18/21 the dietary manager was the cook on duty for the morning shift and there were 3 dietary aides on the morning shift. The evening shift on 8/18/21 listed 1 cook and 1 dietary aide. No one was assigned as the assistant dietary manager. The consulting Registered Dietitian (RD) was interviewed on 8/18/21 at 11:20 AM. She stated she only scheduled to work at the facility 1 or 2 days each month. She said the previous dietary manager was struggling because of losing staff so she just walked off of the job one day. She did not know when this occurred but stated it was before the current Administrator started working at the facility. The RD added she had assisted with passing trays due to dietary staff shortages and to help get the food to the residents quickly because it was being served in disposable foam containers which were not able to keep the foods warm.	F 802	On 9/9/2021, the Administrator initiated an audit of all dietary staff to ensure the facility had sufficient and adequately trained dietary staff to carry out the functions of the food and nutrition service. The Dietary Consultant and Administrator will address all concerns identified during the audit to include initiating training of staff when indicated. Audit will be completed by 9/28/21. On 9/10/2021, the Administrator reviewed Dietary Staffing Schedule with the Dietary Manager for the next 7 days to ensure sufficient and adequately trained staff were scheduled to carry out the functions of the food and nutrition service. The Dietary Manager will address all concerns identified during the review to include scheduling appropriate trained staff. On 9/10/2021, the Dietary Consultant initiated an in-serviced the Dietary Manager, Administrator and Director of Nursing in regards Dietary Staffing with emphasis on ensuring sufficient and adequately trained dietary staffing to carry out the functions of the food and nutrition service. In-service will be completed by 9/28/21. All newly hired Dietary Manager, Administrator and/or DON will be in-serviced during orientation in regards to Dietary Staffing. The Administrator will review the schedule for dietary staff weekly x 4 weeks then monthly x 1 month utilizing the Dietary Staffing Audit Tool. This audit is to ensure the kitchen maintains sufficient and adequately trained staff each meal shift to carry out the functions of the food and nutrition service. The Administrator and	

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 08/20/2021

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 802	Continued From page 53 During an interview with Dietary Cook #1 on 8/18/21 at 12:10 PM she stated there was a time when she was the only cook because the morning cook was out and there was no one else. She stated Maintenance Director worked as a cook for a few weeks. She also reported other facility staff including housekeeping staff and receptionists assisted in the kitchen due to dietary staff shortages. On 8/19/21 at 2:30 PM the corporate food service consultant stated they were having a difficult time with hiring dietary staff and the morning cook was now out on leave of absence. She stated she had also recently returned to work from a leave of absence, so she was not available during the times when the other facility staff assisted in the kitchen due to dietary staffing shortages. She stated they continued to have staffing shortages so that was the reason they continued to use disposable foam containers for food delivered to the residents. On 8/19/21 at 3:16 PM the Maintenance Director stated he received a call from the previous administrator who told him there was no manager or assistant manager for dietary so he went to the facility and started cooking so the residents would have food. He stated he did not follow the menu, but he cooked eggs, grits, bacon, and toast. He stated he received training at his previous maintenance position at another facility about diets and food consistencies such as mechanical soft and pureed. He had not received training at this facility. He was not certified in food safety. He added he had cooked at this facility for 21 shifts when the morning cook was not available.	F 802	Dietary Manager will address all concerns identified during the audit to include scheduling of adequately trained staff or training of staff when indicated. The DON will review the Dietary Staffing Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will present the findings of the Dietary Staffing Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Dietary Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further 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 08/20/2021

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 802	Continued From page 54 The Administrator said during an interview on 8/18/21 at 11:30 AM since she started in May 2021 as the Administrator, she had hired some temporary employees to assist in the kitchen. She stated a temporary certified dietary manager worked on an emergency basis but was not scheduled a routine assignment. She reported the morning cook was put into the assistant dietary manager position after the previous dietary manager left without notice. This morning cook was now out on leave of absence. The Administrator added the current dietary manager was hired 3 weeks ago.	F 802		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interviews with residents (Resident #28, #290, #54, #68) and staff, review of grievances (Resident #45), resident council minutes and a test tray the facility failed to provide food that was at an appetizing temperature for 4 of 4 residents reviewed for food palatability. This had the potential to affect all the residents in the facility. The findings included: A grievance dated 3/20/21 by Resident #45's	F 804	On 8/17/21, the Dietary Consultant suspended meal service delivery from the community-dining kitchen and meal service delivery initiated from the main kitchen area to ensure food was served timely and at an appropriate and appetizing temperature. On 8/23/21, the Administrator placed an order for new insulated food carts and serving tray system to ensure meals are maintained at an appropriate and	9/28/21

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 08/20/2021

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 804	Continued From page 55	F 804		

family member read; "Breakfast tray was late, and meal was cold."

The May 13, 2021 Resident Council meeting minutes revealed under New Business read "Facility plans meeting with kitchen staff concerning time served, warmth of food and alternate meal choices."
The July 14, 2021 Resident Council meeting minutes revealed under New Business read "Resident all agree that the food is better, and it has more flavor."

The August 11, 2021 Resident Council meeting minutes revealed under New Business read "Dietary- addressed food concerns, i.e. - Hard edges on fried food sometimes unchewable, food being cold at times ..."

a. Resident #28 was admitted to the facility on 8/12/20. His quarterly minimum data set dated 6/12/21 revealed he was cognitively intact.

On 8/16/21 at 10:32 AM Resident #28 reported the food was usually served cold.

b. Resident #290 was admitted to the facility on 8/12/21. An admission minimum data set assessment had not been completed. The nursing notes revealed he was oriented and able to answer questions appropriately.

On 8/16/21 at 10:52 AM Resident #290 stated the eggs were always cold and the biscuit was also cold.

c. Resident #54 was admitted to the facility on 10/29/21. His significant change minimum data set dated 7/7/21 revealed Resident #54 was

appetizing temperature. The new insulated tray system will be initiated by 9/28/21
On 9/10/21, the Director of Nursing initiated an in-serviced with all nurses and nursing assistants in regards to Meal Delivery with emphasis on passing meal trays timely to ensure meals served at an appropriate and appetizing temperature. The in-service will be completed by 9/28/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Meal Delivery.
The Social Worker will interview all alert and oriented residents to include resident # 28, # 290, # 54, # 68 and #45 utilizing the Meal Delivery Questionnaire weekly x 4 weeks then monthly x 1 month. This interview is to ensure meals are served timely and at an appropriate and appetizing temperature. The Social Worker will address all concerns identified during the interview. The Administrator will review Meal Delivery Questionnaire weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.
The Dietary Manager, Director of Nursing, Nurse Supervisor will complete a test tray 3 times a week to include all meals and weekends utilizing the Tray Assessment Tool. This audit is to ensure meals are served at appropriate and appetizing temperature. The Dietary Manager, Director of Nursing and/or Nurse Supervisor will address all concerns identified during the audit to include providing additional meal at appropriate temperature to residents and/or education

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 08/20/2021

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 804	Continued From page 56 cognitively intact. On 8/16/21 at 11:14 AM Resident #54 stated the food was frequently cold. During a dining meal observation on 8/16/21 the meal trays for the Clayton Halls were delivered at 12:45 PM. All of food items were served in disposable foam containers. During a dining meal observation on 8/17/21 the meal trays for the Clayton Halls were delivered at 5:25 PM. All of the food items were served in disposable foam containers. The trays were removed from the open delivery tray cart and placed on the dining tables in the dining area. There were 2 nurse aides (NA) and 1 medication technician (MT) working on the Clayton Halls. The MT #2 wrote the room number for each tray on the top of the hinged disposable foam containers. The MT #2 said she wrote the room numbers on the top to help the NAs know where the tray needed to be delivered to help the delivery go faster. The last tray delivered was at 6:16 PM (51 minutes later) to Resident #68. d. Resident #68 was admitted to the facility on 7/17/20. Her quarterly minimum data set dated 7/15/21 indicated she was cognitively intact. On 8/17/21 at 6:23 PM Resident #68 stated her food was cold but she was accustomed to eating cold food. On 8/18/21 at 12:31 PM dietary aide #1 began plating foods for the whole facility from the kitchenette on Clayton Corners. At 1:40 PM the last tray was placed on the cart to be delivered to the residents of Clayton Corners. The last tray	F 804	of staff. The Administrator will review the Tray Assessment Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed. The Administrator will present the findings of the Tray Assessment Tool and Meal Delivery Questionnaires to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Tray Assessment Tool and Meal Delivery Questionnaires to determine trends and/or issues that may need further interventions put into place and to determine the need for further 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 08/20/2021

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 804	Continued From page 57 delivered to the residents of Clayton Corners occurred at 2:00 PM and a test tray evaluation was conducted with the Dietary Manager and the surveyor. The food items in the hinged disposable foam container included glazed pork chop, whipped sweet potatoes, steamed broccoli, and a roll. There was also a foam cup of tea and an individual container of ice cream on the tray. There was no steam coming from the food items when the disposable food tray was opened. The Dietary Manager reported the glazed pork chop was barely warm. The sweet potatoes and broccoli were not warm enough. The Dietary Manager also noted the tea did not contain any ice. The Dietary Manager stated he was hired into his position 3 weeks ago. On 8/19/21 at 10:54 AM Resident #54 stated breakfast was cold again this morning. On 8/19/21 at 11:30 AM the Administrator stated the residents had expressed concerns with cold food and there were grievances for cold food. She had recently hired the current Dietary Manager and the complaints about cold food had decreased. She stated she thought the foods were served in disposable containers because of COVID-19.	F 804		
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	F 812		9/28/21

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 08/20/2021

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 58 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 with the dietary manager the facility failed to label opened foods with a use by date for 1 of 3 kitchen observations. This practice had the potential to affect food served to foods served to residents. The findings included: An observation of the walk-in refrigerator was conducted on 8/16/21 at 10:47 AM with the Dietary Manager (DM). The observation revealed there was no label on one opened package of deli ham and one opened package of deli turkey. During an interview with the DM on 8/16/21 at 10:50 AM he stated he was not able to determine when the packages of deli meat were opened because there was no label or date on the packages. He stated opened items should be discarded 7 days after the open date. He added would discard the packages of deli meat. On 8/18/21 at 11:25 AM the corporate food service consultant stated all opened food items should have a label which included a date when	F 812	On 8/16/21, the Dietary Manager discarded the deli meat not labeled when opened per facility protocol On 8/16/21, the Dietary Consultant and Dietary Manager completed an audit of all items in the walk in refrigerator to ensure all items labeled with a use by date when opened per facility protocol. The Dietary Consultant and Dietary Manager addressed all concerns identified during the audit to include discarding all items not labeled per facility protocol. On 8/16/21, the Dietary Consultant initiated an in-service with the Dietary Manager and dietary staff in regards to Labeling Food Items When Opened with emphasis on labeling all food items in the walk in refrigerator with a use by date when opened. In-service will be completed by 9/28/21. All newly hired Dietary Staff will be in-serviced during orientation in regards to Labeling Food Items When Opened. The Maintenance Director and/or Housekeeping Supervisor will complete	

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 08/20/2021

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 59 the item was opened or a use by date.	F 812	an audit of the walk in refrigerator weekly x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure all items in the walk in refrigerator are labeled with a use by date per facility protocol when opened. The Dietary Manager will address all concerns identified during the audit to include discarding items not labeled per facility protocol and re-education of staff. The Administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns addressed. The Administrator will present the findings of the Kitchen Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Kitchen Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/28/21

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 08/20/2021

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 880	Continued From page 60 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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 08/20/2021

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 880	Continued From page 61 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to place a newly admitted, non-COVID-19 vaccinated resident on the new admission quarantine hall, post enhanced barrier precaution signage for the resident's room, and don gloves, gown, and N-95 respirator while providing care for 1 of 3 newly admitted residents (Resident #140). Findings included: Resident #140 was admitted to the facility on 8/13/21. Her active diagnoses included diabetes mellitus, and acute renal failure superimposed on stage 3 chronic kidney disease. Resident #140's chart revealed she was not vaccinated for COVID-19. During observation on 8/16/21 at 11:48 AM Resident #140 was observed to be in a room that was not inside the newly admitted quarantine unit (Room 806). There were no enhanced barrier precaution signage observed posted at the room,	F 880	On 8/16/2021, the facility moved resident # 140 to a designated quarantine room with appropriate signage for isolation precautions indicated (Enhanced Droplet Precautions). On 9/10/21, the Infection Preventionist and Director of Nursing under the oversight of the Facility Consultant initiated an audit of all admissions/readmissions for the past 14 days to ensure all non-COVID 19 vaccinated residents were placed in a designated quarantine room with the appropriate signage for isolation precautions indicated. There were no additional concerns identified. On 8/16/2021 the Administrator in-serviced the Admission Coordinator in regards to Guidelines for Admission/Readmission during COVID Pandemic with emphasis on placing non-COVID vaccinated residents in a designated quarantine room with appropriate signage for isolation	

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 08/20/2021

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 880	Continued From page 62 and no personal protective equipment placed outside the entrance to the room. During an interview on 8/16/21 at 11:48 AM Resident #140 stated she had been admitted two or three days ago. She stated she was not vaccinated for COVID-19. She concluded some staff had worn full personal protective equipment when in her room and some staff had not. During an interview on 8/16/21 at 11:50 AM the Director of Nursing stated Resident #140 was admitted to the facility on 8/13/21. She further stated the resident was not vaccinated for COVID-19 and should be on the quarantine hall and have the appropriate signage for enhanced barrier precautions upon admission. She stated she believed there was a mix up in rooms when Resident #140 arrived, and she was admitted to the wrong room which did not have signage and was not on the quarantine hall. During an interview on 8/16/21 at 12:00 PM Nurse #1 stated the resident did not have enhanced barrier precaution signage and was not on the newly admitted quarantine hall, so she assumed Resident #140 was fully vaccinated for COVID-19. She stated she did not wear a gown, gloves, face shield, or N-95 respirator when entering the resident's room that morning for medication pass and just wore a KN-95 while providing care. During an interview on 8/16/21 at 12:51 PM Nurse Aide #2 stated that morning she provided Resident #140 activities of daily living care and weighed the resident. She also provided the resident her breakfast tray, and Nurse Aide #2 did not don a gown or wear gloves, an N-95	F 880	precautions indicated. On 8/16/2021, the Infection Preventionist/ADON initiated an in-serviced with all nurses and Admission staff in regards to Guidelines for Admission/Readmission during COVID Pandemic with emphasis on placing non-COVID vaccinated residents in a designated quarantine room with appropriate signage for isolation precautions indicated. In-service will be completed by 9/28/21. All newly hired nurses and Admission Staff will be in-serviced during orientation in regards to Guidelines for Admission/Readmission during Covid Pandemic. ¿The Facility Leadership staff to include the Infection Preventionist, Director of Nursing, Administrative Nurses, Admission Coordinator and Administrator will review all admissions/readmissions 5 times a week x 4 weeks then monthly x 1 month utilizing the Admission Audit Tool. This audit is to ensure all non-Covid 19 vaccinated residents were placed in a designated quarantine room with the appropriate signage for isolation precautions indicated. The Infection Preventionist and/or Administrative nurses will address all concerns identified during the audit. The Director of Nursing and/or Administrator will review the Admission Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Admission Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. 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 08/20/2021

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 880	Continued From page 63 respirator, or face shield during any of Resident #140's care as the resident did not appear to be on any isolation precautions and this was her first time taking care of the resident. She concluded she had just worn her KN-95 when interacting with Resident #140. During an interview on 8/17/21 at 1:28 PM the Admissions Coordinator stated Resident #140 was not vaccinated for COVID-19 and was to be admitted to the 14 day quarantine unit. When the Admission's Coordinator entered the resident's data for Resident #140's new admission she had entered the wrong room into the system and told the staff the wrong room to place the resident. The reason was because she believed room 806 was physically further down the hall from room 805 where the quarantine unit started; however, because of the unusual lay out of the rooms, room 806 was outside of the quarantine unit. She concluded this resulted in the resident not being placed in the quarantine unit and therefore staff assumed she was fully vaccinated and did not implement 14 day quarantine. During an interview on 8/17/21 at 4:12 PM the Infection Control Nurse stated Resident #140 was not vaccinated for COVID-19. She further stated if a resident is a new admission who was unvaccinated, they were to be on the quarantine unit for 14 days. She concluded Resident #140 should have been on the quarantine unit, isolation signage should have been in place, and personal protective equipment should have been available outside her room.	F 880	Executive QA Committee will meet monthly for 2 months and review the Admission Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	