	-	ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVED 10. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345569	B. WING		0	C 2/22/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00			
F 000		3.73, Emergency ht ID #OUHB11.	F0	00			
		plaint survey was conducted 2/22/19. Substandard dentified at:					
	(H).	600 at a scope and severity 686 at a scope and severity					
F 580 SS=G		njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 5	080		3/18/19	
	consult with the resid consistent with his or representative(s) whe (A) An accident invol results in injury and h physician intervention (B) A significant char mental, or psychosol	nediately inform the resident; lent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; nge in the resident's physical,					
	status in either life-th clinical complications (C) A need to alter tro a need to discontinue treatment due to adv commence a new for	reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or					
	resident from the fac	nsfer or discharge the ility as specified in SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

03/18/2019

					FC	FED: 03/27/2019 RM APPROVED NO. 0938-039	
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
	345569	B. WING				C 02/22/2019	
ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•		
			195	SPRINGBROOK AVENUE			
ROOK NURSING & REH	ABILITATION CENTER		CLA	AYTON, NC 27520			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE	
§483.15(c)(1)(ii).		F	580				
 (14)(i) of this section, all pertinent information is available and proving physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must rupdate the address (riphone number of the 	the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and						
that is a composite di §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi interviews the facility resident's physician re a pressure wound on	stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations is not met as evidenced iew and staff and physician failed to consult with a egarding the development of the heel for 1 of 3 residents			Center acknowledges receipt of Statement of Deficiencies and p this Plan of Correction to the ext	the roposes tent that		
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ROOK NURSING & REH/ SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and proving physician. (iii) The facility must at resident and the resident when there is- (A) A change in room as specified in §483.1 (B) A change in resident State law or regulation (e)(10) of this section (iv) The facility must at representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclosed its physical configuration locations that comprised part, and must specific room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revin interviews the facility resident's physician re- a pressure wound on	CORRECTION IDENTIFICATION NUMBER: JA45569 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to consult with a resident's physician regarding the development of a pressure wound on the heel for 1 of 3 residents	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345569 B. WING ROVIDER OR SUPPLIER 345569 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 1 F4 \$483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in \$483.15(c)(2) is available and provided upon request to the physician. F4 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in \$483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). \$483.10(g)(15) Admission to a composite distinct part. A facility that is a composit	S FOR MEDICARE & MEDICAID SERVICES PF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE C A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES 9: DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIERCILA IDENTFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345569 B. VING ROVIDER OR SUPPLIER 345569 ROOK NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 195 SPRINGBROOK AVENUE CLAYTON, NC 27520 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORR (EACH ORRECTIVE ACTION SUPPLIER) Continued From page 1 \$483.15(c)(1)(ii). ID (iii) The facility must ensure that all pertinent information specified in \$483.15(c)(2) is available and provided upon request to the physician. F 580 Continued in Generative Record and periodically update the address (mailing and email) and phone number of the resident representative(s). F 581 \$483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part, and must specify the policies that apply to room changes between its different locations under \$483.15(c)(2). Springbrook Nursing and Reha Center acknowledges receipt of Statement of Deficiencies and p this Plan of Correction to the exident represent of Deficiencies and p t	VENT OF HEALTH AND HUMAN SERVICES FC SP OR MEDICARE & MEDICARE SKEDICALD SERVICES OMB SP OR MEDICARE & MEDICARE SKEDICALD SERVICES OMB CORRECTION (X) PROVIDER/SUPPLIER (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION SOMDER OR SUPPLIER 345569 B. WING (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION ROM NURSING & REHABILITATION CENTER IS SPRINGBROOK AVENUE CLAYTON, NC 27520 (EAC) MORECIVE ACTION ACTION ACTION ACTION ACTION ACTION AC	

Facility ID: 100679

If continuation sheet Page 2 of 114

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE :	. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	(X3) DATE : COMPL	
			A. BOILDING	·		2
		345569	B. WING	······		22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
	ROOK NURSING & REH	ADULTATION CENTER		195 SPRINGBROOK AVENUE		
SPRINGD	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE. CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From pag	e 2	F 58	30		
				written allegation of com	-	
		admitted to the facility on		Springbrook Nursing an		
		agnoses of dementia without		Center s response to the Deficiencies does not de		
	benaviors, insomnia	and chronic kidney disease.		with the Statement of De	J	
	Review of the Nursin	g Notes from 11/28/18 to		does it constitute an adr		
		o documentation of the		deficiency is accurate.		
	physician being notif	ied of Resident #188's heel		Springbrook Nursing an	d Rehabilitation	
	wound.			Center reserves the righ	2	
				the deficiencies on this		
		neet of Non-Ulcer Skin		Deficiencies through Inf	-	
		28/18, completed by the nd Care Nurse (WCN),		Resolution, formal appe and/or any other admini	-	
	revealed Resident #7	188 had a pink ruptured right vas no pain or infection		proceedings.		
		no measurements of the		The facility immediately	put in measures	
		ption of the area surrounding		to inform the resident, c	onsult with the	
		tment was to apply betadine		resident⊡s physician, a		
		n dressing every other day.		resident representative		
		ian notification date on the		change in the resident		
	form.			requires such notificatio	n.	
	Review of the Physic	tian's Orders dated 11/28/18,		A 100% audit of all nurs	ina proaress notes	
		g home's WCN, revealed a		for the period of 2/15/19		
		se Resident #188's right heel		was completed by 3/18/		
		apply betadine, and then		Facilitator, Director of N		
		rent dressing with foam every		designee. The audit ide	2	
		red blister. The order was		resident with a change i the physician and respo		
	initialed by the physic	Plan initiated on 11/29/18		not consulted/notified.	nsible party were	
		blister had been noted on		A 100% in-service to all	licensed nurses	
	-	t heel. The goal was for the		and certified nursing as		
		al without complications		notification of resident c		
	-	ew. Interventions included to		initiated on 2/18/19 by the		
		the right heel and to perform		Director of Nursing or de		
		d and to notify the physician		be completed by 3/19/19		
	of any changes.			focused on changes in t		
				status related to accider	nts resulting in	

Facility ID: 100679

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	1 Y	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		CON	
		345569	B. WING			C 02/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0/	
				19	95 SPRINGBROOK AVENUE		
SPRINGE	ROOK NURSING & REH	ABILITATION CENTER		С	LAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIOI DATE
F 580	Continued From page	e 3	F 58	80			
		ian Progress Note dated			injury and has the potential to require		
	12/04/18 revealed no	mention of Resident #188's			physician intervention, significant char	iges	
	ruptured right heel bli	ister.			in the resident s physical, mental, or		
	Poviow of the Dhysic	ian Progress Note dated			psychosocial status, a need to alter treatment significantly, and a decision	to	
	-	mention of Resident #188's			transfer/discharge a resident from the	10	
	ruptured right heel bli				facility. All newly hired licensed nurse	s	
					and certified nursing assistants will be		
		neet of Non-Ulcer Skin			in-serviced on notification of resident		
		03/19, completed by the			changes.		
		l, revealed Resident #188 ight heel blister that was			Notification of resident change in statu	6	
		surrounding the wound was			will be monitored through the facility		
		pain or infection present.			Interdisciplinary Team (IDT) process u		
		urements of the wound. The			QI tools by the Assistant Director of		
	treatment was to con				Nursing, Unit Manager or designee.		
		sing with foam every other			Progress notes, 24 hour sheets, IDT	l ha	
	the form.	hysician notification date on			observations, and physician orders wil reviewed 3 times per week for 4 week		
					a total of ten residents, then 3 times per		
	Review of the Physic	ian Progress Notes dated			week for 4 weeks for a total of 5		
		mention of Resident #188's			residents, then monthly times 1 month	for	
	ruptured right heel bli	ister.			5 residents. The licensed nurses and		
	Deview of the Flower	a of Non Llicor Skin			certified nursing assistants will be		
		neet of Non-Ulcer Skin 23/19, completed by the			immediately re-trained by the auditor fa any identified areas of concern. The	UI	
		l, revealed Resident #188			Director of Nursing or designee is		
		ight heel blister that was			responsible and will review and initial t	he	
	improving. The area	surrounding the wound was			QI tool for completion to ensure all are		
		pain or infection present.			of concerns were addressed.		
		urements of the wound. The				to	
	treatment was to con transparent film dress	tinue betadine and sing with foam every other			The Executive QI committee will meet review the notification of changes QI to		
		hysician notification date on			monthly times 3 months to determine	501	
	the form.	,			issues and trend to include continued monitoring frequency.		
	Review of the Physic	ian Progress Notes dated					
	-	mention of Resident #188's					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 580	Continued From page	2 4	F	580			
	Conditions dated 01/2 nursing home's WCN had a pink ruptured ri improving. The area intact. There was no There were no measu treatment was to cont transparent film dress day. There was no p the form. Record review reveal discharged from the f Health on 02/07/19. Review of the Home Assessment dated 02 #188 had a stage 3 p heel. The wound me was 0.5cm deep. The loss involving damage subcutaneous tissue. of thin, watery, pale, n wound. The wound to 25% of the wound co The skin color surrou normal for the resider In an interview on 02/ nursing home's WCN had a fluid filled bliste heel that developed fi Resident #188's foot she did not know how place prior to its ruptu admission. She india	sing with foam every other hysician notification date on ed Resident #188 was acility to home with Home Health Comprehensive Adult 2/08/19 revealed Resident ressure wound on the right asured 2cm by 2cm and ere was full thickness skin e or necrosis of There was a small amount red/pink drainage from the bed was pink with less than vered with epithelial tissue. nding the wound was nt.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345569	B. WING				C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 580	The WCN indicated the should be assessed we measurements, staging a description of the we of the surrounding ski not notified Resident at the ruptured blister but treatment using the si indicated she did not when Resident #188 facility because she we was being discharged In an interview on 02/ PM the Assistant Direct verified that she supe WCN and indicated the at the facility on 01/02 wound was discovered notified the physician In a telephone intervie Physician #2 stated he #188 had had a wour unaware that there we heel. He indicated if blister and then ruptu weekly wound assess The physician indicate notified him of the wo remember initialing at In a follow-up intervie the nursing home's Wo order that was written order was actually fro that she had not spok regarding the heel woo	hat a pressure wound weekly and should include ing, drainage, infection, odor, ound bed and a description in. She stated that she had #188's physician regarding at she had begun a tanding orders. She perform a skin assessment was discharged from the vas not aware the resident d. 20/19 at approximately 1:20 isctor of Nursing (ADON) rvised the nursing home's hat she had started working 2/19 which was after the ed and so she had not of the wound. ew on 02/21/19 at 11:37 AM e was aware that Resident ad on the ankle but was as a wound on the right the wound had started as a red he would expect a sment with measurements. ed that the facility had not und and he did not hy orders for treatment. w on 02/21/19 at 1:45 PM /CN stated the physician's o n 11/28/18 as a verbal m the standing orders and	F	580				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 MAPPROVED). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345569	B. WING				C 22/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
SPRINGBI	ROOK NURSING & REHA	ABILITATION CENTER		195 SPRINGBROOK AVI CLAYTON, NC 27520			
							a (-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page		F 5	80			
	However, she stated s initialed the order on f	know when that happened. since the physician had 12/04/18 that served as und to the physician					
F 585 SS=D	notification of the wound to the physician. In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) stated that she expected the WCN or a staff nurse to notify the physician when a wound was discovered on a resident. She indicated that when a physician initialed an order it was considered notification but she expected the nurse to notify the physician of the wound sooner than six days after the wound was discovered. This would allow the physician the opportunity to provide treatment orders or to agree with the standing orders of the facility. 5 Grievances		F 5	85			3/18/19
	grievances to the faci that hears grievances reprisal and without fe reprisal. Such grievan respect to care and the furnished as well as the furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The resid	s. ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or nees include those with eatment which has been hat which has not been or of staff and of other concerns regarding their LTC					
	resolve grievances the accordance with this p §483.10(j)(3) The faci	e resident may have, in					

Facility ID: 100679

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345569	B. WING		_		C 22/2019
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SPRINGR	ROOK NURSING & REHA	BILITATION CENTER	1	95 SPRINGBROOK AVEN	IUE		
				CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From page to the resident.	7	F 585				
	of all grievances rega contained in this para provider must give a c to the resident. The g include: (i) Notifying resident in postings in prominent facility of the right to f (meaning spoken) or grievances anonymou of the grievance offici can be filed, that is, h address (mailing and number; a reasonable completing the review to obtain a written dec grievance; and the co independent entities v be filed, that is, the pe Quality Improvement Agency and State Lor program or protection (ii) Identifying a Griev responsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associate example, the identity grievances submitted written grievance dec coordinating with state	asure the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy rievance policy must andividually or through locations throughout the ile grievances orally in writing; the right to file usly; the contact information al with whom a grievance is or her name, business email) and business phone expected time frame for of the grievance; the right cision regarding his or her ntact information of with whom grievances may ertinent State agency, Organization, State Survey ng-Term Care Ombudsman and advocacy system; ance Official who is eeing the grievance process, g grievances through to their any necessary investigations ning the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/2019 FORM APPROVEI OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345569	B. WING		C 02/22/2019
	Rovider or supplier	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 195 SPRINGBROOK AVENUE CLAYTON, NC 27520	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 585	prevent further poten right while the alleged investigated; (iv) Consistent with § reporting all alleged v abuse, including injur and/or misappropriati anyone furnishing se provider, to the admin as required by State (v) Ensuring that all v include the date the g summary statement of the steps taken to inv summary of the pertin regarding the resider as to whether the grid confirmed, any correct taken by the facility a and the date the writt (vi) Taking appropriat accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or loca confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance 3 years from the issu decision. This REQUIREMENT by: Based on record rev interviews, the facility grievances and failed	tial violations of any resident d violation is being 483.12(c)(1), immediately violations involving neglect, ries of unknown source, ton of resident property, by rvices on behalf of the nistrator of the provider; and law; written grievance decisions grievance was received, a of the resident's grievance, vestigate the grievance, a nent findings or conclusions tt's concerns(s), a statement evance was confirmed or not ctive action taken or to be s a result of the grievance, en decision was issued; te corrective action in e law if the alleged violation s is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents'	F 5	The facility immediately to make prompt efforts to maintain a written record the resident may have al grievance summary to th	o complete and d of grievances nd issue a

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345569	B. WING		C 02/22/2019
NAME OF PR	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP	CODE
				195 SPRINGBROOK AVENUE	
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 585	Continued From page	e 9	F 58	5	
		ces. (Resident #76 and	1 30	5	
	Resident #189).	ces. (Resident #70 and		The facility completed a gi	rievance form to
				record the grievance for re	
	Findings Included:			shared results with family	
	Ū			expressing the concern.	
		s admitted to the facility on			
		is included; Kidney Failure,		The facility completed a gi	
	History of Falls, Muse	cle Weakness, and		record the grievance that	
	Dementia.			misplaced for resident #18	
	The Minimum Date O			grievance was placed in th	ne grievance log
		Set (MDS) dated 11/18/18		and properly recorded.	
		ear speech, with moderately		A 100% in-service to all st	aff on the
		she exhibited no rejection of		grievance process was ini	
		xtensive two-person physical		2/26/19 by the Staff Facilit	
	-	ity, transfers, and activities		completed by 3/18/19. Th	
	of daily living.			focused on ensuring that a	all grievances
				are completed on a grieva	
		iducted on 2/18/19 at 1:00		investigated, have results	
		6's family member. She		resident or residents repre	
		ost days and if not her		have a written record in th	
	-	er would visit to assure care et. She voiced a concern with		All newly hired staff will be the facility s grievance po	
		e unit. She stated there were		process for resolving.	
	•	ich there was only one			
		signed on the unit. She stated		Resident grievances will b	be monitored
	she had voiced this c			through the facility 's Inte	
		ith the Vice President over		Team (IDT) process using	
		oncerns were still ongoing.		Concern QI tools by the S	
		eceived no resolution from		Directors, Director of Nurs	-
	the facility.			Director of Nursing, Unit M	
	A review of the facility	v grievance log from		designee. The Nursing He Administrator will review th	
		bugh February 2019 revealed		tool for completion to ensu	•
		filed for resident #76. On		concerns were addressed	
		was filed regarding a diet		weeks and monthly times	-
		regarding a room change.		pertinent staff will be imme	
		ed for resident #76 regarding		re-trained by the auditor for	-
	insufficient staffing.			areas of concern.	

Facility ID: 100679

	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLF	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:					LETED	
							C	
		345569	B. WING			02/	22/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER						
				С	LAYTON, NC 27520			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE	
	1				Deficiency)			
F 585	Continued From page	10		-0-				
1 303				585				
	An interview was con	ducted on 2/20/19 at 12:08			The Executive QI committee will meet	to		
	PM with the Director	of Nursing. She stated she			review the notification of changes QI to	ol		
		t #76's concern regarding			monthly times 3 months to determine			
		he stated she was not was filed for the resident.			issues and trend to include continued monitoring frequency.			
		was med for the resident.			monitoring frequency.			
	An interview was con	ducted on 2/22/19 at 11:35						
		rator. He stated he was the						
	concerns voiced from	cial. He stated many of the						
		onversation and therefore he						
		ent as an official grievance.						
		ent #76's family member had						
		to him regarding lack of						
	-	nd agreed that he didn't n as an official grievance.						
	He stated that he wou	-						
		ber immediately to resolve						
	her concerns.							
	2) Resident #189 was	s admitted to the facility on						
		diagnoses included fracture						
	of the phalanx of the	right little finger, and						
	lymphedema.							
	Review of Resident #	189's minimum data set						
		2/27/18 revealed the resident						
	was assessed as cog	nitively intact.						
	Review of the griover	nce log for the facility from						
	-	ugh February 2019 revealed						
		nces logged by the facility for						
	Resident #189.							
	During an interview a	n 2/20/10 at 2:41 DM Nurse						
	-	n 2/20/19 at 3:41 PM Nurse ent #189 told him one day						
		e aides were nasty to her.						

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If continuation sheet Page 11 of 114

	-	D HUMAN SERVICES MEDICAID SERVICES				RINTED: 0 FORM AF <u>MB NO. 09</u>	PROVED
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(>	(3) DATE SUR COMPLETE	
		345569	B. WING			C 02/22/2	2019
NAME OF PRO	VIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
			1	95 SPRINGBROOK AVENUE			
SPRINGBRU	OOK NURSING & REHA	BILITATION CENTER	0	CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE		(X5) DMPLETION DATE
H Y V X S F A C E A O F F O F E A F a r s a H t v s s c c a F H r	the reported the concer- viole #1 stated he did but reported it. He furth vent to the Administra- with the resident about stated within ten minu Resident #189 about for Administrator speak we concern. During an interview or Administrator stated the grievances he had reco urther stated he had no Resident #189 that we prievance log and he we or the facility. During an interview or Administrator stated the Resident #189 becaus and left a message or meet with him with Resident #189 about food preferences he requested the dieta he concern and from vere no additional food stated in addition she some moisture that has conditioning system. Hopportunity to move b and the staff on that u probably come from c He further stated he the maintenance and ther	n he was informed of this rm to the on-staff nurse member who it was. Nurse not complete a grievance ther stated the nurse then ator who went and spoke at her concerns. He further tes of him being told by the concern he saw the <i>i</i> th Resident #189 about the a 2/21/19 at 8:06 AM the ne grievance log had all the ceived for all residents. He no other grievances for build not be listed on the was the grievance official a 2/21/19 at 10:08 AM the e was introduced to se the family member called a his phone requesting to esident #189. He further shared concerns with him e. The Administrator stated ary manager follow up on that period forward there of preference concerns. He voiced a question about ad been coming from the air	F 585				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	D: 03/27/2019 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	345569	B. WING			C 1 22/2019
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	• •	
		1	95 SPRINGBROOK AVENUE		
SPRINGBROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
said it was on the floo he saw no signs of pr maintenance guy trea an approved odorless grounds. The Admini professional to treat a were no more concer about ants in the faci her final concern was an extended period fo He further stated Res how long it took to wa long time for them to further stated he ask and she said it happe #189 informed him it during meal times. H her on her unit at any multiple people who sometimes she may sometimes she may Administrator stated understood that. He s grievance form for Re had contacted him at stated with her multip there was a grievanc concluded he did not on the grievance log Review of the grievan 10:30 AM with the Ac	ere the ant was at and she for. The Administrator stated ests, but the former ated the grounds and used is ant bait outside on the strator stated he called in a around the building and there rns related to moisture or lity. The Administrator stated is that at times it could take or staff to meet her needs. sident #189 never told him at but only stated it took a respond to her call bell. He ed if it happened all the time ened sometimes. Resident was at random times and e further stated he then told y given time there can be require multiple needs, and be the first one and be the last one. The Resident #189 told him she stated he did not complete a esident #189 once the family bout the concerns. He further ole grievances he thought e form completed. He know why her name was not as well.	F 585			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345569	B. WING		C 02/22/2019
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	•
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		95 SPRINGBROOK AVENUE LAYTON, NC 27520	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 585	She concluded becau discharged, any griev the grievance binder were none. She conc	e 13 t into the grievance binder. use the resident was now vances should have been in and did not know why there luded she did not have a ces completed for Resident	F 585		
F 600 SS=H	Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or	F 600		3/18/19
	interview, and record 3 of 3 sampled reside #188) reviewed for pr complete initial and w for these residents. No initial or weekly w included measureme wound bed, tunneling	n, physician interview, staff review the facility neglected ents (Resident #48, #62, and ressure ulcers by failing to veekly wound assessments ound assessments (which nts and descriptions of the or undermining, possible ainage, odor, and pain) were		Residents #62 and #188 are discharge from the facility. Pressure relieving mattresses are in use for all residents including Resident #48 who has an air mattress. On 2/20/19, the wound care nurse was immediately educated on following the wound/skin policies and process and physician orders.	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/27/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345569	B. WING_				C / 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	95 SPRINGBROOK AVENUE		
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		С	LAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	from 12/16/18, when 01/08/19. The facility wound center consult documented as being 01/08/19 for a deep ti resident's right heel. dressing in accordance care management of heel pressure ulcer. Resident #48's heels recommended by the implemented by the p pressure ulcer to Ress presented with yellow and was painful. Whe at the wound clinic or to the resident's right documented was a D wound, was identified pressure ulcer with sl wound bed and a mo No initial or weekly pr (which included meass of wound bed, tunnelin necrosis/infection, dra completed for Reside when a blister opened her discharge from th 02/08/18 home health pressure ulcer to Ress being a stage III woun centimeters (cm).	ant #48's right heel ulcer it was identified, until neglected to expedite a for Resident #48 which was grequested by the facility on assue injury (DTI) to the The facility failed to apply a ce with the facility's wound DTIs to Resident #48's right The facility failed to off-load from the bed as wound center and ohysician. On 01/08/19 the sident #48's wound //green purulent drainage, en Resident #48 was seen n 01/30/19 the pressure ulcer heel, which the facility TI and then as stage II	F	600	The facility initiated education on 2/20 for all nurses and aides regarding communication of changes in skin condition and notifying nursing. On 2/18/19 nurses were additionally educ that they must document changes to reflect change in cognition, behaviors physical conditions. All education wa completed by 3/18/19. On 3/13/19 the director of nursing, assistant director of nursing, staff facilitator, and quality improvement no completed a 100% skin audit to ensur resident skin issues were identified, assessed, and with proper document and treatment/interventions were in p 100% in-service to all staff, including licensed staff and certified nursing assistants, was initiated on freedom of neglect with a focus on treatment/ser to prevent/heal pressure ulcers. This education was initiated on 3/12/19 and was completed by 3/18/19. Free from abuse and neglect will be monitored by utilizing an abuse/negle audit tool by the staff facilitator, unit manager, assistant director of nursing designee. The audit tool will be used three times a week for four weeks, the weekly for four weeks then monthly for one month. The director of nursing or designee will review and initial the au tool for completion to ensure all areas abuse/neglect concerns are addresse	cated and s urse re all ation lace. of vices d ct g, or en or dit s of	
		ne initial wound assessment			The Executive QI committee will mee		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 // APPROVED). 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345569	B. WING				C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			95 SPRINGBROOK AVENUE LAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 600	 01/16/19 when it was and was painful to too Findings included: 1. a. Resident #48 w 07/10/17. The resider included pressure uld deficiency anemia, hy A 12/16/18 skin referr "Description: necrotic staff." The form door necrotic area to the ir #48's right heel. The the skin referral was a On 12/20/18 the facili documented on the s Resident #48 had a " injury)". A 01/08/19 QA (Quali Review documented right heel measured 4 (cm), had yellow/gree was painful. Orders a center consult. A 01/08/19 physician on Doxycycline (antitid daily (mg BID) x 7 da (review of the resider Administration record administered as orde A 01/10/19 Wound U by the facility's Treatment of the set of	a found with dried drainage, uch and movement. The set of the facility on ent's documented diagnoses set to right heel, iron ypertension, and dementia. The form documented, c area" and "Observer: cumented there was a finer aspect of Resident staff member who created unable to be identified. The form that right heel DTI (deep tissue ity Assurance) Skin Wound the DTI to Resident #48's 4.5 cm by 3.5 centimeters en purulent drainage, and were provided for a wound order started Resident #48 biotic) 100 milligrams twice ys for right heel cellulitis it's Medication I revealed the antibiotic was	F	600	review the abuse/neglect audit tool monthly for three months to identify is and/or trends, including the need for continued monitoring.	sues		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF PRO	OVIDER OR SUPPLIER		- 1	;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SPRINGBR	OOK NURSING & REHA	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
	4.5 x 3.5 x 0.5 cm. A 01/18/19 Wound UI facility assessment of ulcer prior to being se documented Residen pressure ulcer to her in the facility and mea The facility's Treatme wound presented with no necrosis, no tunne odor. The wound bec purple/pink. A 01/30/19 wound cer Resident #48 present unstageable pressure which measured 2.5 x bed was described as slough and eschar an drainage. The wound facility's Treatment Nu 01/31/19 and 02/08/11 Resident #48 had a s right heel which meas presented with no dra eschar in the wound to A 02/13/19 wound cer Resident #48 present unhealed pressure ulo measured 2 x 2 x 0.3 described as yellow/p and 1 - 25% granulati	I in the facility and measured cer Flowsheet (the last Resident #48's right heel en by the wound center) t #48 had a stage II right heel which developed asured $4.5 \times 3.5 \times 0.5$ cm. Int Nurse documented the no drainage, no infection, ling or undermining, and no d was described as ther consult documented ed to the clinic with an e ulcer on the right heel $(1.5 \times 0.2 \text{ cm})$. The wound a tan/yellow with a mixture of d a moderate amount of d was debrided. They documented tage II pressure ulcer to her sured $4 \times 3 \times 0.5$ cm, and inage and no slough or bed. The wound bed was ink with 76 - 100% slough on tissue. A moderate nage was documented, and	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	9 17	F	600	,		
	on Keflex (antibiotic)	order started Resident #48 500 mg three times daily ossible infection to the right					
	Resident #48 had a s right heel which deve measured 1.5 x 1 x 0 Treatment Nurse doc presented with no dra necrosis, no pain, no	-					
	Nurse on 02/19/19 at could not remember to wound when she view commented the area reported that the wou instead. She stated I were usually purple/b to the WCN, she was wound measurements and presence of drain tunneling/undermining infection during her in assessments, but she took until 01/10/19 for documentation for Re	g, pain, necrosis, and itial and weekly wound e could not explain why it r her to provide this sident #48.					
	(DON) on 02/19/19 at skin referral was rece be that the facility's T wound within 24 - 48	vith the Director of Nursing t 4:18 PM she stated once a ived her expectation would reatment Nurse assess that hours. She reported this include measurements,					

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO): 03/27/2019 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	LETED
		345569	B. WING		_		22/2019
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENI CLAYTON, NC 27520	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page		F 600				
	necrosis or infections.	ining, pain, and possible She commented wounds per the facility policy which					
	Resident #48's right h made with the facility' Assistant Director of N Treatment Nurse state being used to treat the it was an anti-microbia	AM an observation of leel pressure ulcer was s Treatment Nurse and Nursing (ADON). The ed Silvasorb was currently e resident's heel ulcer since al gel, and the resident was und of antibiotics to treat					
	light pink to bright pin slough, and there was	right heel wound bed was k with a small amount of tan s no odor. The Treatment mated measurements of the x 0.2 cm.					
	Director, who was Re physician (Physician a wounds to be assesse were found, no later the He reported measure	#1), stated he expected ed, if not on the day they han the next business day. ments and description of the ortant pieces of information,					
	Treatment Nurse to us what type of wound th DTI, pressure wound, reported after the initianeeded to be assessed often if significant chan noted. He stated he resident at the end of commented if he remo- thought the wound pro-	se her expertise to diagnose he resident had (such as a venous/stasis wound). He al assessment the wound ed every 7 - 10 days or more inges in the wound were did his initial visit with the December (12/30/18). He					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	 Physician #1 commer develop quickly becau the surface within ever did not order wound of consider them to be a wounds. During a follow-up inter Treatment Nurse on O stated in her experient slough and eschar wa one that occurred over saw no slough or esc before the resident's of commented she miss wound between 12/20 During a telephone in AM Wound Center Nu eschar did not develo she had seen instanc slough/eschar were re one week, and when later for a follow-up, th wound bed again. b. Resident #48 w 07/10/17. The reside included pressure ulc deficiency anemia, hy A 01/08/19 QA (Qualit Review documented to right heel measured 4 (cm), had yellow/gree 	ed, and he started the tric due to purulent drainage. Inted purulent drainage could use infection could rise to en 24 hours. He reported he cultures, and did not a valid tool in treating erview with the facility's 02/22/19 at 9:08 AM she nee the development of as a gradual process, not er night. She reported she har in Resident #48's wound 01/30/19 wound consult, but ed assessments of the 0/18 and 01/10/19. terview on 2/22/19 at 11:50 urse #1 stated slough and p in a 1 - 2 day period, but es where small amounts of emoved from a wound bed the patient returned a week here was slough in the vas admitted to the facility on nt's documented diagnoses	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE	ECONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _			
		345569	B. WING				C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ROOK NURSING & REHA			1	95 SPRINGBROOK AVENUE		
SPRINGE	KOOK NUKSING & KEHA	ABILITATION CENTER		C	CLAYTON, NC 27520		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG		,			DEFICIENCY)		
F 600	Continued From page	e 20	F	600			
		progress note written by					
		nted, "Patient seen for heel nues to worsen and now					
		ation, patient confirms it is					
		and Plan: right heel ulcer:					
		vorsen and now needs					
		Nill set up wound clinic					
	referral."						
	Δ 01/10/19 Wound LI	cer Flowsheet documented					
	under Comments, "wo						
	, ···-						
		cer Flowsheet (the last					
	-	Resident #48's right heel					
		en by the wound center)					
	documented Residen	right heel which developed					
	-	asured 4.5 x 3.5×0.5 cm.					
		nt Nurse documented the					
		n no drainage, no infection,					
		ling or undermining, and no					
		s documented the resident					
	wound bed was desci	n his dressing changes. The ribed as purple/pink					
	Resident #48's initial	wound center consult on					
		she presented to the clinic					
		pressure ulcer on the right					
		2.5 x 1.5 x 0.2 cm. The					
		ribed as tan/yellow with a I eschar and a moderate					
	-	The wound was debrided.					
	-	ith the facility's Treatment					
		3:52 PM she stated the					
		ed one wound clinic for those					
	patients who needed	wound referrals to an reported she usually got a					
		sponed one doudiny you a					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	resident seen at this y of days. She comme could not get a reside the week the referral set up an appointmen The Treatment Nurse it took so long to get I wound clinic, with a w 01/08/19 and the resident On 02/20/19 at 12:35 Director, who was Re physician (Physician observed the resident 01/09/19 he thought t explained he felt the p indication of infection an antibiotic. He con recommended a surg Physician #1 stated a more than two weeks wound consult since t care to the wound dur revealed Resident #4 weeks to be seen at t 1. c. Resident #48 w 07/10/17. The reside included pressure ulc deficiency anemia, hy On 12/20/18 the facilit documented on a skin #48 had a "right heel Resident #48's Treatment the resident's treatment	wound clinic within a couple need at the latest, if she ent into this wound center on was made, she was able to at early the following week. was unable to explain why Resident #48 seen at the yound consult requested on dent not seen until 01/30/19. PM the facility's Medical sident #48's primary #1), stated when he t's right heel ulcer on he wound had changed. He purulent drainage was an , and started the resident on mented he also ical consult for debridement. wait of one week and no would be acceptable for a the facility was providing ring the wait (record review 8 had to wait 21 days or 3 he wound center). vas admitted to the facility on nt's documented diagnoses er to right heel, iron ypertension, and dementia. ty's Treatment Nurse n referral form that Resident DTI (deep tissue injury)".	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/27/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		PLETED
		345569	B. WING				C / 22/2019
	ROVIDER OR SUPPLIER	ABILITATION CENTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	as having no slough/e between 01/18/19 an consult) was calcium every other day. (The Manual, version dated treatment for a DTI w normal saline solution cleansing solution. A to dry thoroughly. Co cover with a foam dre normal saline solution cleansing solution. C every other day and p unclear who was resp calcium alginate to tre wound. During an interview w Nurse on 02/19/19 at the standing orders for skin prep and protect She was unable to ex was used to treat Res which was classified and 01/18/19 and wa slough/eschar or drai wound center consult On 02/20/19 at 10:34 Nursing (ADON) state alginate was used for usually discontinued a reported she did not t be appropriate for tre On 02/20/19 at 12:35 Director, who was Res	d 01/18/19 and documented eschar or drainage present d a 01/30/19 wound center alginate applied topically e facility's Wound Care d 05/22/18, documented as "1) Cleanse wound with n or appropriate wound pply skin sealant and allow omplete daily. 2) May also essing after cleansing with n or appropriate wound theck dressing daily, change orn (as needed).") It was bonsible for ordering the eat Resident #48's right heel with the facility's Treatment 3:52 PM she reported that or DTI treatment included ive booties to the heels. cplain why calcium alginate sident #48's right heel wound as a DTI between 12/21/18 s documented as having no nage before the initial c on 01/30/19. AM the Assistant Director of ed she thought calcium t debridement and was as the wound healed. She think calcium alginate would ating a DTI. PM the facility's Medical	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	was typically utilized i which contained sloug unsure why the facility calcium alginate if a v a wound did not have 1. d. Resident #48 w 07/10/17. The reside included pressure ulc deficiency anemia, hy A 12/16/18 skin referr Resident #48 had a p aspect of her right he to "float heels on pillo A 01/08/19 QA (Quali Review documented right heel measured 4 (cm), had yellow/gree was painful. Foam bo bilateral heels, and th elevated on a pillow. On 01/31/19 wound of Resident #48 to "Kee please!!" was implem A 02/15/19 physician heel off loaded, float w Nurse on 02/19/19 at were many factors wh unhealed status of Re	est frequently used He also reported that absorptive properties, and n wounds with drainage gh. He commented he was y would have been using yound was truly a DTI and if slough or eschar in it. vas admitted to the facility on nt's documented diagnoses er to right heel, iron rpertension, and dementia. al form documented ressure ulcer to the inner el, and the intervention was w". ty Assurance) Skin Wound the wound to Resident #48's 4.5 cm by 3.5 centimeters in purulent drainage, and boties were applied to e resident's heels were enter recommendation for p heel off bed. Offload ented via physician order. order documented, "Keep with no contact with bed." ith the facility's Treatment 3:52 PM she stated there	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345569	B. WING				C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #48's right h made with the facility' Assistant Director of h attempt was made to meaningful conversat unable to participate. bed with her right here sheet. The sheep ski the resident's right ankle. covering the resident's sock on the resident's sock on the resident's pillows in the bed or u off-loading. As the Aff resident's room, she p pillow case from furnit that once a pillow case then needed to be plat legs. On 02/20/19 at 12:35 Director, who was Re physician (Physician a important thing for tre heels was to off-load heels. He explained to on underneath the ski important to ensure a wound by off-loading. effective and easiest was to place a pillow bunny boots.	ht's heels. AM an observation of heel pressure ulcer was s Treatment Nurse and Nursing (ADON). An engage the resident in ion, but the resident was Resident #48 was found in al on the bed, resting on the n bootie was not covering wel, but was up around the A sheep skin bootie was s left heel, and a fluffy sock s left foot. There was no a right foot. There was no a right foot. There were no under the resident's legs for DON was leaving the bicked up a pillow without a ture in the room, and stated was applied, the pillow aced under the resident's PM the facility's Medical sident #48's primary #1), stated the most atment of a DTI on the pressure exerted on the there could be things going in of a DTI so it was good blood supply to the He stated one of the most way to off-load pressure behind the calves and apply	F	600			
		ith Nursing Assistant (NA) 5 PM she stated Resident					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	legs and fluffy socks a both feet to protect th she had not had a pro- interventions in place shift rounds. Accordination seen a problem with the coming off. She was Resident #48 was witt interventions when the completed on 02/20/1 for the resident on first During an observation Resident #48 was in the were in place on both on both feet. There we case which was at the under the resident's les sheep skin booties, we NA #5 stated she wor over this morning. She been told by the nurse supposed to have sood and a pillow was suppresident's legs. She for sure but she felt lift pillow under her legs before 7:00 AM on 02 resident sometimes k under her legs. During an interview we 8:52 AM she stated R to have bunny boots of legs, but the resident the boots and pillow. explained to the resident	have two pillows under her and sheep skin boots on e heels. She commented oblem finding these when she started her first ing to NA #3, she had not he resident's heel booties unable to explain why hout some of these e wound observation was 9 (she was assigned to care at shift that morning). n on 02/21/19 at 8:22 AM bed. Her sheep skin booties feet, and there were socks vas a pillow with a pillow e bottom of the bed, but not egs. The heels, covered by rere on the bed. At this time ked third shift, but stayed he commented she had e that the resident was cks and booties on both feet,	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	apt to comply. During an interview w 4:51 PM she stated F bunny boots all the tir the resident did not a because she did not I body. Nurse #8 state Resident #48 more fr booties stayed in place During an observation Resident #48 was aw and booties on both f the bottom of bed, bu not elevated by a pillo crossed with the right left foot. During an interview w 10:46 AM she stated to have sheep skin bo pillows under her legs she commented keep place was difficult for compromised cognitio occasional combative there were problems resident, but the resid so she could be educ about the importance keeping the pillows un also remarked that th the resident more free 2. Resident #188 was	with Nurse #8 on 02/21/19 at Resident #48 was to wear me when in bed, although Iways to keep them on ike things touching her ad the staff had to check on equently to make sure the ced. In on 02/22/19 at 8:14 AM rake in bed. She had socks eet. There was a pillow at t the resident's legs were ow. The resident's feet were theel resting on top of the with the DON on 02/22/19 at Resident #48 was supposed bots covering her heels and as for off-loading. However, bing these interventions in this resident because of her on, impulsiveness, and the behavior. She commented keeping the boots on the bent had periods of alertness ated during these periods of keeping the boots on and nder her legs. The DON e staff needed to check on quently.	F	600			
	about the importance keeping the pillows up also remarked that th the resident more free 2. Resident #188 was 11/07/18 and had dia	of keeping the boots on and nder her legs. The DON e staff needed to check on quently.					

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DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID					FORM	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE	ER/SUPPLIER/CLIA CATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED
	345569	B. WING				22/2019
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGBROOK NURSING & REHABILITATION	CENTER			95 SPRINGBROOK AVENUE LAYTON, NC 27520		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF D (EACH DEFICIENCY MUST BE PRI REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
 F 600 Continued From page 27 Resident #188 was discharged h Health on 02/07/19. Review of the Physician's Orders revealed a verbal order to cleans #188's right heel with Normal Sal betadine, and then cover with a ti dressing with foam every other da blister. Review of the Flowsheets of Non Conditions dated 11/28/18, 01/03 and 01/31/19 revealed Resident a ruptured right heel blister. There infection present. There were no of the wound and no description surrounding the wound. The treat apply betadine and a transparent every other day. There was no p notification date on the form. Review of the Care Plan initiated revised on 11/29/18 revealed Rest at risk for skin breakdown and the of pressure wounds. The goal with #188 to not develop any skin breat pressure wounds through the neat Interventions included to encourat #188 to change position frequent observe the skin daily for any abb Review of the Care Plan initiated revealed a ruptured blister had bo Resident #188's right heel. The g ruptured blister to heal without co through the next review. Interver keep pressure off of the right heet treatments as ordered and to not of any changes. 	dated 11/28/18 e Resident ine, apply ansparent ay for a ruptured -Ulcer Skin /19, 01/23/19, #188 had a pink was no pain or measurements of the area tment was to film dressing hysician on 11/07/18 and sident #188 was e development as for Resident akdown or tt review. ge Resident by and to normal changes. on 11/29/18 een noted on goal was for the implications titions included to I and to perform	F	500			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY
			A. BUILDI	ING	·		C
		345569	B. WING				/22/2019
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE		
					CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	28	F	60	0		
	dated 02/01/19 revea risk for but did not har Resident #188 was co the extensive assistan mobility, dressing, an Review of the Home I Assessment Dated 02 #188 had a stage 3 p heel. The wound me was 0.5cm deep. The loss involving damage subcutaneous tissue. of thin, watery, pale, r wound. The wound b	ognitively intact and needed nce of one person for bed d hygiene. Health Comprehensive Adult 2/08/19 revealed Resident ressure wound on the right asured 2cm by 2cm and ere was full thickness skin e or necrosis of There was a small amount red/pink drainage from the bed was pink with less than vered with epithelial tissue. nding the wound was					
	most important thing pressure wounds was keep pressure off of t In an interview on 02/ Wound Care Nurse (N #188 had a fluid filled right heel that develop Resident #188's foot she did not know how place prior to its ruptu perform weekly skin of that a ruptured blister	I Director) stated that the for prevention of heel s to offload the heels and hem. (20/19 at 1:55 PM the WCN) indicated Resident blister on the bottom of the ped from the positioning of on the mattress. She stated y long the blister was in ure as the facility did not checks. The WCN stated y would be considered a und. The WCN indicated					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	staging, if there was of infection, the presence of the wound bed and surrounding skin. Sh assessments would s she was working a me the day the assessme that the floor nurses w would not perform the leaving them for her t WCN role. The WCN missing documentation wound. The WCN state been problems with the wounds and she was proactive with the sch She indicated she did assessment when Ree from the facility becaus resident was being di that if she had known would have written a agency about the would in the facility since 01 she supervised the W ideal world pressure w and documented wee In a telephone intervite Physician #2 stated h #188 had had a wour unaware that there wa heel. He indicated if the blister and then ruptu	drainage, any signs of e of an odor, a description I a description of the e indicated that ometimes not be done if edication cart or was off on ent was due. She stated would do the treatments but e required assessments o do on her return to the admitted there was on for Resident #188's ated she knew there had ne weekly assessment of now trying to be more reduling of assessments. I not perform a skin sident #188 was discharged use she was not aware the scharged. She indicated about the discharge she note to the home health und. 20/19 at approximately 2:20 she had only been working /02/19. She verified that /CN and stated that in an wounds would be assessed	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			LETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE		
					CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page In a follow-up intervie the WCN stated the p written on 11/28/19 as from the standing ord spoken to the physicia wound. In an interview on 02/ Assistant (NA) #2, wh #188, stated she was developed the blister indicated she looked with care and reporte the nurse. NA #2 ind #188 got the wound of "bunny" boot on her r bed. In an interview on 02/ indicated that when F admitted she was onl She stated that in tim to being able to get u one person. NA #9 in wore a "bunny" boot of was in the bed and di	e 30 w on 02/21/19 at 1:45 PM hysician's order that was is a verbal order was actually ers and that she had not an regarding the heel 21/19 at 2:45 PM Nursing to had worked with Resident not sure when the resident on the right heel. She at each resident's skin daily d any abnormal findings to icated that after Resident on her heel she wore a soft ight foot when she was in 21/19 at 4:31 PM NA #9 Resident #188 was first y able to get up with therapy. e Resident #188 progressed p with two people and then ndicated that Resident #188 on her right foot when she d not recall when the blister		600	DEFICIENCY)		
	expected the assess include measurement wound bed, and if any noted such as puruler the facility could track improving. She indica wound to be assesse She indicated she exp	22/19 at 9:14 AM the OON) indicated that she nent of a pressure wound to ts, a description of the y signs of infection were ht drainage or odor so that					

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		ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			LETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		22/2013
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE		
				0	CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From none	- 24		000			
F 000	Continued From page the facility so the physical			600			
	standing orders were wanted a different tre	appropriate or if they					
	1/4/19. His active diag intertrochanteric fract hypertension, heart fa and chronic obstructiv Review of Resident # assessment and refer revealed Resident #6 knee cap skin tear as There were no press s left heel identified u referral was locked or reviewed by the Wour Review of a nurse's n the nurse noted a pre	ailure, muscle weakness, ve pulmonary disease. 62 ' s admission skin rral form dated 1/4/19 2 had a left hand and left well as a left hip wound. ure ulcers to Resident #62 ' pon admission. This skin n 1/10/19 and signed as nd Care Nurse.					
	completed and new o	el. A skin referral was rders for bunny boots while ft heel elevated on pillows.					
	1/6/19 revealed the p Resident #62 had a le	eft heel pressure ulcer and e wound care nurse provide					
	the left heel. A new of boots to the left heel a This skin referral was referral would no long	ocumented a new ulcer to rder was made for bunny and elevate the heel in bed.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				22/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	care nurse to evaluate Resident #62's left he There were no wound between 1/6/19 and 1 Review of a nurse pra dated 1/7/19 revealed bunny boots in place heel pain was greater Review of a physiciar 1/9/19 revealed Resid boots in place and ha pain greater than the Review of a nurse pra dated 1/14/19 revealed bunny boots in place left heel pain was gre Left heel stage II pres drainage noted to the The wound was painf minimal movement. T pressure ulcer to com wound nurse and pain pain medication. Review of a physiciar 1/16/19 reveled Resid boots in place. The le stage II pressure ulcer the inside of the bunn	nd Care Nurse. I's order dated 1/6/19 n ordered for the wound e a stage II pressure ulcer to bel. d assessments documented /16/19. actitioner progress note d Resident #62 had bilateral and had heel pain. The left than the right heel pain. h's progress note dated dent #62 had bilateral bunny d heel pain with the left heel right heel pain. actitioner progress note ed Resident #62 had bilateral and bilateral heel pain. the sprogress note d Resident #62 had bilateral and bilateral heel pain. actitioner progress note d Resident #62 had bilateral and bilateral heel pain. asure ulcer noted with old inside of the bunny boot. ul to the touch and with the plan was for the stage II tinue being followed by the n controlled with as needed h's progress note dated dent #62 had bilateral bunny ft heel was noted to have a r with old drainage noted to ny boot. Pain was present to	F	600			
	pressure ulcer to com wound nurse and pair pain medication. Review of a physiciar 1/16/19 reveled Resid boots in place. The le stage II pressure ulce	tinue being followed by the in controlled with as needed in 's progress note dated dent #62 had bilateral bunny ft heel was noted to have a er with old drainage noted to by boot. Pain was present to					

Facility ID: 100679

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION			LETED
		345569	B. WING		_		C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER		195 SPRINGBROOK AVEN CLAYTON, NC 27520	IUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	adhesive dressing with the stage II pressure of Review of a wound flor revealed the resident pressure ulcer to his I centimeters by 1 cent treatment was to appl dressing with foam ev Review of Resident # record revealed Reside and adhesive dressing as being performed u Review of the Reside 1/17/19 revealed the for a pressure ulcer to interventions included wound healing as ord in skin integrity or skin or symptoms of infect boots or pressure relia provide treatments as Review of Resident # assessment dated 2/1 was assessed as cog extensive assistance locomotion on and off and personal hygiene with eating. Resident	an orders revealed on was ordered betadine and th foam every other day to ulcer on the left heel. by sheet dated 1/16/19 had an in-house stage II eft heel which measured 3 imeter. The ordered y betadine and an adhesive very other day. 62's January 2019 treatment dent #62's order for betadine g with foam was not initialed ntil 1/19/19. nt #62 ' s care plan dated resident was care planned o his left heel. The I to provide medications for ered, observe for changes n impairment such as signs ion and pain, specialty eving boots to both feet, and a ordered. 62 ' s minimum data set 1/19 revealed the resident nitively intact. He required with bed mobility, transfers, f unit, dressing, toilet use, . He required supervision #62 had one unhealed r which was not present	F 60				
		owsheet dated 2/1/19 2 had a stage II pressure					

If continuation sheet Page 34 of 114

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING .			C
		345569	B. WING				22/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	no depth. Review of a wound flar revealed Resident #6 ulcer to his left heel w centimeters long, 2 ca centimeters deep. Review of a wound flar revealed Resident #6 ulcer to his left heel w centimeters long, 1.5 than 0.25 centimeters During an interview o Resident #62 and his had a pressure ulcer stated the nurses had treatments and they w developed it. He cond but at first not all his of being done. During observation or Wound Care Nurse w wound care to Reside identified with the woo measured to be 1.5 c centimeters wide, and deep. During an interview o	 which measured 3 1.5 centimeters wide with bwsheet dated 2/5/19 2 had a stage II pressure which measured 3 entimeters wide, and 0.5 bwsheet dated 2/18/19 2 had a stage II pressure which measured 1.5 centimeters wide, and less a deep. n 2/18/19 at 1:26 PM family member stated he to his left heel. They further d missed some of his were not sure when he cluded care was better now dressing changes were n 2/18/19 at 2:58 PM the vas observed providing ent#62. No concerns were und care. The wound was 	F	600			
	something is identified Resident #62 did not	referral from the nurse if d. She further stated have any pressure ulcers Wound Care Nurse stated					

Facility ID: 100679

If continuation sheet Page 35 of 114

		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001112011011		A. BUILDIN	G	
		345500			C
		345569	B. WING		02/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	, CODE
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE	
				CLAYTON, NC 27520	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	. ,
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE DATE
F 600	Continued From page	e 35	F 6	00	
		would be issued for newly	10		
		She further stated she			
		errals within the first 24			
		erals within the first 24 eekend she would then go			
		ent the next work week day.			
		e would have done all new			
		19 which was the first work			
		he 1/6/19 when the referral			
		I have been the day following			
		further stated the nurse who			
		rm in the system for the			
		e II pressure ulcer on 1/6/19			
		1/6/19 which meant the			
		t to her when she came back			
		ne further stated she saw			
		19 for his surgical incision			
	but was not aware of				
		e. The Wound Care Nurse			
		supposed to close out newly			
		Is because it would not show			
	•	how she knew when there			
	were newly identified				
		ey did close them out they			
		nder the door and that was			
		d Care Nurse stated she was			
		ne pressure ulcer on 1/16/19			
		the management team			
		ral order placed on 1/6/19.			
		was her expectation that the			
	-	her attention as soon as it			
	,	was not done due to the			
	-	erral which caused the			
		in her report. The Wound			
		was too long of a gap from			
		ne wound to her being			
		not know what state the			
	wound was in on the	6th, however the physician			
	documented it as a s				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	between her last two stated on 1/16/19 whe the pressure ulcer and assessment on that d was no dressing on the that point and then the day for betadine with on the pressure ulcer further stated she did was not initialed as co treatment record beca dressing on 1/16/19 w the wound. She conclet through January 16th assessments or meas Resident #62's stage During an interview on Director of Nursing st with newly identified p wound care nurse wo assessment and meas status of the wound w identification. She furt acceptable to allow a without having an ass following its identificat stated skin referrals w the Wound Care Nurse and Nurse #1 should form before the Wour that she had received During an interview of Physician #1 stated it Wound Care Nurse d measurements within the request for a wour	measurements. She further en she was made aware of d performed her first ay with the physician there he wound but bunny boots at eatment was initiated on that an adhesive foam dressing with the physician. She not know why the treatment ompleted until 1/19/19 on the ause she had placed the first when she was first aware of luded from January 6th there were no wound surements performed on II pressure ulcer. In 2/19/19 at 3:21 PM the ated it was her expectation oressure ulcers that the uld perform an initial sure and document that within 24 to 48 hours of ther stated it was not wound to go ten days sessment performed tion. The Director of Nursing were not to be closed prior to se signing off on the referral not have closed the referral not have could sign off l.	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		PLETED
		345569	B. WING				C /22/2019
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600 F 623 SS=B	did not feel that there in the wound between 1/6/19 and 1/16/19 du facility. During an interview o #1 stated skin referrat the wound care nurse She further stated the on 1/6/19 was comple 1/6/19 before the Wou She further stated the believed the wound h resident entered the f Wound Care Nurse al was why she closed if Wound Care Nurse. Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility transf resident, the facility m (i) Notify the resident representative(s) of th the reasons for the m language and manner facility must send a co representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and	had been any deterioration in the time he saw it on ue to any lack of care by the in 2/20/19 at 7:56 AM Nurse is were not to be locked until e was aware of the issue. e skin referral she completed eted and locked by her on und Care Nurse could see it. e family had stated they ad been there since the facility on 1/4/19 so the iready knew about it and t and did not inform the Before Transfer/Discharge r(6)(8) before transfer. fers or discharges a nust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section.		600			3/18/19

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/27/2019 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345569	B. WING			_		22/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SPRINGB	ROOK NURSING & REHA	BILITATION CENTER			95 SPRINGBROOK AVENI LAYTON, NC 27520	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	 (c)(8) of this section, t discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Contem notice specified in par must include the follow (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; 	I in paragraphs (c)(4)(ii) and he notice of transfer or der this section must be cleast 30 days before the or discharged. Ide as soon as practicable charge when- riduals in the facility would paragraph (c)(1)(i)(C) of riduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge,)(i)(B) of this section; after or discharge is nt's urgent medical needs,)(i)(A) of this section; or resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; ich the resident is ged; resident's appeal rights, ddress (mailing and email), r of the entity which ts; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and	F	623				

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 03/27/2019 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345569	B. WING			C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SPRINGR	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE		
SF KINGDI		ADIENTIANON CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individ §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification pri to the State Survey A State Long-Term Carr the facility, and the re- well as the plan for the relocation of the resic 483.70(I). This REQUIREMENT by:	budsman; y residents with intellectual isabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act. es to the notice. ne notice changes prior to or discharge, the facility bients of the notice as soon he updated information in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of esident representatives, as ue transfer and adequate dents, as required at §	F 62			
		iew and staff interview the de written notice of discharge		The facility immediately put in meas to notify the resident and the resider		

Facility ID: 100679

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			0/02 100				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	SURVEY PLETED
			7	° <u> </u>			С
		345569	B. WING			02	/22/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETIO DATE
F 623	Continued From page	<u>-</u> 40	F 62	23			
1 020	· · · · · · · · · · · · · · · · ·	dent representative for a	F 02	23	representative of the resident□s trans	for	
		arge to the hospital for 1 of 1			or discharge from the facility and the		
	-	r hospitalization (Resident #			reasons for the move in writing and se	end	
	90).	· · · · ·			a copy to the Office of the State Long		
					Term Care Ombudsman. All residents	-	
	The findings included	:			discharged from the facility will receive	e the	
	Desident #00				notice of transfer or discharge form.		
		mitted to the facility on ses that included coronary			Resident #90 no longer resides in the facility.		
	artery disease and hy				lacinty.		
					An in-service used the notice of transf	er	
	Review of a nurse's n	ote dated 11/16/18 revealed			form as the template to educate all so	-	
	Resident #90 was set	nt to the hospital for			services and accounts receivable staff	fon	
	evaluation of chest pa	ain.			the transfer and discharge process wa		
					initiated on 3/12/19 by the Nursing Ho		
		note dated 11/20/18 revealed			Administrator and will be completed by		
	the hospital on 11/20/	admitted to the facility from			3/12/19. The in-service focused on th facility permitting each resident to rem		
		10.			in the facility, and not transfer or		
	A review of the medic	al record revealed no			discharge the resident from the facility	,	
	written notice of disch	narge was provided to the			unless (A) The transfer or discharge is	3	
		e for the resident's hospital			necessary for the resident⊡s welfare a		
	transfer on 11/16/18.				the resident s needs cannot be met in		
	During on interview w	ith the Casial Marker on			the facility, (B) The transfer or dischar	-	
		vith the Social Worker on he indicated she did not			is appropriate because the resident shealth has improved sufficiently so the		
		discharge to the resident or			resident no longer needs the services		
		tive for emergent hospital			provided by the facility, (C) The safety		
	transfers. She repor				individuals in the facility is endangered		
	contacted the ombud	sman regarding			due to the clinical or behavioral status	of	
	facility-initiated discha	arges.			the resident, (D) The health of individu	lals	
	During on intervie				in the facility would otherwise be	- d	
	-	vith the Administrator on estated he was unaware			endangered, (E) The resident has faile after reasonable and appropriate notic		
		harge was to be sent to the			to pay for a stay at the facility, or (F) T		
		representative with a copy			facility ceases to operate. All newly hi		
		udsman. He stated the			staff will be in-serviced on the facility		
		ending these written notices			transfer and discharge process.		
		tions for emergent hospital					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/20 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345569	B. WING		C 02/22/2019		
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		95 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 623	Continued From page 41 F 623 transfers. Resident transfers and discharges will monitored through the facility □ s Interdisciplinary Team process by the Accounts Receivable, Social Services, designee. The Nursing Home Administrator will be responsible for th QI tools and will audit weekly times 4 weeks then monthly times 2 months. The retrained by the auditor for any identifiareas of concern. The Executive QI committee will meet review the discharge QI tool monthly times 3 months to determine issues ar trend to include continued monitoring frequency.		or e The ied to				
F 641 SS=D	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revi facility failed to accura on a Minimum Data S residents (Resident # ulcers. Findings inclu Resident #188 was a	of Assessments. at accurately reflect the is not met as evidenced iew and staff interviews the ately code a pressure wound Set (MDS) for 1 of 3 sampled 188) reviewed for pressure uded: dmitted to the facility on	F 641	The facility immediately put in measur to accurately assess each resident and code the Minimum Data Set (MDS). The Minimum Data Set (MDS) assessment for Resident #188 was reviewed by the MDS Nurse. The curr	ent		
	behaviors, insomnia a Review of Resident # revealed a Flowsheet			assessment of the resident is accurate Resident #188 no longer resides in the facility. A 100 % audit of the last completed MI assessment, section M, for all resident	DS		

Event ID: 0UHB11

Facility ID: 100679

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		MEDICAID SERVICES					<u>O. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	1 Y /	E SURVEY PLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	G			
			5.44440				С
		345569	B. WING			02	/22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGR	ROOK NURSING & REH	ABILITATION CENTER		195	5 SPRINGBROOK AVENUE		
				CL	LAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 641	Continued From pag	e 42	F 64	11			
	1.0	01/31/19 that specified			was initiated on 3/15/19 by the MDS		
	,	pink ruptured right heel			nurses, Director of Nursing, Assistant		
		oving. The area surrounding			Director of Nursing, Wound Care Nurs		
	the wound was intac			and Staff Facilitator to ensure the mos			
	infection present. Th			recent MDS assessment accurately			
	of the wound. The tre			reflects the residents current conditi	on		
	betadine and transpa			to include coding of pressure wounds	to		
	every other day.				be completed by 3/18/19. For all area	as of	
					concern identified, a modification or		
	· ·	rly Minimum Data Set (MDS)			significant correction of prior assessm	ient	
	dated 02/01/19 revea			(Quarterly/Comprehensive) will be			
		ave a pressure wound.			completed by the MDS nurses as		
		ed the extensive assistance			indicated by the Resident Assessmen	t	
	hygiene.	d mobility, dressing, and			Instrument (RAI) manual by 3/18/19. On 3/15/19, an in- service was initiate	d for	
	nygiene.				the Care Plan Team to include MDS		
	In an interview on 02	2/20/19 at 1:55 PM the			Nurses, Activities, Social Services,		
		(WCN) indicated Resident			Dietary, and the Director of Nursing b	v the	
		d blister on the bottom of the			Staff Facilitator, corporate consultant		
		s not identified until it ruptured			designee regarding proper coding of t		
	on 11/28/18, which d	-			MDS assessments per the Resident		
	positioning of Reside				Assessment Instrument (RAI) Manual	,	
	_	d she did not know how long			and was completed by 3/18/19. Whe		
		ce prior to its rupture as the			coding the MDS assessment, the MD	S	
		m weekly skin checks,			Nurse and the Care Plan Team to incl		
		e Nursing Assistants (NAs) to			Activities, Social Services and Dietary		
		ily of any change in a			follow the instructions for proper codir	ng	
		WCN stated that a ruptured			found in the Resident Assessment	U 4	
		sidered a stage 2 pressure			Instrument (RAI) Manual and ensure		
		ised the Flowsheet of			the assessment accurately reflects the resident s current condition.	e	
	Non-Ulcer Skin Conc	esident #188's wound. She					
		ne documentation should			An audit of completed Minimum Data	Set	
	-	essure wound assessment			(MDS) assessments will be reviewed		
		taff would know Resident			times per week for 4 weeks for a total		
		pressure wound. She			ten residents, then 3 times per week f		
	indicated she did not				weeks for a total of 5 residents, then		
		non-ulcer assessment sheet.			monthly times 1 month for 5 residents	i.	
	She indicated she di				The audits will be conducted by the M		

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If continuation sheet Page 43 of 114

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · ·	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C
		345569	B. WING			02/22/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 43	F 64	1		
		esident #188 was discharged		Nurse, Director of Nursing or des ensure compliance and accuracy MDS to include coding for pressu	of the	
		/20/19 at approximately 1:20		wounds utilizing a MDS Audit Too	I. All	
		she had only been working //02/19. She verified that		Identified areas of concern will be addressed immediately by the Dir		
	she supervised the W	/CN and stated that in an		Nursing or designee through retra		
	ideal world pressure	wounds would be orrect assessment forms so		and by modification or significant correction of the MDS Assessment	at by the	
		be available to all staff.		MDS Nurse to accurately reflect t		
				resident s current condition.		
		/22/19 at 9:14 AM the DON) indicated that she		The results of the MDS Audit tool	will be	
		be documented on the		reviewed by the Administrator we		
		prrect information was		Director of Nursing or designee w		
	available to everyone).		audit results to the Quality Improv Executive Committee will review		
				results monthly for 3 months for f	urther	
				recommendations, take action as appropriate, and to monitor contir		
				compliance.	lueu	
F 660 SS=D	Discharge Planning F CFR(s): 483.21(c)(1)		F 660)		3/18/19
	§483.21(c)(1) Discha	rge Planning Process				
		elop and implement an				
		anning process that focuses harge goals, the preparation				
		ive partners and effectively				
		st-discharge care, and the				
	reduction of factors le	eading to preventable cility's discharge planning				
	process must be con	sistent with the discharge				
		1.15(b) as applicable and-				
	(I) Ensure that the dis resident are identified	scharge needs of each I and result in the				
	development of a dis					
	resident.					

Facility ID: 100679

If continuation sheet Page 44 of 114

		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345569	B. WING				22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	identify changes that discharge plan. The d updated, as needed, i (iii) Involve the interdi by §483.21(b)(2)(ii), in developing the dischar (iv) Consider caregive and the resident's or o person(s) capacity an required care, as part discharge needs. (v) Involve the resider representative in the d discharge plan and in resident representative (vi) Address the resider treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local conta appropriate entities m (B) Facilities must up comprehensive care p appropriate, in respor from referrals to local appropriate entities. (C) If discharge to the to not be feasible, the made the determinatii (viii) For residents wh SNF or who are disch LTCH, assist resident representatives in sel	evaluation of residents to require modification of the lischarge plan must be to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support d capability to perform of the identification of the and resident development of the form the resident and re of the final plan. ent's goals of care and s. resident has been asked receiving information the community. cates an interest in returning facility must document any act agencies or other lade for this purpose. date a resident's olan and discharge plan, as use to information received contact agencies or other e community is determined facility must document who on and why. o are transferred to another larged to a HHA, IRF, or	F	660	0		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345569	B. WING		C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 95 SPRINGBROOK AVENUE	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 660	limited to SNF, HHA, patient assessment of measures, and data of the data is available. the post-acute care s assessment data, dat data on resource use the resident's goals of preferences. (ix) Document, comp on the resident's nee record, the evaluation needs and discharge evaluation must be d resident's representa information must be i discharge plan to fac to avoid unnecessary discharge or transfer This REQUIREMENT by: Based on record rev facility failed to devel effective discharge pl an effective transition the area of pressure (Resident #188) who Findings included: Resident #188 was a 11/07/18 and had dia behaviors, insomnia a Review of the last Flo Conditions assessme Resident #188 had a blister (the ruptured h 11/28/18) that was im	IRF, or LTCH standardized lata, data on quality on resource use to the extent The facility must ensure that tandardized patient ta on quality measures, and e is relevant and applicable to of care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident ncorporated into the ilitate its implementation and d delays in the resident's T is not met as evidenced iew and staff interviews the op and implement an lanning process that allowed to post-discharge care in ulcers for 1 of 3 residents se discharge was reviewed. dmitted to the facility on gnoses of dementia without and chronic kidney disease. pwsheet of Non-Ulcer Skin ent dated 01/31/19 revealed pink ruptured right heel neel blister was discovered	F 660	The facility immediately put in measu to ensure a discharge planning proce for residents in accordance to F660, 483.21 (c)(1) Discharge Planning Process. Beginning 3/18/19 the facility administrator and director of nursing ensured all parties in the discharge planning process are aware of reside discharges. The appropriate parties (social worker, MDS, activities, dietar therapy, and wound nurse when applicable) will be notified during interdisciplinary team meetings (IDT) in the morning and afternoon and/or clinical meetings.	ss nt y,

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345569	B. WING		0	C 2/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE		
	1	-		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 660	Continued From page	e 46	F 66	60		
	pain or infection pres measurements of the to continue betadine dressing with foam en Review of the quarter dated 02/01/19 revea risk for but did not ha Resident #188 was of the extensive assista mobility, dressing, an Review of the Discha Care dated 02/06/19 to be discharged hom 02/07/19. A follow-up Practitioner had been AM and orders for a t were included. Resid regular diet with a die each day. The name along with the name a contact person were Review of the Patient dated 02/07/19 revea medications and prn Review of the Discha 02/07/19 directed the admission diagnoses pertinent clinical findi "see chart" was listed was listed as stable a home with home hea at 10:35 AM.	ent. There were no e wound. The treatment was and transparent film very other day. rly Minimum Data Set (MDS) aled Resident #188 was at ve a pressure wound. ognitively intact and needed nce of one person for bed id hygiene. rrge Instructions and Plan of revealed Resident #188 was ne with Home Health on to appointment with a Nurse in made for 02/28/19 at 9:50 treatment to the right heel dent #188 was to receive a etary shake supplement twice and telephone number of a provided. t Discharge Instructions aled a list of routine (as needed) medications.		An in-service to all licensed nu social services, and medical d the discharge planning process required elements was initiate by the Staff Development Coo Director of Nursing and was c 3/18/19. The in-service focus use of discharge planning forr document pressure ulcer vs nu skin condition, interest in rece information regarding returning community and if d/c to comm unfeasible, documentation of v determination and why. All ne licensed nursing staff, social s medical directors will be in-set the facility s discharge planni Each resident s discharge planni Each resident discharge planni interdisciplinary Team (IDT) pr QI tools will be reviewed by th services directors three times for four weeks for a total of ter then three times per week for for a total of five residents, the for one month for five resident The Executive QI Committee v review the discharge planning monthly times three months to issues and trends to include th continued monitoring.	irrector on iss and d on 3/8/19 rrdinator and ompleted by ed on the ns and to on pressure iving g to unity is who made evely hired services, and rviced on ng process. anning he facility' s rocess. The e social per week n residents, four weeks en monthly is.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345569 B. WING 02/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 02/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 195 SPRINGBROOK AVENUE CLAYTON, NC 27520 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			D HUMAN SERVICES				FORM): 03/27/2019 APPROVED). 0938-0391
345569 B: WHO 02/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE JP CODE 102/2011 SPRINGBROOK NURSING & REHABILITATION CENTER ISTERT ADDRESS. CITY, STATE JP CODE 102/2012 OPENDERS FUNCTION & REALINGTION CENTER ISTERT ADDRESS. CITY, STATE JP CODE 102/2012 OPENDERS FUNCTION & REALINGTION CENTER ISTERT ADDRESS. CITY, STATE JP CODE 102/2012 CODE TOTS IN STATE JP CODE 102/2012 OPENDERS FUNCTION CONSTRUCTION CENTER CODE TOTS IN STATE JP CODE TAGE STATE JP CODE 102/2012 CODE TOTS IN STATE JP CODE 102/2012 CODE TOTS IN STATE JP CODE 102/2012 CODE TOTS IN STATE JP CODE 102/2012 STATE JP CODE TOTS IN STATE JP CODE 102/2012 INT JOINT STATE JP CONSTRUCTION STATE JP CONSTRU	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, <i>'</i>		-	(X3) DATE COMP	SURVEY LETED
MALE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JP CODE SPRINGBROOK NURSING & REHABILITATION CENTER ISTREET ADDRESS, CITY, STATE, JP CODE ISS SPRINGBROOK AVENUE CLATTON, NC 27520 (PA) IN TAG SUMMARY STATEMENT OF DEFICIENCIES INCLOSE DENTIFYING INFORMATION ID PRETIX TAG IP MOVERSY PLAOF CORRECTION IEACH DEFICIENCIES INCLOSE DENTIFYING INFORMATION ID PRETIX TAG IP MOVERSY PLAOF CORRECTION IEACH DEFICIENCIES INCLOSE ID PRETIX TAG IP MOVERSY PLAOF CORRECTION IEACH DEFICIENCIES INCLOSE DENTIFYING INFORMATION IP EX IEACH DEFICIENCE ID PRETIX TAG IP MOVERSY PLAOF CORRECTION IEACH DEFICIENCIES INCLOSE IP MOVERSY PLAOF CORRECTION IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES INCLOSE IP MOVERSY PLAOF CORRECTION IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES IEACH DEFICIENCIES I			345569	B. WING				
SPRINGBROOK NURSING & REHABILITATION CENTER CLAYTON, NC 27520 (%1)D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EDFICIENCY MUST BE PROCEEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROFILES PAGE (EACH EDFICIENCY MUST BE PROCEEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENEST PAGE (EACH EDFICIENCY MUST BE PROCEEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENEST PAGE (EACH EDFICIENCY MUST BE PROCEEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENEST PAGE (EACH EDFICIENCY MUST BE PROCEEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENEST (EACH CONSTRUCTION (EACH EDFICIENCY) OWNET (EACH EDFICIENCY) F 660 Continued From page 47 F188 had a fluid filled bilster on the bottom of the right heel that developed from the positioning of Resident #188 foot on the matters. She stated she did not know how long the bilster was in place prior to its rupture as the facility fill ont perform weekly skin checks. The WCN indicated that she used the Flowsheet of Non-Uicer Skin Conditions to document information about Resident #188's wound. She acknowledged that the documentiation should have been on the pressure wound assessment sheet and she did not know why she had documentents, staging, drainage, infection, cofor, a description of the wound bed and a description of the surrounding skin. She indicated that assessments would sometimes not be done if she was working a medication car or was off on the day the assessment was due. The WCN admitted there were missing weekly assessments for Resident #188 wound. The WCN stated she knew there habeen problems with the weekly assessments. Wounds and she was now trying to be more proactive with the scheduling of assessessment would have withen a note to the indicated th	NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
With Display the second process of the second proces of the second process of the second process of the secon	0000000				195 SPRINGBROOK AVE	NUE		
Pricing TXG (EACH DEFICIENCY NOLST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPX TAG CEACH OBJECT VECTOR CATION OWNETTION TAG F 660 Continued From page 47 F 660	SPRINGBI	ROOK NURSING & REHA	BILITATION CENTER		CLAYTON, NC 27520			
#188 had a fluid filled blister on the bottom of the right heal that developed from the positioning of Resident #188's foot on the mattress. She stated she did not know how long the blister was in place prior to its rupture as the facility did not perform weekly skin checks. The WCN indicated that she first assessed the heal wound on 11/28/18. The WCN stated that a ruptured blister would be considered a stage 2 pressure wound but that she used the Flowsheet of Non-Ulcer Skin Conditions to document information about Resident #188's wound. She acknowledged that the documentation should have been on the pressure wound assessment sheet and she did not know why she had documented on the non-ulcer assessment sheet furing Resident #188's stay in the facility. The WCN indicated that a pressure wound assessment sheet and she did not know why she had documented on the non-ulcer assessment skeet throw CN indicated that a pressure wound should be assessed weekly and should include measurements, staging, drainage, infection, odor, a description of the wound bed and a description of the surrounding skin. She indicated that assessments would sometimes not be done if she was working a medication cart or was off on the day the assessment was due. The WCN admitted there were missing weekly assessments for Resident #188's wound. The WCN stated she knew three had been problems with the weekly assessment of wounds and she was now trying to be more proactive with the scheduling of assessment was being discharged. She indicated that if she had known about the discharge she would have written a note to the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRI	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA		COMPLETION
In an interview on 02/21/19 at 3:10 PM Nurse #4	F 660	#188 had a fluid filled right heel that develop Resident #188's foot of she did not know how place prior to its ruptu perform weekly skin of that she first assessed 11/28/18. The WCN s would be considered but that she used the Skin Conditions to do Resident #188's wour the documentation sh pressure wound asse not know why she had non-ulcer assessmen #188's stay in the faci that a pressure wound weekly and should ind staging, drainage, infe the wound bed and a surrounding skin. She assessments would s she was working a me the day the assessmen admitted there were m for Resident #188's w knew there had been assessments. She in a skin assessment wh discharged from the fa aware the resident wa indicated that if she h discharge she would be home health agency a	blister on the bottom of the bed from the positioning of on the mattress. She stated along the blister was in re as the facility did not checks. The WCN indicated d the heel wound on stated that a ruptured blister a stage 2 pressure wound Flowsheet of Non-Ulcer cument information about nd. She acknowledged that ould have been on the ssment sheet and she did d documented on the t sheet during Resident lity. The WCN indicated d should be assessed clude measurements, ection, odor, a description of description of the e indicated that ometimes not be done if edication cart or was off on ent was due. The WCN nissing weekly assessments ound. The WCN stated she problems with the weekly ls and she was now trying to h the scheduling of dicated she did not perform nen Resident #188 was acility because she was not as being discharged. She ad known about the have written a note to the about the wound.	F 6	60			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		LETED	
		345569	B. WING				C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)			3E	(X5) COMPLETION DATE		
F 660	provided a copy of the of the Discharge Instr the family member tha #188 home. She indi performed a skin asse #188's discharge. In an interview on 02/ Worker (SW) #1 state talked about from the indicated there were r Resident #188's famil discharge. SW #1 ind was aware of Resider treatment. She stated and a medication list Resident #188's famil Review of the Home I Assessment dated 02 #188 had a stage 3 p heel. The wound mea was 0.5cm deep. The loss involving damage subcutaneous tissue. of thin, watery, pale, r wound. The wound b 25% of the wound co The skin color surrour normal for the resider In a telephone intervie the Home Health Mar Resident #188 was as 02/08/19 the wound co as a stage 3 pressure	harged Resident #188 she e medication list and a copy fuctions and Plan of Care to at came to take Resident cated she had not essment prior to Resident 21/19 at 4:16 PM Social ed discharge plans were time of admission. She multiple discussions with y about the planned dicated that home health nt #188's heel wound and its d that discharge instructions had been provided to y at discharge. Health Comprehensive Adult 2/08/19 revealed Resident ressure wound on the right asured 2cm by 2cm and ere was full thickness skin e or necrosis of There was a small amount red/pink drainage from the hed was pink with less than vered with epithelial tissue. nding the wound was nt.	F	660				

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		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVE D. 0938-039	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/22/2019		
		345569	B. WING					
	ROVIDER OR SUPPLIER	ABILITATION CENTER	·	1	STREET ADDRESS, CITY, STATE, ZIP CODE 95 SPRINGBROOK AVENUE CLAYTON, NC 27520	S, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 661 SS=C	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)		F	661			3/18/19	
	must have a discharge but is not limited to, th (i) A recapitulation of includes, but is not lim of illness/treatment of radiology, and consul (ii) A final summary of include items in parage the time of the dischar release to authorized the consent of the rest representative. (iii) Reconciliation of a medications with the medications (both pre- over-the-counter). (iv) A post-discharge developed with the pa- and, with the resident representative(s), wh adjust to his or her ne post-discharge plan of the individual plans to that have been made care and any post-dis non-medical services This REQUIREMENT by: Based on record rev facility failed to comp facility stay for 2 of 3 planned discharge from	cipates discharge, a resident le summary that includes, he following: the resident's stay that nited to, diagnoses, course r therapy, and pertinent lab, tation results. If the resident's status to graph (b)(1) of §483.20, at urge that is available for persons and agencies, with sident or resident's all pre-discharge resident's post-discharge escribed and plan of care that is articipation of the resident t's consent, the resident t's consent, the resident to avail assist the resident to ew living environment. The of care must indicate where o reside, any arrangements for the resident's follow up scharge medical and is not met as evidenced iew and staff interviews the lete a recapitulation of the residents reviewed for a			Residents #188 and #61 no longer reside in the facility. The facility immediately put in measur to provide a discharge summary to residents in accordance to F661, 483. (c)(2) Discharge Summary.			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345569	B. WING		C
	ROVIDER OR SUPPLIER	343303		STREET ADDRESS, CITY, STATE, ZIP CODE	02/22/2019
				195 SPRINGBROOK AVENUE	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
F 661	Continued From page	e 50	F 661		
	 Review of the med Resident #188 was a 11/07/18 with diagnos kidney disease and in Review of the quarter dated 02/01/19 revea cognitively intact and assistance of one per dressing and hygiene to the community disc Resident #188. Review of the medica #188 was discharged review revealed the fa recapitulation of Resi facility. In an interview on 02/ Director of Nursing (I recapitulation of Resi completed. She state completing a recapitu discharge. In an interview on 02/ Administrator stated to completing a recapitu because he was unay the facility stay for resi completed. He stated Utilization Review, th Services Department make sure the recapit 	lical record revealed dmitted to the facility on ses of dysphagia, chronic nsomnia. rly Minimum Data Set (MDS) aled Resident #188 was needed the extensive rson for bed mobility, e. There was an active return charge plan in place for al record revealed Resident I home on 02/07/19. Further acility did not complete a dent #188's stay in the /21/19 at 11:50 AM the DON) indicated that no dent #188's stay had been ed the facility had not been alation for the resident's at /22/19 at 9:10 AM the facility that the facility was not alation of any resident's stay ware that a recapitulation of sidents needed to be		 An in-service to all licensed nursir social services and providers on the discharge summary required elem was initiated on 3/8/2019 by the S Development Coordinator and Dir Nursing and will be completed by The in-service focused on providir residents a discharge summary the includes a recapitulation of the resistay. Each resident discharge summary monitored through the facility s Interdisciplinary Team process by Social Services Directors, Assista Director of Nursing, and Unit Man The Director of Nursing will be responsible for the QI tools that w reviewed 3 times per week for 4 wa a total of ten residents, then 3 time week for 4 weeks for a total of 5 residents. The pertinent staff wi immediately re-trained by the aud any identified areas of concern. The Executive QI committee will m review the discharge summary au monthly times 3 months to determ issues and trend to include continimonitoring frequency. 	he h

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE		
		345569	B. WING				C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE CLAYTON, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 661	Continued From page	9 51	F	661	1			
	dated 02/08/19 indica cognitive impairments	y Minimum Data Set (MDS) ated that resident had severe s, and needed extensive to all activities of daily living						
	he was discharged to 02/14/19. Further rev revealed the facility fa	61's closed record revealed another skilled facility on view of the closed records ailed to complete a dent #61's stay in the facility.						
	Director of Nursing (Director of Nursing)							
	Director of Nursing (E aware that the facility "Recapitulation of Sta Resident #61's stay a the facility per regulat from the facility, and o discharge recapitulati Resident #61, and tha going forward, that sh	2/19 at 8:40 AM with the DON) revealed she was not should have completed a ay": A concise summary of and course of treatment in tion, at the time of discharge did not. She stated the on was not completed on at it was her expectation, he complete the discharge a resident's anticipated						
	it was his expectation completed a "Recapit	npleted with the 2/19 at 8:50 AM. He stated that the facility should have culation of Stay": A concise #61's stay and course of						

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TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		MB NO: 0938-039 3) DATE SURVEY COMPLETED
		345569	B. WING _			C 02/22/2019
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, C 195 SPRINGBROOM CLAYTON, NC 27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	(EACH (VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 661 F 684 SS=D	of discharge from the Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a reside that residents receive accordance with profe practice, the compret care plan, and the reside this REQUIREMENT by: Based on observation interviews with reside failed to communicate she had already adm hypertension and mu #52, putting 1 of 1 sa receiving duplicate m Findings included: Resident # 52 was ac 1/16/19. Her diagnost and Hypertension.	ty per regulation, at the time facility, and did not. are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices. is not met as evidenced ns, record review, and ent and staff, a facility nurse e with another nurse that inistered two medications for scle spasms to Resident mpled resident at risk of	F 6	84 The facility in to ensure tha and care in a standards of Resident #52 administratio has received with physicia Facility ensur administratio residents by:	mmediately put in measures at residents receive treatmen accordance with professional practice. 2 did not receive a duplicate n of medication. Patient #52 medication in accordance n orders. red the safe and accurate n of medications for all other	t 2
	coded as an admission Resident #52 had cle	on assessment indicated		immediately on following t channels neo	educated Nurse # 9 and #5 the proper communication cessary when exchanging r for a medication cart and	
		cian orders dated 1/16/19 lace for Carvedilol Tablets			-service was initiated on le Staff Facilitator to all	

Facility ID: 100679

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-03
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	345569	B. WING		C 02/22/2019
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02:22:2010
ROOK NURSING & REH	ABILITATION CENTER			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
Continued From page	e 53	F 684	1	
twice a day for hypert tablets 750mg (milligr spasms. An interview was con 02/18/19 at 4:00 PM. concerns regarding re specifically nurses bri medications and bring times. She stated ever had resulted in a med An observation was of PM. The surveyor observer of resident #52 6.25mg (milligrams) for Methocarbamol tab 7 muscle spasms. Ten the surveyor observer of resident #52 and a same two medication nurse and stated that given her the same two stated that she was p medication cart for ar know the other nurse the resident the medic An interview was con PM with Nurse #9. Sh administer medication was pulled away from	ducted with resident #52 on She stated she had epeated medication errors, inging the wrong ging them at the wrong ery single medication pass dication error. conducted on 2/18/19 at 4:25 served Nurse #9 enter the and administered Carvedilol or hypertension, along with 50mg (milligrams) for minutes later at 4:35 PM, d Nurse #5 enter the room ttempted to administer the s. The resident stopped the another nurse had just vo medications. Nurse #5 ulled away from the n admission and didn ' t had already administered cations. ducted on 2/20/19 at 5:05 ne stated that she did ns for Nurse #5 when she n her medication cart. She		 licensed nurses with a completion of 3/18/19. The in-service focused or of care related to medication pass of the nurse are garding (a) proper hand off of key during a medication pass to the nurse accepting responsibility of the cart documentation of e-MARs immedia following a medication pass (c) communication with resident when administering a medication and (d) medications per MD order. All new hired licensed nurses will be in-service from medication errors. Free from medication errors will be monitored by utilizing a QI audit too Medication Administration by the S Facilitator, Unit Manager, Assistant Director of Nursing, or Director of N Audit tool will be used 3 times a wee X s 4 weeks, then weekly X s 4 w then monthly X s 1 month. The lice nurses will be immediately re-trained the auditor for any identified areas concern. The Director of Nursing of designee is responsible and will revand initial the Medication Pass Aud for completion to ensure all areas of concern were addressed. The Executive QI committee will m review the Medication Administration to detail tool monthly times 3 months to detail tool monthly times 3 mont	n quality errors ys rse (b) ately giving wly viced of for taff t vursing. eek veeks ensed ed by of r view lit Tool of eet to on QI ermine
	Continued From page 6.25mg (milligrams) g twice a day for hyperf tablets 750mg (milligr spasms. An interview was con 02/18/19 at 4:00 PM. concerns regarding re specifically nurses bri medications and bring times. She stated eve had resulted in a med An observation was co PM. The surveyor observe of resident #52 6.25mg (milligrams) f Methocarbamol tab 7 muscle spasms. Ten the surveyor observe of resident #52 and a same two medication nurse and stated that given her the same two stated that she was p medication cart for ar know the other nurse the resident the medication p M with Nurse #9. She administer medication was pulled away from stated she had not ta	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345569 ROVIDER OR SUPPLIER 345569 ROOK NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 6.25mg (milligrams) give one tablet by mouth twice a day for hypertension, and Methocarbamol tablets 750mg (milligrams) twice a day for muscle spasms. An interview was conducted with resident #52 on 02/18/19 at 4:00 PM. She stated she had concerns regarding repeated medication errors, specifically nurses bringing the wrong medications and bringing them at the wrong times. She stated every single medication pass had resulted in a medication error. An observation was conducted on 2/18/19 at 4:25 PM. The surveyor observed Nurse #9 enter the room of resident #52 and administered Carvedilol 6.25mg (milligrams) for hypertension, along with Methocarbamol tab 750mg (milligrams) for muscle spasms. Ten minutes later at 4:35 PM, the surveyor observed Nurse #5 enter the room of resident #52 and attempted to administer the same two medications. The resident stopped the nurse and stated that another nurse had just given her the same two medications. Nurse #5 stated that she was pulled away from the medication cart for an admission and didn ' t know the other nurse had already administered the resident the medications. An interview was conducted on 2/20/19 at 5:05 PM with Nurse #9. She stated that she did administer medications for Nurse #5 when she was pulled away from her medication cart. She stated she had not taken the time at that point to	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345569 ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 53 6.25mg (milligrams) give one tablet by mouth twice a day for hypertension, and Methocarbamol tablets 750mg (milligrams) twice a day for muscle spasms. An interview was conducted with resident #52 on 02/18/19 at 4:00 PM. She stated she had concerns regarding repeated medication errors, specifically nurses bringing the wrong medications and bringing the wrong medications and bringing the mat the wrong times. She stated every single medication pass had resulted in a medication error. An observation was conducted on 2/18/19 at 4:25 PM. The surveyor observed Nurse #9 enter the room of resident #52 and administered Carvedilol 6.25mg (milligrams) for hypertension, along with Methocarbamol tab 750mg (milligrams) for muscle spasms. Ten minutes later at 4:35 PM, the surveyor observed Nurse #5 enter the room of resident #52 and attempted to administer the same two medications. The resident stopped the nurse and stated that another nurse had just given her the same two medications. Nurse #5 stated that she was pulled away from the medication cart for an admission and didn ' t know the other nurse had already administered the resident the medications. An interview was conducted on 2/20/19 at 5:05 PM with Nurse #9. She stated that she did administer medications for Nurs	OF DEROBENCIES CORRECTION (X1) PROVIDERSUPPLIENCLAN IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 345569 B. WING SOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CONTROL OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST FEREFORE DE PYOLL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETEX Continued From page 53 F 684 6.2.5mg (milligrams) give one tablet by mouth twice a day for hypertension, and Methocarbanol tablets 750mg (milligrams) twice a day for muscle spasms. F 684 An interview was conducted with resident #52 on Q2/19/19 at 4:00 PM. She stated she had concerns regarding repeated medication pass had resulted in a medication error. F 684 No observation was conducted on error. Free from medication pass (c) communication of e-MARs immedia following a medication pass (c) communication of e-MARs immedia following a medication pass (c) communication with resident when administering a medication errors. An observation was conducted on 2/18/19 at 4:25 PM. The surveyor observed Nurse #9 enter the room of resident #52 and administer the same two medications. The resident stoped the nurse will be im-self on the surveyor observed Nurse #9 enter the room fresident #52 and administer the sated that another nurse had already administer the sated that another nurse had just given her the same two medications. Nurse #5 stated that another nurse had just given her the same two medications. Nurse #5 stated that she was pulled away from the medication stors. Nurse #5 w

Facility ID: 100679

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 684 F 686 SS=H	5:15 PM with Nurse # Nursing. Nurse #5 sta hall and was pulled an Nurse #9 took over he admission came in. N to the medication card highlighted yellow, so and took it to the resid communicate with Nur regarding what medic stated she pulled the took them into the resid took them into the resid atted she pulled the took them into the resid An interview was con AM with the Director of expectation is that all the correct medication active communication nurses. Treatment/Svcs to Pri CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and c ulcers unless the indi- demonstrates that the (ii) A resident with pre- necessary treatment is with professional standard	was conducted on 2/20/19 at 55, and the Director of ated she was working the way for an admission, and er medication cart when the lurse #5 stated upon return t the MAR was still she pulled the medications dent. She stated she did not irse #9 as she should have cations had been given. She residents medications and sident ' s room to give them. ducted on 02/22/19 11:30 of Nursing. She stated her nurses are administering hs, at the correct times, and a is expected between all event/Heal Pressure Ulcer (i)(ii) rrity re ulcers. hensive assessment of a hust ensure that- s care, consistent with is of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent		684			3/18/19

Facility ID: 100679

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG			
					С		
		345569	B. WING			2/22/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
		ABILITATION CENTER		195 SPRINGBROOK AVENUE			
SPRINGE	ROOK NORSING & REP	ABILITATION CENTER		CLAYTON, NC 27520			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETIO	
F 686	Continued From pag	je 55	F 6	86			
	This REQUIREMEN by:	T is not met as evidenced					
	Based on observation	on, physician interview,		On 3/12/19, the administrat			
		ew, home health interview,		initiation of a 100% head-to			
		ne facility failed to conduct		to ensure all residents are a	•		
		ound assessments which ents and descriptions of the		assessed and have assess completed. On 3/13/19 thro			
		g or undermining, possible		the director of nursing, assis	-		
		rainage, odor, and pain for 3		of nursing, staff facilitator, a			
		nts (Resident #48, #62, and		competed a 100% skin audi			
	-	ulcers. No initial or weekly		residents.	t of our one		
	wound assessments	2					
		heel ulcer from 12/16/18,		The wound care nurse and	other licensed		
		d, until 01/08/19 when a		nurses were proactively edu	ucated on		
	Quality Assurance (QA) Skin Wound Review		following the wound/skin po			
		x 3.5 centimeter (cm) ulcer theel was painful and		procedures and physician o	rders.		
	presented with yello	w/green purulent drainage.		Residents #48 and #62 wer	e immediately		
	No initial or weekly p	pressure ulcer assessments		assessed and had a chart a	udit		
	which included meas	surements and descriptions		completed to ensure proper	treatments		
	of wound bed, tunne	ling or undermining, possible		were in place. Resident #18	88 was		
		rainage, odor, and pain were		discharged home from the f			
		ent #188 from 11/28/18,		Pressure relieving mattress			
		ed on her right heel, through		for all residents and Reside	nt #48 has an		
	-	he facility on 02/07/18. On		air mattress.			
		th services assessed the		The facility initiated advertig	$n = \frac{1}{2}$		
		sident #188's right heel as		The facility initiated education			
		und measuring 2 x 2 x 0.5 cm in referral was submitted for		for all nurses and aides rega communication of skin cond			
	-	06/19 due to a painful stage		notifying nursing on any cha			
		an initial wound assessment		On 2/28/19 nurses were add	-		
		or the resident until 01/16/19		educated that they must do			
		ned Resident #62 had a		changes to reflect change in			
	stage II pressure ulc	er to the left heel. This ulcer		behaviors and physical cond			
		l drainage, and the wound		education was completed by			
	was painful to touch						
				Beginning 3/18/19, the staff			
		ty failed to expedite a wound		manager, assistant director			
	center consult for Re	esident #48 which was		and/or director of nursing w	ill use a quality		

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		MEDICAID SERVICES	a			B NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3)) DATE SURVEY COMPLETED
			A. BUILDIN	G		С
		345569	B. WING			02/22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	02/22/2015
				195 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE	(X5) COMPLETIC DATE
F 686	Continued From page	- 56	F 68	86		
1 000		g requested by the facility on		improvement monitoring t	tool The audit	
		issue injury (DTI) to the		tool will be used three tim		
		The wound center consult		four weeks, then weekly f		
	•	/30/19 at which time the heel		then monthly for one mor		
		an unstageable pressure		of nursing or assistant dir	-	
		eschar in the wound bed		will review and initial the		
	and a moderate amo	unt of drainage.		ensure all areas of conce	rn are	
	In addition, based on	facility documentation the		addressed.		
		facility documentation, the y applied calcium alginate,		The Executive QI Commi	ttee will meet to	
		xcess fluid and promote		review the QI audit tool m		
		via enzymes, to Resident		months to determine issu	•	
	#48's right heel ulcer	from 12/21/18 until		include the need for conti	nued monitoring.	
		/ documented this wound as				
	-	20/18 until 01/18/19 and as				
	01/18/19 until a woun	h/eschar and drainage from				
	01/30/19 until a wour 01/30/19.	id center consult on				
		y failed to off-load Resident				
		bed as recommended by the plemented by the physician.				
	Findings included:					
	1. a. Resident #48 w	as admitted to the facility on				
		ent's documented diagnoses				
	included pressure uld	er to right heel, iron				
	deficiency anemia, hy	pertension, and dementia.				
	A 11/11/18 scale for p	predicting pressure ulcer risk				
		it #48 was at high risk for				
	pressure ulcer develo					
		ing into this risk included the				
		physical condition, being				
		nd, having very limited inent of bowel and bladder,				
		f hypertension, and receiving				
	five or more medicati					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION IENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE (OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ЗE	(X5) COMPLETION DATE		
F 686	resident at risk for ski A 12/16/18 skin referr "Description: necrotic staff." The form doc necrotic area to the ir #48's right heel. On 12/20/18 the facili documented on the sl Resident #48 had a "h injury)". A 12/30/18 physician Physician #1 (not four electronic medical rec printed off from the ph system documented, ulcer. Assessment at continue aggressive v strategies." A 01/08/19 QA (Quali Review documented fright heel measured 4 (cm), had yellow/gree was painful. A 01/08/19 physician on Doxycycline (antib daily (mg BID) x 7 dat (review of the resident Administration record administered as order A 01/09/19 physician Physician #1 docume decubitus. This conti	n integrity issues. al form documented, c area" and "Observer: sumented there was a aner aspect of Resident ty's Treatment Nurse kin referral form that right heel DTI (deep tissue progress note written by nd in the resident's cord or paper chart, but hysician's own electronic "she has a right heel nd Plan: right heel ulcer: wound care and preventative ty Assurance) Skin Wound the DTI to Resident #48's 4.5 cm by 3.5 centimeters en purulent drainage, and order started Resident #48 iotic) 100 milligrams twice ys for right heel cellulitis t's Medication revealed the antibiotic was	F	68	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345569	B. WING				C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER		-	:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			3E	(X5) COMPLETION DATE	
F 686	 painful. Assessment patient continues to was urgical evaluation On 01/09/19 Resident the following problem with structural integrit right heel pressure use physician to right heel problem included "tree physician to right heel A 01/10/19 Wound UI Resident #48 had a sheel which developed 4.5 x 3.5 x 0.5 cm. The documented the woury yellow/green drainage no pain, no tunneling odor. A 01/18/19 Wound UI facility assessment of ulcer prior to being see documented Resident pressure ulcer to her in the facility and meas The facility's Treatme wound presented with no necrosis, no tunned odor. However, it was experienced pain with wound bed was descord. Resident #48's 01/23, set (MDS) documented was moderately impatibehaviors including required moderate as 	and Plan: right heel ulcer: vorsen and now needs " t #48's care plan identified : "Ulceration or interference y of layers of skin related to cer." Interventions to this atment as ordered by I pressure ulcer." cer Flowsheet documented uspected DTI to her right I in the facility and measured he facility's Treatment Nurse nd presented with e, no infection, no necrosis, or undermining, and no cer Flowsheet (the last Resident #48's right heel een by the wound center) t #48 had a stage II right heel which developed asured 4.5 x 3.5 x 0.5 cm. nt Nurse documented the n no drainage, no infection, eling or undermining, and no s documented the resident n his dressing changes. The ribed as purple/pink. (19 annual minimum data ed the resident's cognition ired, she exhibited no	F	686	3			

Facility ID: 100679

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345569	B. WING				C 22/2019
NAME OF PROVID	DER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGBROO	K NURSING & REHA	BILITATION CENTER			95 SPRINGBROOK AVENUE LAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
she and whi A 0 Resums whi bed slow dra On the and imp A 0 Res righ me Tre pre ned and pin A 0 Res righ me Tre pre ned and pin A 0 Res slow dra A 0 Res righ me Tre pre ned and pin A 0 Res righ me Tre pre and pin A 0 Res right me Tre pre A 0 Res right Me Res right Me Slow dra A 0 Res right Me Slow dra A 0 Res right Me Tre pre ned and pin A 0 Res right Me Res right Me Slow dra A 0 Res right Me Slow dra Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res right Me Res Res Res Res Res Res Res Res Res Re	d she had one stag ich was not presen 1/30/19 wound cer sident #48 present stageable pressure ich measured 2.5 x d was described as ugh and eschar and inage. The wound 01/31/19 wound ca application of "Silv d net and change 3 blemented via phys 1/31/19 Wound Uk sident #48 had a st th heel which devel asured 4 x 3 x 0.5 atment Nurse docu- sented with no dra crosis, no pain, no th d no odor. The wou k. 2/08/19 Wound Uk sident #48 had a st th heel which devel asured 4 x 3 x 0.5 atment Nurse docu- sented with no dra crosis, no pain, no th d no odor. The wou sented with no dra crosis, no pain, no th d no odor. The wou sented with no dra crosis, no pain, no th asured 4 x 3 x 0.5 atment Nurse docu- sented with no dra crosis, no pain, no th d no odor. The wou ple/maroon. 2/13/19 wound cer	ds, her weight was stable, e II unhealed pressure ulcer t on admission or re-entry. hter consult documented ed to the clinic with an ulcer on the right heel a 1.5 x 0.2 cm. The wound tan/yellow with a mixture of d a moderate amount of was debrided. enter recommendation for vasorb gel, 4 x 4, Kling tape x a week" was ician order. cer Flowsheet documented tage II pressure ulcer to her oped in the facility's umented the wound inage, no infection, no tunneling or undermining, und bed was described as cer Flowsheet documented tage II pressure ulcer to her oped in the facility and cm. The facility's	F	586			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345569	B. WING				22/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02,	22/2010
SPRINGB	ROOK NURSING & REH/	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	unhealed pressure uli measured 2 x 2 x 0.3 described as yellow/p and 1 - 25% granulati amount of yellow drai the wound was debrid A 02/13/19 physician on Keflex (antibiotic) = (TID) x 10 days for po- heel ulcer. A 02/15/19 physician Silvasorb gel, 4 x 4, k x/week to right heel, s A 02/18/19 Wound UI Resident #48 had a s right heel which deve measured 1.5 x 1 x 0 Treatment Nurse doc presented with no dra necrosis, no pain, no and no odor. The wo red/slough. During an interview w Nurse on 02/19/19 at could not remember w Resident #48's wound 12/16/18 by completin reported she could no right heel wound whe but she commented ti She remarked that the instead. She stated I were usually purple/b to the Treatment Nurse	cer on the right heel which cm. The wound bed was ink with 76 - 100% slough on tissue. A moderate nage was documented, and ded. order started Resident #48 500 mg three times daily ossible infection to the right order documented, "Apply (ling and net and change 3 stage II." cer Flowsheet documented tage II pressure ulcer to her loped in the facility and .25 cm. The facility's	F	686			

If continuation sheet Page 61 of 114

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 03/27/2019 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMP	SURVEY LETED
		345569	B. WING		_	(02//	C 22/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				19	95 SPRINGBROOK AVEN	JE		
SPRINGB	ROOK NURSING & REHA	BILITATION CENTER		С	LAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	and presence of drain tunneling/undermining infection during her in she not sure why this #48. The Treatment completed weekly wo Thursdays. She corr Assistant Director of N wound rounds togethe Wednesdays. Accor Nurse, wounds were to basis and should includ drainage, infection, or and peri-wound bed of Nurse was unable to of assess Resident #48' these components un the facility's Treatment antibiotics was begun 02/13/18 when a sma found in the right heel a "mild" odor and sma Treatment Nurse also small amount of sloug 02/18/19 so she shou pressure ulcer as stage During an interview w (DON) on 02/19/19 at skin referral was rece be that the facility's Tr wound within 24 - 48 assessment should in description of wound tunneling and underm necrosis or infections.	age, odor, g, pain, necrosis, and itial wound assessment, but did not occur for Resident Nurse reported she und assessments on mented that she and the Aursing (ADON) completed er on Tuesdays and ding to the Treatment to be assessed on a weekly ude measurements, staging, dor, wound bed description, lescription. The Treatment explain why she did not s right heel wound for all til 01/10/19. According to t Nurse, a second round of for Resident #48 on II green/yellow area was wound bed, and there was all amount of drainage. The reported that there was a sh in the wound bed on Id have probably staged the ge III wound. ith the Director of Nursing 4:18 PM she stated once a ived her expectation would reatment Nurse assess that hours. She reported this clude measurements, bed, drainage, odor, ining, pain, and possible . She commented wounds per the facility policy which	F	686				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	03/27/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
	345569	B. WING		C 02/22/2019	
NAME OF PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
			195 SPRINGBROOK AVENUE		
SPRINGBROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
Resident #48's right I made with the facility Assistant Director of attempt was made to meaningful conversa unable to participate. stated the wound dew with the resident digg She stated Silvasorb treat the resident's he anti-microbial gel, an her second round of wound bed was light small amount of tan s odor. The Treatment measurements of the cm. On 02/20/19 at 12:35 Director, who was Re physician (Physician wounds to be assess were found, no later of He reported measure wound bed were imp but the most importan Treatment Nurse to u what type of wound t DTI, pressure wound reported after the init needed to be assess often if significant cha noted. He stated he resident at the end of commented if he rem	A AM an observation of heel pressure ulcer was 's Treatment Nurse and Nursing (ADON). An o engage the resident in tion, but the resident was . The Treatment Nurse veloped because of sheering, ging her heels into the bed. . was currently being used to eel ulcer since it was an of the resident was now on antibiotics. The right heel pink to bright pink with a slough, and there was no t Nurse stated she estimated e wound to be 1.5 x 1.2 x 0.2 5 PM the facility's Medical esident #48's primary #1), stated he expected sed, if not on the day they than the next business day. ements and description of the portant pieces of information, nt thing was for the facility's use her expertise to diagnose the resident had (such as a l, venous/stasis wound). He tial assessment the wound were e did his initial visit with the f December (12/30/18). He nembered correctly he resented as a DTI. On	F 686			

Facility ID: 100679

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345569	B. WING				_ 22/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	SPRINGBROOK NURSING & REHABILITATION CENTER				95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	might be cellulitis or a closer examination he was more of an indica started the resident o commented purulent quickly because infect within even 24 hours. order wound cultures to be a valid tool in tre During a follow-up int Treatment Nurse on 0 stated in her experient eschar was a gradual definite time frame was such as nutritional sta entered into the time saw no slough or esc before the resident's commented she miss wound between 12/20 During a telephone in AM Wound Center Nu eschar did not develo she had seen instanc slough/eschar were re one week, and when later for a follow-up, th wound bed again. 1. b. Resident #48 w 07/10/17. The reside included pressure ulc deficiency anemia, hy A 01/08/19 QA (Quali Review documented the	an abscess. He reported on a felt the purulent drainage ation of an infection, and n an antibiotic. Physician #1 drainage could develop tion could rise to the surface He reported he did not , and did not consider them eating wounds. erview with the facility's 02/22/189 at 9:08 AM she nee the development of process, but establishing a as difficult because factors atus and co-morbidities frame. She reported she har in Resident #48's wound 01/30/19 wound consult, but ed assessments of the 0/18 and 01/10/19. terview on 2/22/19 at 11:50 urse #1 stated slough and p in a 1 - 2 day period, but es where small amounts of emoved from a wound bed the patient returned a week here was slough in the	F	686			

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	APPROVED 0. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345569	B. WING _				C 22/2019
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGBROOK NURSING & REHAE	BILITATION CENTER			5 SPRINGBROOK AVENUE LAYTON, NC 27520		
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
 was painful. Orders w center consult. A 01/09/19 physician p Physician #1 document decubitus. This continu- needs surgical evaluati painful. Assessment at patient continues to wo surgical evaluation. Wireferral." On 01/09/19 Resident at the following problem: with structural integrity right heel pressure ulcer." A 01/10/19 Wound Ulca under Comments, "wou heel pressure ulcer." A 01/18/19 Wound Ulca facility assessment of F ulcer prior to being see documented Resident at pressure ulcer to her rig in the facility's Treatment wound presented with in no necrosis, no tunnelli odor. However, it was experienced pain with if wound bed was descritt Resident #48's 01/23/1 	a purulent drainage, and vere provided for a wound progress note written by tted, "Patient seen for heel ues to worsen and now ion, patient confirms it is and Plan: right heel ulcer: orsen and now needs fill set up wound clinic #48's care plan identified "Ulceration or interference of layers of skin related to er." Interventions to this and clinic referral for right er Flowsheet documented und clinic referral". er Flowsheet (the last Resident #48's right heel en by the wound center) #48 had a stage II ght heel which developed sured 4.5 x 3.5 x 0.5 cm. t Nurse documented the no drainage, no infection, ng or undermining, and no documented the resident his dressing changes. The bed as purple/pink.	F	586			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345569	B. WING				22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	behaviors including re- required moderate as dependent on staff for she weighed 91 poun and she had one stag which was not presen Resident #48's initial 01/30/19 documented with an unstageable p heel which measured wound bed was desce mixture of slough and amount of drainage. During an interview w Nurse on 02/19/19 at facility primarily utilize patients who needed outside source. She resident seen at this w of days. She comme could not get a reside the week the referral set up an appointmen The Treatment Nurse it took so long to get F wound clinic, with a w 01/08/19 and the resi On 02/20/19 at 12:35 Director, who was Re physician (Physician a observed the resident 01/09/19 he thought t explained he felt the p indication of infection, an antibiotic. He com	esistance to care, she sistance to being totally r her activities of daily living, ds, her weight was stable, je II unhealed pressure ulcer it on admission or re-entry. wound center consult on a she presented to the clinic pressure ulcer on the right 2.5 x 1.5 x 0.2 cm. The ribed as tan/yellow with a eschar and a moderate The wound was debrided. ith the facility's Treatment 3:52 PM she stated the ed one wound clinic for those wound referrals to an reported she usually got a wound clinic within a couple nted at the latest, if she int into this wound center on was made, she was able to at early the following week. was unable to explain why Resident #48 seen at the round consult requested on dent not seen until 01/30/19. PM the facility's Medical sident #48's primary #1), stated when he t's right heel ulcer on he wound had changed. He purulent drainage was an , and started the resident on	F	680			

Facility ID: 100679

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETER C	SURVEY
345569 B. WING 02/22/2	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SPRINGBROOK NURSING & REHABILITATION CENTER 195 SPRINGBROOK AVENUE CLAYTON, NC 27520	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
F 686 Continued From page 66 F 686 Physician #1 stated a wait of one week and no more than two weeks would be acceptable for a wound consult since the facility was providing care to the wound during the wait (record review revealed Resident #48 had to wait 21 days or 3 weeks to be seen at the wound center). 1. 1. c. Resident #48 was admitted to the facility on 07/10/17. The resident's documented diagnoses included pressure ulcer to right heel, iron deficiency anemia, hypertension, and dementia. On 12/20/18 the facility's Treatment Nurse documented on a skin referral form that Resident #48 had a "right heel DTI (deep tissue injury)". Resident #48's Treatment Administration Record (TAR) documented on a skin referral form that Resident is pressure ulcer (classified as a DTI by the facility between 12/20/18 and 01/18/19 and ad01/18/19 and ad01/18/19 and ad01/30/19 wound center consult) was calcium alginate applied topically every other day. (The facility's Wound Care Manual, version dated 05/22/18, documented treatment of the applied topically every with a facility sealant and allow to dry thoroughly. Complete daily. 2) May also cover with a face delaying allow and dena fuce ansing solution. Apply skin sealant and allow to dry thoroughly. Complete daily, 2) May also cover with a face delaying after cleansing with normal saline solution or appropriate wound cleansing solution. Apply skin related billy, change every other day and prn (as needed).") On 01/09/19 Resident #48's care plan identified the following problem: "Uccaration or interference with structural integrity of layers of skin related to right heel pressure ulcer." Interventions to this	

Facility ID: 100679

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	problem included "tre physician to right hee Resident #48's 01/23. set (MDS) documente was moderately impa behaviors including re required moderate as dependent on staff fo she weighed 91 poun and she had one stag which was not preser During an interview w Nurse on 02/19/19 at the standing orders fo skin prep and protecti She was unable to ex was used to treat Res which was classified a and 01/18/19 and was slough/eschar or draii wound center consult On 02/20/19 at 10:34 Nursing (ADON) state alginate was used for usually discontinued a reported she did not t be appropriate for treat On 02/20/19 at 12:35 Director, who was Re physician (Physician a betadine were the mot treatments for DTIs. calcium alginate had was typically utilized i	atment as ordered by I pressure ulcer." (19 annual minimum data ed the resident's cognition ired, she exhibited no esistance to care, she sistance to being totally r her activities of daily living, ds, her weight was stable, re II unhealed pressure ulcer it on admission or re-entry. The facility's Treatment 3:52 PM she reported that or DTI treatment included twe booties to the heels. plain why calcium alginate sident #48's right heel wound as a DTI between 12/21/18 s documented as having no hage before the initial on 01/30/19. AM the Assistant Director of ed she thought calcium debridement and was as the wound healed. She hink calcium alginate would ating a DTI. PM the facility's Medical sident #48's primary #1), stated skin prep or ost frequently used	F	686	3		

Facility ID: 100679

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	-	D HUMAN SERVICES				FORM): 03/27/2019 MAPPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345569	B. WING		_	C 02/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				195 SPRINGBROOK AVEN	IUE		
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER		CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	9 68	F 68	36			
	calcium alginate if a w	y would have been using vound was truly a DTI and if slough or eschar in it.					
	07/10/17. The reside included pressure ulc	vas admitted to the facility on nt's documented diagnoses er to right heel, iron vpertension, and dementia.					
		ressure ulcer to the inner el, and the intervention was					
	Review documented the right heel measured 4 (cm), had yellow/greewas painful. Foam bo	ty Assurance) Skin Wound the wound to Resident #48's 4.5 cm by 3.5 centimeters in purulent drainage, and poties were applied to e resident's heels were					
	the following problem with structural integrit right heel pressure use	t #48's care plan identified : "Ulceration or interference y of layers of skin related to cer." Interventions to this -load heels when in bed."					
	set (MDS) documenter was moderately impa behaviors including re- required moderate as dependent on staff for she weighed 91 poun and she had one stag which was not presen	esistance to care, she sistance to being totally r her activities of daily living, ds, her weight was stable, le II unhealed pressure ulcer t on admission or re-entry.					
	On 01/31/19 wound c	enter recommendation for					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345569	B. WING				_ 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGBROOK NURSING & REHABILITATION CENTER					95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	please!!" was implem A 02/15/19 physician heel off loaded, float w During an interview w Nurse on 02/19/19 at were many factors wh unhealed status of Re which included difficu booties on the residen On 02/20/19 at 10:34 Resident #48's right h made with the facility' Assistant Director of N attempt was made to meaningful conversat unable to participate. bed with her right hee sheet. The sheep skit the resident's right ankle. covering the resident's sock on the resident's sock on the resident's pillows in the bed or u off-loading. As the Al resident's room, she p pillow case from furni that once a pillow cass then needed to be pla- legs.	p heel off bed. Offload ented via physician order. order documented, "Keep with no contact with bed." with the facility's Treatment 3:52 PM she stated there hich entered into the esident #48's heel ulcer Ity keeping the protective nt's heels. AM an observation of heel pressure ulcer was 's Treatment Nurse and Nursing (ADON). An engage the resident in tion, but the resident was Resident #48 was found in el on the bed, resting on the in bootie was not covering teel, but was up around the A sheep skin bootie was 's left heel, and a fluffy sock is left foot. There was no is right foot. There were no under the resident's legs for DON was leaving the picked up a pillow without a ture in the room, and stated was applied, the pillow aced under the resident's PM the facility's Medical isident #48's primary	F	686			
	physician (Physician						

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						10.0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
			A. BUILDING			С	
		345569	B. WING				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/22/2019		
				195 SPRINGBROOK AVENUE			
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETIO DATE	
IAG	REGULATORTORT		IAG	DEFICIENCY)			
F 000							
F 686	Continued From page		F 68	36			
		pressure exerted on the					
		there could be things going					
	on underneath the sk						
		good blood supply to the					
		. He stated one of the most					
		way to off-load pressure					
	was to place a pillow	behind the calves and apply					
	bunny boots.						
	During an interview w	vith Nursing Assistant (NA)					
	•	5 PM she stated Resident					
		in bed, occasionally shifting					
		see out her window. She					
		was supposed to have two					
	-						
		s and fluffy socks and sheep					
		et to protect the heels. She					
		not had a problem finding					
		place when she started her					
		cording to NA #3, she had					
	-	vith the resident's heel					
		She was unable to explain					
	-	as without some of these					
		e wound observation was					
	-	19 (she was assigned to care					
	for the resident on fire	st shift that morning).					
	During an observation	n on 02/21/19 at 8:22 AM					
	Resident #48 was in	bed. Her sheep skin booties					
	were in place on both	feet, and there were socks					
	on both feet. There v	vas a pillow with a pillow					
		e bottom of the bed, but not					
	under the resident's le	egs. The heels, covered by					
		vere on the bed. At this time					
	•	rked third shift, but stayed					
		he commented she had					
		e that the resident was					
		cks and booties on both feet,					
		posed to be under the					

Facility ID: 100679

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DEPARTMENT OF HEALTH AND HUN CENTERS FOR MEDICARE & MEDIC					FORM): 03/27/2019 1 APPROVED). 0938-0391
	OVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED C	
	345569	B. WING				22/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S			
SPRINGBROOK NURSING & REHABILITA	TION CENTER		195 SPRINGBROOK AVEN CLAYTON, NC 27520	NUE		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 Continued From page 71 for sure but she felt like the r pillow under her legs when s before 7:00 AM on 02/21/19 resident sometimes kicked th under her legs. During an interview with Nur 8:52 AM she stated Residen to have bunny boots on and legs, but the resident would the boots and pillow. She re explained to the resident wh utilize these interventions the apt to comply. She commer done dressing changes on F the facility's Treatment Nurse building or not available. Ac Resident was eventually folle clinic, and the resident's pre- right heels was supposed to During an interview with Nur 4:51 PM she stated she had changes for Resident #48 w Treatment Nurse was not av the wound had not had odor she did the dressing change the resident was to wear bur when in bed, although the re to keep them on because sh touching her body. Nurse #8 to check on Resident #48 m make sure the booties staye According to Nurse #8, she were any other interventions resident was in bed to lessen resident's heels, but she wou guide to check.	the checked on her She stated the he pillow out from se #4 on 02/21/19 at t #48 was supposed a pillow under her not always tolerate ported that if she y it is important to e resident was more the d that she had Resident #48 when e was not in the cording to Nurse #4, owed by the wound ssure ulcer to her be assessed weekly. se #8 on 02/21/19 at done the dressing hen the facility's ailable. She reported or drainage when s. She commented my boots all the time esident did not always e did not like things 8 stated the staff had ore frequently to d in placed. was not sure if there to use when the n pressure to the	F 68	6			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345569	B. WING		_		C 22/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
SPRINGBI	ROOK NURSING & REHA	ABILITATION CENTER		195 SPRINGBROOK AVEN CLAYTON, NC 27520	IUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Resident #48 was aw and booties on both fe the bottom of bed, bur not elevated by a pillo crossed with the right left foot. During an interview w 10:46 AM she stated to have sheep skin bo pillows under her legs she commented keep place was difficult for compromised cognitio occasional combative there were problems for resident, but the resid so she could be educe about the importance keeping the pillows un also remarked that the the resident more free 2. Resident #188 was 11/07/18 and had diag behaviors, insomnia a Resident #188 was di Health on 02/07/19. Review of the Physici revealed a verbal ord #188's right heel with betadine, and then co dressing with foam ex	n on 02/22/19 at 8:14 AM ake in bed. She had socks eet. There was a pillow at t the resident's legs were ow. The resident's feet were heel resting on top of the ith the DON on 02/22/19 at Resident #48 was supposed oots covering her heels and a for off-loading. However, ing these interventions in this resident because of her on, impulsiveness, and behavior. She commented keeping the boots on the lent had periods of alertness ated during these periods of keeping the boots on and nder her legs. The DON e staff needed to check on quently. admitted to the facility on gnoses of dementia without and chronic kidney disease. ischarged home with Home an's Orders dated 11/28/18 er to cleanse Resident	F 68				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345569	B. WING			C 02/22/2019		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 686	Review of the Care P revealed Resident #1 breakdown and the dwounds. The goal wa develop any skin breat through the next revie encourage Resident # frequently and to obse abnormal changes. Review of the Care P revealed a ruptured b Resident #188's right ruptured blister to heat through the next revie keep pressure off of t treatments as ordered of any changes. Review of the Flowsh Conditions dated 11/2 #188 had a pink ruptu was no pain or infecti measurements of the of the area surroundin treatment was to appl transparent film dress was no physician noti Review of the Physici 12/04/18 revealed no ruptured right heel bli Review of the Flowsh	lan revised on 11/29/18 88 was at risk for skin evelopment of pressure as for Resident #188 to not akdown or pressure wounds ew. Interventions included to #188 to change position erve the skin daily for any lan initiated on 11/29/18 dister had been noted on heel. The goal was for the al without complications ew. Interventions included to he right heel and to perform d and to notify the physician eeet of Non-Ulcer Skin 28/18 revealed Resident ured right heel blister. There on present. There were no wound and no description ng the wound. The ly betadine and a sing every other day. There ification date on the form. an Progress Note dated mention of Resident #188's ster.	F	686				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345569	B. WING			C 02/22/2019		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 686	 #188 had a pink ruptu was improving. The a was intact. There was present. There were wound. The treatmen and a transparent film other day. There was date on the form. Review of the Quality Review dated 01/08/1 had a ruptured blister measured approxima cm. The wound was wound was cleaned a were applied. There area surrounding the Review of the Quality Review dated 01/16/1 had a ruptured blister healing well. The skin without signs or symp worsening breakdowr measurements of the how the area surroun Review of the Physici 01/17/19 revealed no ruptured right heel bli Review of the Flowsh Conditions dated 01/2 #188 had a pink ruptu was improving. The was intact. There was present. There were wound. The treatmen 	 ared right heel blister that area surrounding the wound s no pain or infection no measurements of the t was to continue betadine a dressing with foam every a no physician notification Assurance- Skin/Wound 19 revealed Resident #188 on the right heel that tely 2 cm (centimeters) by 1 healing and pink. The and betadine and a dressing was no indication of how the wound appeared. Assurance- Skin/Wound 19 revealed Resident #188 to the right heel that was pink and healthy boms of infection or n. There were no wound or any indication of ding the wound appeared. an Progress Notes dated mention of Resident #188's ster. eet of Non-Ulcer Skin 23/19 revealed Resident area surrounding the wound 	F	68				

Facility ID: 100679

If continuation sheet Page 75 of 114

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY LETED
		345569	B. WING				22/2019
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	other day. There was no physici form. Review of the Physici 01/29/19 revealed no ruptured right heel bli Review of the Flowsh Conditions dated 01/3 #188 had a pink ruptu was improving. The was intact. There was present. There was present. There was date on the treatmen and transparent film co other day. There was date on the form. Review of the quarter dated 02/01/19 revea risk for but did not ha Resident #188 was co the extensive assistant mobility, dressing, an Review of the Home I Assessment Dated 02 #188 had a stage 3 p heel. The wound mea- was 0.5cm deep. The loss involving damage subcutaneous tissue. of thin, watery, pale, r	an notification date on the an Progress Notes dated mention of Resident #188's ster. eet of Non-Ulcer Skin 81/19 revealed Resident ured right heel blister that area surrounding the wound s no pain or infection no measurements of the t was to continue betadine dressing with foam every a no physician notification ly Minimum Data Set (MDS) led Resident #188 was at we a pressure wound. ognitively intact and needed nee of one person for bed d hygiene. Health Comprehensive Adult 2/08/19 revealed Resident ressure wound on the right asured 2cm by 2cm and ere was full thickness skin e or necrosis of There was a small amount red/pink drainage from the ed was pink with less than wered with epithelial tissue. nding the wound was	F	686	5		

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	S FOR MEDICARE &					0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 ,		(X3) DATE COMP	SURVEY LETED
			A. BUILDING	3		
		245500	B. WING		(
		345569	B. WING			22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
SPRINGB	ROOK NURSING & REH	IABILITATION CENTER	195 SPRINGBROOK AVENUE			
				CLAYTON, NC 27520		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIOI DATE
E 000		70				
F 686			F 68	36		
		2/20/19 at 1:55 PM the				
	Wound Care Nurse ((WCN) indicated Resident				
		d blister on the bottom of the				
		pped from the positioning of				
		on the mattress. She stated				
	she did not know how	w long the blister was in				
	place prior to its rupt	ure as the facility did not				
	perform weekly skin	checks, instead relying on				
	the Nursing Assistan	ts (NAs) to inform the nurses				
	daily of any change i	n a resident's skin. The				
	WCN stated that a ru	uptured blister would be				
	considered a stage 2	2 pressure wound but that				
	she used the Flowsh	eet of Non-Ulcer Skin				
	Conditions to docum	ent information about				
	Resident #188's wou	Ind. She acknowledged that				
	the documentation s	hould have been on the				
	pressure wound ass	essment sheet and she did				
	not know why she ha	ad documented on the				
	non-ulcer assessme	nt sheet. The WCN				
	indicated that a pres	sure wound should be				
	assessed weekly and	d should include				
	-	ing, drainage, infection, odor,				
	-	vound bed and a description				
		kin. She indicated that				
		sometimes not be done if				
		nedication cart or was off on				
	•	ient was due. She stated				
	-	would do the treatments but				
		e required assessments				
	-	to do on her return to the				
	-	N admitted there was				
		on for Resident #188's				
	-	vould provide all that she				
		t the Assistant Director of				
		iewed all the wound care				
		ed weekly for pressure ulcers				
			1			
	and also visualized t	he wound. A Quality				
		he wound. A Quality and note would then be				

Facility ID: 100679

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345569	B. WING			C 02/22/2019		
NAME OF P	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	been problems with the wounds and she was proactive with the sch She indicated she did assessment when Re- from the facility becau- resident was being di that if she had known would have written a agency about the would in an interview on 02/ PM the ADON stated in the facility since 01 she supervised the W- ideal world pressure with documented on the ca and that assessments In a telephone intervier Physician #2 stated he #188 had had a wour unaware that there was heel. He indicated if f blister and then ruptu weekly wound assess In a follow-up intervier the WCN stated the p written on 11/28/19 as from the standing ord spoken to the physicia wound. In an interview on 02/ who had worked with was not sure when the blister on the right here	he weekly assessment of now trying to be more heduling of assessments. I not perform a skin hisident #188 was discharged use she was not aware the scharged. She indicated about the discharge she note to the home health und. 20/19 at approximately 1:20 she had only been working /02/19. She verified that /CN and stated that in an wounds would be orrect assessment forms a would be done weekly. ew on 02/21/19 at 11:37 AM e was aware that Resident ad on the ankle but was as a wound on the right the wound had started as a red he would expect a sment with measurements. w on 02/21/19 at 1:45 PM ohysician's order that was a verbal order was actually ers and that she had not an regarding the heel 21/19 at 2:45 PM NA #2, Resident #188, stated she e resident developed the	F	686				

	MENT OF HEALTH AN					FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
		345569	B. WING			C 02/22/2019		
NAME OF F	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
SPRINGE	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	reported any abnormal In an interview on 02/ Director of Nursing (E expected the assess include measurement wound bed, and if any noted such as puruler the facility could track improving. She indicate wound to be document weekly. She indicate notify the physician of acquired in the facility decide if standing ord they wanted a different In a telephone intervie the Home Health Mar Resident #188 was as wound on the right he pressure wound. She odor and there were no 3. Resident #62 was a 1/4/19. His active diag intertrochanteric fract hypertension, heart fa and chronic obstruction Review of Resident #6 knee cap skin tear as There were no pressure s left heel identified u	al findings to the nurse. 22/19 at 9:14 AM the DON) indicated that she ment of a pressure wound to is, a description of the y signs of infection were at drainage or odor so that if the wound was ated she expected the need on the correct form d she expected the WCN to f any wounds a resident y so the physician could ers were appropriate or if nt treatment. ew on 02/22/19 at 1:46 PM hager confirmed that when ssessed on 02/08/19 the bel presented as a stage 3 e indicated there was no no signs of infection. admitted to the facility on gnoses included displaced ure of the left femur, ailure, muscle weakness, ye pulmonary disease. 62 ' s admission skin rral form dated 1/4/19 2 had a left hand and left well as a left hip wound. ure ulcers to Resident #62 ' pon admission. This skin n 1/10/19 and signed as	F	680	6			

Facility ID: 100679

If continuation sheet Page 79 of 114

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG _		с		
		345569	B. WING			02/22/2019		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	9 79	F	686				
	Review of a nurse's n the nurse noted a pre Resident #62's left he completed and new o in bed and to keep left Review of a physician 1/6/19 revealed the pl Resident #62 had a le he wished to have the a consult and avoid p Review of a skin refer revealed the nurse do the left heel. A new of boots to the left heel a This skin referral was referral would no long Wound Care Nurse) of reviewed by the Woun Review of a physician care nurse to evaluate Resident #62's left he There were no wound between 1/6/19 and 1 Review of a nurse pra dated 1/7/19 revealed bunny boots in place heel pain was greater	ote dated 1/6/19 revealed ssure ulcer noted to sel. A skin referral was rders for bunny boots while it heel elevated on pillows. It's progress note dated hysician documented eff heel pressure ulcer and e wound care nurse provide ressure to the heel. Tral form dated 1/6/19 boumented a new ulcer to rder was made for bunny and elevate the heel in bed. locked (meaning the be on reports run by the on 1/6/19 and not signed as nd Care Nurse. It's order dated 1/6/19 n ordered for the wound e a stage II pressure ulcer to the. A assessments documented /16/19. Actitioner progress note I Resident #62 had bilateral and had heel pain. The left than the right heel pain.						
	1/9/19 revealed Resid	' s progress note dated lent #62 had bilateral bunny d heel pain with the left heel right heel pain.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		345569	B. WING			C 02/22/2019		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 686	Continued From page	80	F	686				
	Review of a nurse pra	actitioner progress note						
	dated 1/14/19 revealed	ed Resident #62 had bilateral						
		and bilateral heel pain. The ater than right heel pain.						
		ssure ulcer noted with old						
	, united and the second s	inside of the bunny boot. ul to the touch and with						
		he plan was for the stage II						
		tinue being followed by the n controlled with as needed						
	pain medication.							
	Review of a physiciar	n ' s progress note dated						
	1/16/19 reveled Resid	dent #62 had bilateral bunny						
	· ·	ft heel was noted to have a r with old drainage noted to						
	the inside of the bunn	y boot. Pain was present to						
	the ulcer with movem	ent and to touch.						
		an orders revealed on						
		was ordered betadine and the foam every other day to						
	the stage II pressure							
	Review of a wound flo	owsheet dated 1/16/19						
		had an in-house stage II						
	pressure ulcer to his l centimeters by 1 cent	left heel which measured 3 timeter. The ordered						
	treatment was to appl	ly betadine and an adhesive						
	dressing with foam ev	very other day.						
		62's January 2019 treatment						
		dent #62's order for betadine g with foam was not initialed						
	as being performed u	-						
	Review of the Reside	nt #62 ' s care plan dated						
		resident was care planned						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF		
		345569	B. WING					
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	,		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	for a pressure ulcer to interventions included wound healing as ord in skin integrity or skin or symptoms of infect boots or pressure reli provide treatments as Review of Resident # assessment dated 2/ was assessed as cog extensive assistance locomotion on and off and personal hygiene with eating. Resident stage II pressure ulce upon admission. Review of a wound flor revealed Resident #6 ulcer to his left heel w centimeters long and no depth. Review of a wound flor revealed Resident #6 ulcer to his left heel w centimeters long, 2 co centimeters deep. Review of a wound flor revealed Resident #6 ulcer to his left heel w centimeters long, 1.5 than 0.25 centimeters During an interview o Resident #62 and his	 b his left heel. The d to provide medications for lered, observe for changes in impairment such as signs ion and pain, specialty eving boots to both feet, and a ordered. 62 's minimum data set 1/19 revealed the resident initively intact. He required with bed mobility, transfers, f unit, dressing, toilet use, e. He required supervision #62 had one unhealed er which was not present bwsheet dated 2/1/19 2 had a stage II pressure /hich measured 3 1.5 centimeters wide with bwsheet dated 2/5/19 2 had a stage II pressure /hich measured 3 entimeters wide, and 0.5 bwsheet dated 2/18/19 2 had a stage II pressure /hich measured 1.5 centimeters wide, and less a deep. 	F	680	6			

Facility ID: 100679

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	195 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		0	CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	stated the nurses had treatments and they we developed it. He cond but at first not all his of being done. During observation of Wound Care Nurse we wound care to Reside identified with the work measured to be 1.5 c centimeters wide, and deep. During an interview of Wound Care Nurse st would receive a skin is something is identifie Resident #62 did not upon admission. The another skin referral we identified concerns. St usually sees new refer hours but if it's the we and assess the reside She further stated she skin referrals on 1/7/1 week day following th was made and would the skin referral. She placed the referral on referral never made iff to work on 1/7/19. Sh Resident #62 on 1/7/1 but was not aware of conditions at that time	a missed some of his were not sure when he cluded care was better now dressing changes were an 2/18/19 at 2:58 PM the vas observed providing ent #62. No concerns were und care. The wound was entimeters long, 1.5 d less than 0.25 centimeters an 2/19/19 at 2:15 PM the tated upon admission she referral from the nurse if d. She further stated have any pressure ulcers Wound Care Nurse stated would be issued for newly she further stated she errals within the first 24 eekend she would then go ent the next work week day. e would have done all new 19 which was the first work te 1/6/19 when the referral have been the day following further stated the nurse who rm in the system for the e II pressure ulcer on 1/6/19 1/6/19 which meant the it to her when she came back e further stated she saw 19 for his surgical incision	F	686			

Facility ID: 100679

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345569	B. WING		_		C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
0000000				195 SPRINGBROOK AVEN	IUE		
SPRINGB	ROOK NURSING & REHA	BILITATION CENTER		CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	in her report and was were newly identified continued stated if the should slide a copy un not done. The Wound first made aware of the when someone from the showed her the referr She further stated it we wound be brought to a was identified, and it we nurse closing the refer referral to not appear Care Nurse stated it we the identification of the notified and she did ne wound was in on the documented it as a st increased in stage and between her last two stated on 1/16/19 whe the pressure ulcer and assessment on that de was no dressing on the that point and then the day for betadine with on the pressure ulcer further stated she did was not initialed as con- treatment record beca- dressing on 1/16/19 we the wound. She concu- through January 16th assessments or meas Resident #62's stage	s because it would not show how she knew when there skin conditions. She ey did close them out they nder the door and that was Care Nurse stated she was the pressure ulcer on 1/16/19 the management team al order placed on 1/6/19. Was her expectation that the her attention as soon as it was not done due to the rral which caused the in her report. The Wound was too long of a gap from e wound to her being ot know what state the 60th, however the physician age II and it had not d had decreased in size measurements. She further en she was made aware of d performed her first ay with the physician there he wound but bunny boots at eatment was initiated on that an adhesive foam dressing with the physician. She not know why the treatment ompleted until 1/19/19 on the ause she had placed the first when she was first aware of uded from January 6th there were no wound surements performed on II pressure ulcer.	F 68	36			
		ated it was her expectation					

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ENTER	S FOR MEDICARE &	& MEDICAID SERVICES			OMB NO.	0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		345569	B. WING		C 02/22	2/2019
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				195 SPRINGBROOK AVENUE		
FRINGBI	KOOK NUKSING & RE	HABILITATION CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pa	ne 84	F 68	6		
		d pressure ulcers that the	1 00			
		vould perform an initial				
		easure and document that				
		within 24 to 48 hours of				
		urther stated it was not				
	•	a wound to go ten days ssessment performed				
		cation. The Director of Nursing				
		were not to be closed prior to				
		urse signing off on the referral				
		d not have closed the referral				
	form before the Wo that she had receive	und Care Nurse could sign off				
	that she had receive	ed.				
	During an interview	on 2/19/19 at 4:03 PM				
	•	it was his expectation the				
		do a wound assessment and				
		in the next business day of				
	-	ound care nurse referral order en days. He further stated he				
		re had been any deterioration				
		en the time he saw it on				
	1/6/19 and 1/16/19	due to any lack of care by the				
	facility.					
	During an interview	on 2/20/19 at 7:56 AM Nurse				
	-	rals were not to be locked until				
		se was aware of the issue.				
		he skin referral she completed				
		oleted and locked by her on				
		/ound Care Nurse could see it.				
		he family had stated they had been there since the				
		e facility on 1/4/19 so the				
		already knew about it and				
	was why she closed	d it and did not inform the				
	Wound Care Nurse					
F 732	Posted Nurse Staffi	na Information	F 73	2	3	/18/19

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	
		345569	B. WING				_ 22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ENTERS FOR MEDICARE & MEDICAID SERVICES TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345569 MME OF PROVIDER OR SUPPLIER PRINGBROOK NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g)(1) Data re- must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categ unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must po specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readabh (B) In a prominent pla residents and visitors §483.35(g)(3) Public a staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta	(4) ffing Information. equirements. The facility ig information on a daily and the actual hours worked pories of licensed and aff directly responsible for t: S. I nurses or licensed defined under State law). des. I requirements. post the nurse staffing data in (g)(1) of this section on a inning of each shift. ed as follows: e format. uce readily accessible to caccess to posted nurse cility must, upon oral or a nurse staffing data c for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of	F	732	2		

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	03/27/2019 APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY ETED
		345569	B. WING		02/2	2/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				195 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 732	Continued From page	2.96		22		
1 7 52			F 73	32		
	This REQUIREMENT	「 is not met as evidenced				
		n, record review and staff		The facility immediately		
		failed to update the staff		to ensure the facility upd		
		al number of Nursing Aides or 1 of 1 daily nurse staffing		posting with actual numb aides and licensed nurse		
	forms reviewed. Find	, 0		nursing staffing sheets a		
	Iomis reviewed. Time			front lobby and are upda		
	Review of the Daily N	lursing Staff Posting dated		manner at the beginning	-	
		at on evening shift there		reflect accurate staffing i		
		es (NA) that should have				
	been working.			A 100% in-service initiate	ed by the Staff	
				Facilitator to all licensed		
		PM a tour was conducted		3/12/19 and is to be com		
		 There were nine NAs 		3/19/19. The education		
	-	eighborhoods of the facility.		process of including the information on the staffin	ig sheet: facility	
		/19/19 at 4:25 PM Nurse #5		name, date, current cens		
		l admissions, staffing, and		of actual hours worked b		
		worked as a floor nurse if		nursing staff directly resp		
		it was not her responsibility		resident care per shift	RN⊔s, LPN⊔s,	
		aff posting and believed it / of the receptionist. Nurse		CNA⊡s.		
		were nine NAs working on		Staffing posting sheets a	re filled out	
	the evening shift that			nightly by 11-7 shift on F		
				neighborhood and poste		
	In an interview on 02	/19/19 at 4:56 PM with the				
		e Director of Nursing (DON),		Clinical staff are educate	ed to	
	the Administrator stat	ed that the process for the		highlight/initial staffing sl		
		t midnight when the night		clock as they arrive daily		
		he staffing form with the		assignment to better fac	ilitate tracking of	
		following day from the		staff.		
		ed it was the responsibility of		Numero	here the section of the	
		ate the staff posting but that		Nurses on Clayton neigh		
	-	ve a scheduler at that time.		scheduler will then timely	-	
		expected the daily staffing to		staffing sheets at the beg	ginning of each	
	-	e hour of the start of the hat since the facility did not		shift: 7-3; 3-11; 11-7.		
		uler the responsibility for		Monitoring will include Q	l audit tool for	

Facility ID: 100679

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345569	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/22/2019
				195 SPRINGBROOK AVENUE	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON, NC 27520	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETI
F 732	Continued From page	<u>- 87</u>	F 73	2	
	updating the posting not updated the posti staff posting should a	was hers and that she had ng. She stated the daily ccurately reflect the number iding care to the residents.		 daily nurse staffing sheets and will be monitored by the Staff Facilitator or designee. Audit tool will be used 3 tir a week X s 4 weeks, then weekly X weeks then monthly X s 1 month. TRN s and LPN s will immediately be retrained and re-educated by the aud for any identified areas of concerns. Director of Nursing or designee is responsible and will review and initial audit tool for completion to ensure all areas of concern were addressed. The Executive QI committee will mee review the nurse staffing posting QI to monthly X s 3 months to determine issues and trends to include continue monitoring frequency. 	nes ls 4 he itor The the t to pol
F 759 SS=D		rror Rts 5 Prcnt or More	F 759	9	3/18/19
	The facility must ensu				
	percent or greater;	tion error rates are not 5 is not met as evidenced			
	Based on observatio record review the fac medication administra 5% when a nurse fail insulin pen against th failed to administer A	ns, staff interviews, and ility failed to maintain a ation error rate of less than ed to prime and hold the e skin for 5 seconds and spirin as ordered by the ed in an error rate of 8% for		The facility immediately put in measure to ensure the administration of medications has an error rate of less 5%.	on
	2 of 25 opportunities	ed in an error rate of 8% for observed for 2 of 5 residents ss. (Resident #88 and		following the insulin pen manufacture recommendations and Nurse # 3 was immediately educated to administer medications per MD order.	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/27/2019 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION		LETED
		345569	B. WING				C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				195 S	PRINGBROOK AVENUE		
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		CLA	YTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 759	Continued From page	e 88	F 7	59			
	used by the facility da insulin pen was to be injection. (Priming an remove the air from the ensures the pen is we the insulin pen, the us knob to select 2 units needle pointing up, ta to collect air bubbles dose knob in until it s dose window. The us the tip of the needle. at the tip of the needle repeated no more that no insulin observed at needle would need to the medication, the us	the Humalog insulin pen ated 1/6/17 revealed the primed before each insulin pen means to he needle and cartridge and orking correctly). To prime ser was to turn the dose to hold the pen with the ap the cartridge holder gently at the top, and push the topped and read 0 on the er should see the insulin at If insulin was not observed e the steps were to be an 4 times. If there was still at the top of the needle, the b be replaced. To administer ser was to dial to the desired		n p a a h w a T n fa e re th c a A b	Medical Director in building and verba otified at the time. No additional ord rovided. Facility ensured the safe an iccurate administration of medications II other residents. Resident #88 and ave received medication in accordan <i>i</i> th manufacturer⊡s recommendation nd physician orders. The administrative nurses (director of iursing, assistant director of nursing, acilitator, quality improvement nurse) insured all other residents, including esidents receiving aspirin and insulin eceived the appropriate medication u he six rights. Corporate facility onsultants also initiated medication p udits.	ers ad s for #31 ce as staff sing pass 2/19	
the use the 2/1 me Res	the skin and push the user was then to hold the needle in the skin Resident #88 was ad 2/18/19. Her active di mellitus. Review of Resident #	mitted to the facility on iagnoses included diabetes 88 ' s physician ' s order		T m n h o F n	urses with a completion date by 3/19 The focus of the education is decreasing the dication errors to include following the dication errors instructions and givin the dications per MD order. All newly ired licensed nurses will be in-service in preventing medication errors.	ing g ed or	
	Humalog Pen for slid Review of the sliding sugar of 351 to 499, t 12 units of Humalog.	ed the resident was ordered ing scale insulin one time. scale revealed for a blood the resident was to receive		F D A X	Medication Administration by the Staff facilitator, Unit Manager, Assistant Director of Nursing, or Director of Nurs sudit tool will be used 3 times a week (s 4 weeks, then weekly X s 4 wee nen monthly X s 1 month.	sing. ·ks	
		n 2/20/19 at 4:26 PM, Nurse			The licensed nurses will be immediate	ely	

Facility ID: 100679

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/27/2019 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02	22/2013
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			5 SPRINGBROOK AVENUE		
				CI	LAYTON, NC 27520		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	Continued From page	e 89	F7	759			
	 #2 was observed to a sugar. The blood sug During observation of #2 was observed to p Humalog insulin pen- units. She then enter administered the 12 of #88 's abdomen. The against the resident 'removed the insulin p of insulin was observed to p of insulin was observed the insulin p of insulin was observed the prior to administration site. The edle prior to administering insulin stated she usually het two seconds following the second but Reserved the second but Reserved the purpose of the part of the purpose of	check Resident #88 ' s blood gar result was 380. In 2/20/19 at 4:56 PM, Nurse blace the needle on the and turned the dial to 12 red the resident ' s room and units of insulin to Resident e nurse held the insulin pen s skin for 1 second, ben from the skin, and a drop red to drip from the he nurse did not prime the histration. In 2/20/19 at 4:56 PM, Nurse primed insulin pens prior to via insulin pens. She further eld the insulin pens for one to g insulin pen administration. Inly held the pen at the site ident #88 did not have much ome insulin dripped from the in 2/21/19 at 9:30 AM, the tated it was her expectation		09	re-trained by the auditor for any ident areas of concern. The Director of Nur or designee will review and initial the Medication Pass Audit Tool for complet to ensure all areas of concern were addressed. The Executive QI committee will meet review the Medication Administration tool monthly times 3 months to detern issues and trends to include continue monitoring frequency.	sing etion t to QI nine	
	dosage was administ was a medication err 2. Resident #31 was 10/1/17. His active di	admitted to the facility on					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_			PLETED
		345569	B. WING				C /22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	22/2013
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER			195 SPRINGBROOK AVENUE		
				(0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759	F 759 Continued From page 90 artery. Review of Resident #31 ' s orders revealed on		F	759			
	12/5/18 the resident v	vas ordered chewable					
	Aspirin 81 milligrams	by mouth one time a day.					
		n 2/19/19 at 8:27 AM, Nurse					
	#3 was observed perf administration pass for	forming a medication or Resident #31. The nurse					
	was observed to adm	inister enteric coated					
	· ·	irin means the Aspirin does in the small intestines to					
		Aspirin 81 milligrams by					
	#3 stated she administead of the chewat	n 2/21/19 at 8:05 AM, Nurse stered enteric coated Aspirin ble aspirin which was a ed it was a medication					
	error.						
	Director of Nursing sta nurses follow the physic	he enteric coated aspirin ble aspirin it was a					
F 761	Label/Store Drugs an		F	761			3/18/19
SS=E	CFR(s): 483.45(g)(h)((1)(2)					
	Drugs and biologicals	y and cautionary					

Event ID: 0UHB11

Facility ID: 100679

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	22/2010
		DULTATION OFNED		1	95 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		0	CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	CIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION) Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 761	§483.45(h) Storage o §483.45(h)(1) In accor Federal laws, the faci- biologicals in locked of temperature controls, personnel to have accord §483.45(h)(2) The faci- locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when the package drug distribute quantity stored is min- be readily detected. This REQUIREMENT by: Based on observation facility failed to keep of stored in a locked me- medication carts observation facility failed to keep of stored in a locked me- medication carts observed. (100 - 300 - 400 Hall Medication top of a medication carts) Findings included: 1. During observation 100 - 200 hall medication was observed in the or- nurse's station approv- the open door to the r- no nurses at the nurse	f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. clity must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced n and staff interviews the unattended medications	F	761	The facility immediately put in measure to ensure unattended medications are stored in a locked medication cart. The facility also immediately put in measure to ensure that all medication carts are locked when not supervision by a licen nurse. Nurse #1, #6, #7 were immediately in-serviced on keeping their carts locket while not under supervision and keepin all medications locked while the cart is unattended. A 100% audit all of medication and treatment carts was completed on 2/22 by the Director of Nursing and Assistan Director of Nursing. A 100% in-service was initiated on 2/27	e sed ag 2/19 at	

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	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345569	B. WING		C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
SPRINGB	ROOK NURSING & REH/	ABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI
F 761	Continued From page	e 92	F 761		
	member was observed unlocked medication staff member was observed unlocked medication aide was observed to medication cart. At 1: Nursing approached to Upon observation of the with the surveyor on 2 Director of Nursing st always to remain lock unattended. She conder was unlocked and she Director of Nursing the cart. During an interview o #1 stated she though medication cart and o 2. A. In an observation 6:02 AM a medication left of the closed door and the lock of the me into the hallway. The did not appear to be a observation of the me until 6:05 AM when N room 501 and steppe the three minutes of t no other staff membe on the hall.	ed to walk passed the cart. At 1:31 PM a dietary served to walk passed the cart. At 1:32 PM a nurse walk passed the unlocked 32 PM the Director of the surveyor. the unlocked medication cart 2/21/19 at 1:32 PM the ated medication carts were ked when they were cluded the medication cart ould have been locked. The the nocked the medication		by the Staff Facilitator to all licens nurses with a completion date by 3/18/2019. The focus of the educ appropriate storage of drugs and biologicals. All newly hired licens nurses will be in-serviced on the s and best practice/guidelines. Drug storage will be monitored by a QI audit tool by the Staff Facilita Manager, Assistant Director of Nu designee. Audit tool will be used a week X s 4 weeks, then weekly weeks then monthly X s 1 month licensed nurses will be immediate re-trained by the auditor for any id areas of concern. The Director of or designee is responsible and wil and initial the audit tool for comple ensure all areas of concern were addressed. The Executive QI committee will m review the locked medication cart monthly X s 3 months to determi issues and trends to include contin monitoring frequency.	ation is ed ame utilizing tor, Unit rsing, or 3 times / X □ s 4 . The ly entified Nursing I review etion to neet to QI tool ne
	verified that the medic She stated the medic locked especially if th	/21/19 at 6:06 AM Nurse #6 cation cart was unlocked. ation cart should always be e cart was out of her direct 6 indicated that if not kept			

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	l` í		· · ·	PLETED
			-			С
		345569	B. WING		02	/22/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		95 SPRINGBROOK AVENUE LAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 761	Continued From page medications out.	e 93	F 761			
	Director of Nursing (I medication carts to b indicated that if the m	/22/19 at 9:55 AM the DON) stated she expected e locked at all times. She nedication carts were not gain access to the carts and sue.				
	small white box which medications was see hall medication cart.	n on top of the locked 300 No staff or residents were Nurse #7 approached the				
	confirmed that the wh medication cart conta Boniva with a dosage was one dose left in t medications should a	/21/19 at 6:09 AM Nurse #7 hite box on top of the ained a medication called e of 150 milligrams. There the box. She indicated always be kept secured dication cart and not on top				
	stated she expected at all times and not le carts. She indicated on top of the carts an 3. A continuous obse 02/21/19 from 5:00 P medication cart for th unsupervised and un located at the end of	/22/19 at 9:55 AM the DON that medications be secured eff on top of the medication that if medications were left byone could remove them. rvation conducted on M to 5:05 PM revealed the e 300-400 hall was left locked. The med cart was the hallway near an exit sitting by the med cart in her				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUC G				PLETED
		345569	B. WING _					C 22/2019
NAME OF P	ROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP COD	E		
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER		195 SPRINGE	BROOK AVENUE NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 761 F 812 SS=F	observed to exit from had its door closed ar cart. An interview was com PM with the assigned return to the medicatii thought she had locke the residents ' room, her part. She stated s to make sure she has leaving it unattended, so. An interview was com PM with the Director of her expectation that a always kept locked wi Food Procurement, St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods	a residents ' room which a return to the medication ducted on 2/21/19 at 5:05 nurse (Nurse #2) upon her on cart. She stated that she ed the cart before entering and that it was an error on he typically double checks locked the cart before and this time failed to do ducted on 02/22/19 at 2:42 of Nursing. She stated it ' s ill medications carts are hen unattended. ore/Prepare/Serve-Sanitary 2) y requirements. re food from sources ed satisfactory by federal, es. ood items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable	F 7					3/18/19

Facility ID: 100679

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/27/201 M APPROVE D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345569	B. WING				C / 22/2019
NAME OF PF	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	95 SPRINGBROOK AVENUE		
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		С	LAYTON, NC 27520		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				D BE	(X5) COMPLETION DATE	
F 812	Continued From page	e 95	F	812			
-		ance with professional		012			
	standards for food se	•					
		Γ is not met as evidenced					
	by:						
	•	on and staff interview the			The facility immediately put in measure	sures	
	facility failed to air dry	y items of kitchenware			to comply with F812, 483.60(i)(2) - \$	Store,	
	before stacking them	on top of one another in			prepare, distribute and serve food ir	า	
		monitor dish machine			accordance with professional stand	ards	
		ed in kitchenware not being			for food service safety.		
	-	inal rinse cycle. The facility					
		grease from stove filters			A complete audit of the kitchen was		
		oris and dust/dirt from behind			completed immediately by Director		
		nd racks along the kitchen			Dietary Services following the inspe		
		ty also failed to label and ackaged food items in			by surveyor on 2/20/19. All food ite were properly dated and labeled, pa		
	storage areas. Findi	-			were separated to prevent wet nest		
	storage areas. Finun	ngs meldded.			stove filters were cleaned, and the		
	1 During initial tour	of the kitchen, beginning at			was cleaned of dust and debris from		
		9, 13 of 16 tray pans,			behind equipment and along kitcher		
		op of one another, had			perimeter.		
	moisture trapped bet	-			•		
					A professional cleaning vendor was		
	-	vith the Dietary Manager 10:28 AM she stated about			brought onsite to clean stove filters.		
	six months ago the d				The dishwasher sensor was replace	ed by	
	0	e importance of air drying			the manufacturer s representative	during	
		was stacked in storage.			the survey.		
		e trapped between tray pans					
		nent in which bacteria could			An in-service to all dietary staff on k		
		ed this bacteria had the			sanitation including the proper proce		
	potential for making r	esidents sick.			to store, prepare, distribute and service		
		with Diatons Employee #4 ar			food in accordance with professiona		
		vith Dietary Employee #1 on			standards for food service safety pro		
		I she stated there were racks			was initiated on 2/18/19 by the Dire		
	-	chen/dish machine room for e. She reported dietary staff			Dietary Services and will be comple 3/18/19. All newly hired staff will be	-	
		itchenware should be			in-serviced on the facility storage		
		ree of dried food particles			preparation, distribution, and serving		
	completely ally ally in		1			9	1

Facility ID: 100679

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE	CONSTRUCTION	T	NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			I ` /	DMPLETED
							С
		345569	B. WING	-		(02/22/2019
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	ROOK NURSING & REHA			19	5 SPRINGBROOK AVENUE		
				CL	_AYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	96	F 81	2			
	1 0	ause bacterial growth in		_	drying of pans were added to a weekly		
	0	uld cross-contaminate food			audit tool managed by the Director of		
	that was being stored	in it.			Dietary Services.		
	2 An observation of	the dish machine process			The kitchen sanitation audit tool will be		
		9 between 9:58 AM and			monitored by the Food Service Consul		
		ry employees participating in			or designee for QI purposes. The Nurs		
		watching the wash or final			Home Administrator is responsible for		
	rinse gauges on the d	lish machine. At 10:09 AM			QI tools and will review 3 times per we	ek	
		kitchenware exited the dish			for 8 weeks then monthly times 1 mont	th.	
		I rinse gauge registering 174			The pertinent staff will be immediately		
	-	Dietary Employee #2 placed			re-trained by the auditor for any identifi	led	
		drying rack. At 10:18 AM kitchenware exited the dish			areas of concern.		
		I rinse gauge registering 176			The Executive QI committee will meet	to	
		Dietary Employee #2 placed			review the notification of changes QI to		
	this kitchenware on a				monthly times 3 months to determine issues and trend to include continued		
	0	ith Dietary Employee #2 on			monitoring frequency.		
		I she stated she checked the					
		when the dish machine					
	-	ip after meals. She reported ature was supposed to be					
	165 degrees Fahrenh						
	•	vith the Dietary Manager					
		10:28 AM she stated dietary					
		viced that the minimum final					
	rinse temperature neo kitchenware via the di	-					
		She reported it was the					
	responsibility of the e	•					
		exiting the dish machine to					
	monitor the wash and	I final rinse gauges. She					
		I rinse temperature did not					
		ahrenheit the kitchenware					
	was to be run back th and if the required ter	rough the dish machine,					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED		
		345569	B. WING				C 22/2019		
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE CLAYTON, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	HOULD BE COMPLETIC			
F 812	involve the maintenar contracted service tee DM, since the 02/20/7 a dish machine part w compromising the abid kick in consistently ar During an interview w 02/21/19 at 11:04 AM attended multiple in-s emphasized that whe machine the wash ga least 150 degrees Fa gauge needed to regio order to sanitize kitch those temperatures w was supposed to noti the problem fixed. Sh residents could get si that was not sanitized 3. During initial tour of 11:03 AM on 02/18/19 system located above rivulets of grease on fig grease on the back sp ovens. Food debris, packets, paper, and k along the perimeter k equipment and racks. At 9:17 AM on 02/20/7 the kitchen, five filters above the stove and o on them. There was splash behind the sto dust/dirt, condiment p	 ace department and/or the chnician. According to the 19 dish machine observation vas replaced which was ality of the final rinse cycle to ad efficiently. with Dietary Employee #1 on a she stated she had bervices during which it was n operating the dish uge needed to register at hrenheit and the final rinse ster at least 180 degrees in enware. She reported if vere not met dietary staff fy the DM so she could get the commented that ck eating off kitchenware for the kitchen, beginning at 9, five filters in the hood e the stove and oven had them. There was also plash behind the stove and dust/dirt, condiment sitchenware were found itchen walls, behind 19, during a follow-up tour of s in the hood system located oven had rivulets of grease also grease on the back ve and ovens. Food debris, packets, paper, and nd along the perimeter 	F	812	2				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345569	B. WING				C / 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 812	Continued From page	98	F	812			
	 (DM) on 02/21/19 at 7 time the filters in the h every three months b that frequency had be months. She reporter a possible fire hazard floor boards of the kitt increased the chance commented the perim to be cleaned daily, b happening. During an interview w 02/21/19 at 11:04 AM department had some of work so she though floors were being moj but she commented it since employees had equipment and racks. and food debris could and dust/dirt could green 	with the Dietary Manager 10:28 AM she stated at one nood system were cleaned y a contracted service, but een changed to every six d grease on the filters posed l, and the debris along the chen and dish room of pest problems. She neter floors were supposed ut she was not sure that was with Dietary Employee #1 on I she stated the dietary e employees who were out no the center of the kitchen opped and swept twice a day, t might have been awhile time to clean in behind . She commented grease I breed rodents and pests, ow bacteria and mold.					
	in the dry storage roo dates. These items in of light brown sugar, a (instant potatoes), a 5 two bags of rotini noo noodles. In the walk- 5-pound bag of shred opened 8-pound 10-c opened gallon contain	9, opened food items found m were without labels and ncluded two 1-pound bags a bag of potato pearls 5-pound box of quick grits, idles, and a bag of egg in refrigerator an opened ded mozzarella cheese, an punce container of salsa, ners of Cole slaw dressing I an opened gallon container					
	-	ere without labels and dates.					

Facility ID: 100679

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345569	B. WING		02/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	·
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE	
				CLAYTON, NC 27520	I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 812	Continued From page	99	F 8	12	
	strawberries did not h	have a label and date on it.			
	observation of the kite	AM, during a follow-up chen, there was an opened ne walk-in freezer without a			
	(DM) on 02/21/19 at items which were res should all have labels reported her staff was opened food items ar container or resealed placing labels and da commented that she	and her assistant tried to eas daily to make sure			
F 835	02/21/19 at 11:04 AM dating opened and re important so that resi freshest food possible labeling was a vital el first out) system. She her assistant tried to daily for labeling and was difficult to do. Administration	vith Dietary Employee #1 on I she stated labeling and packaged food items was dents could be served the e. She explained dating and lement in the FIFO (first in, e reported either the DM or monitor all storage areas dating, but sometimes that	F 83	35	3/18/19
SS=H	enables it to use its re efficiently to attain or	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial			

Facility ID: 100679

If continuation sheet Page 100 of 114

		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/27/2019 ORM APPROVED 3 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRU G		(X3)	DATE SURVEY COMPLETED
		345569	B. WING _				C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER	·	•	STREET ADD	DRESS, CITY, STATE, ZIP CODE		
				195 SPRINC	GBROOK AVENUE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		CLAYTON	, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 835	This REQUIREMENT by: Based on observatio wound center intervie staff interview, and re administration failed t leadership and overs wound care policies a that 3 of 3 sampled re and #188) reviewed f initial and weekly wou free from neglect. Th to provide guidance t expedited a wound co appropriate wound tre pressure-reducing int sampled residents (R pressure ulcers. Find This tag is cross-refer 1. F686: Treatment/ Pressure Ulcers: Bas physician interview, w home health interview facility failed to condu	F is not met as evidenced an, physician interview, ew, home health interview, ecord review the facility to provide effective ight in the implementation of and procedures to ensure esidents (Resident #48, #62, for pressure ulcers received und assessments and were he administration also failed o ensure that facility staff onsult, administered an eatment, and implemented terventions for 1 of 3 tesident #48) reviewed for dings included: renced to: Services to Prevent/Heal sed on observation, vound center interview the uct initial and weekly wound	F 8	On 3/ (RVP) met wi nursin Improv wound comple On 3/1 addres team (progra directo provid electro progre docum On 3/1 determ improv added using f	 (13/19, the regional vice pression and the corporate clinical divident the administrator and direction of the Performance vement Plan (PIP) initiated field/skin care to ensure the ongoin of the plan. 13/19, the corporate clinical ssed the use of the interdisc (IDT) to review the wound care and cor, and/or facility consultants bing off-site and on-site revier on the health record for nursing ess notes and wound care nentation. 13/19, the administrative teamined key focus areas can bined key focus areas can bined through the use of: 1) and structured daily standup mether IDT process, 2) newly standard or an entation. 	irector ector of or going director iplinary are l s) is w of the g m e newly eeting tructured ay	
	assessments which in descriptions of the we undermining, possible drainage, odor, and p residents (Resident # pressure ulcers. No assessments were co right heel ulcer from identified, until 01/08/ Assurance (QA) Skin documented the 4.5 y to the resident's right	ncluded measurements and bund bed, tunneling or e necrosis/infection, bain for 3 of 3 sampled 448, #62, and #188) with initial or weekly wound completed for Resident #48's 12/16/18, when it was /19 when a Quality Wound Review x 3.5 centimeter (cm) ulcer		follow- hour re rounds medica by the director reside in rega plans, proceor QAPI	-up IDT meeting, 4) review of report sheets, 5) administrati s, 6) care plan reviews, 7) ration pass audits, 8) wound e director of nursing/assistan for of nursing, 9) notification t ent representatives/family me ards to wound status and tree , 10) physician notification dures, 11) continued use of t process.	of the 24 ve rounds t to embers eatment the	

Facility ID: 100679

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MLU T		CONSTRUCTION	(X3)	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '			· · ·	OMPLETED
							С
		345569	B. WING				02/22/2019
NAME OF PR	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				195	5 SPRINGBROOK AVENUE		
SPRINGE	ROOK NURSING & REH	ABILITATION CENTER		CL	AYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 835	Continued From page	e 101	F 8	335			
		ressure ulcer assessments			initiation of a 100% head-to-toe skin	audit	
		urements and descriptions			to ensure all residents are accurately	/	
	of wound bed, tunnel	ing or undermining, possible			assessed and have assessments		
		ainage, odor, and pain were			completed. The audit was completed	d on	
		ent #188 from 11/28/18,			3/18/19.		
		d on her right heel, through					
	-	e facility on 02/07/18. On services assessed the			On 3/13/19, the nursing home administrator initiated an in-service w	(00	
		sident #188's right heel as			for the interdisciplinary team to include		
	-	nd measuring 2 x 2 x 0.5 cm			MDS nurses, activities, social service		
		n referral was submitted for			dietary, and the director of nursing.	,	
		06/19 due to a painful stage			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		an initial wound assessment			An audit of completed assessments	will	
	was not completed for	or the resident until 01/16/19			be reviewed three times per week for	r four	
		ed Resident #62 had a			weeks for a total of ten residents, the		
	•	er to the left heel. This ulcer			three times per week for four weeks		
		drainage, and the wound			total of five residents, then monthly for		
	was painful to touch a	and movement.			one month for five residents. The au		
	In addition the facility	y failed to expedite a wound			will be conducted by the assistant dir of nursing, unit managers, director of		
		sident #48 which was			nursing or designee to ensure		
		g requested by the facility on			compliance, communication and acc	uracy	
		issue injury (DTI) to the			of the facilities process improvement		
		The wound center consult			initiatives.		
		/30/19 at which time the heel					
		an unstageable pressure			The results of the audit tool will be		
	•	l eschar in the wound bed			reviewed by the administrator weekly		
	and a moderate amo	unt of drainage.			director of nursing or designee will ta		
	In addition, based on	facility documentation, the			audit results to the Quality Improvem Executive Committee monthly for the		
		y applied calcium alginate,			months for further recommendations		
		xcess fluid and promote			determine need for continued monitor		
	-	via enzymes, to Resident				0	
	#48's right heel ulcer						
	-	<pre>/ documented this wound as</pre>					
		20/18 until 01/18/19 and as					
		h/eschar and drainage from					
	01/18/19 until a wour	nd center consult on					

Facility ID: 100679

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	-	ND HUMAN SERVICES				FORM	
		MEDICAID SERVICES	(X2) MUL	TIPLE	CONSTRUCTION		
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	A. BUILDI	NG _			
		0.45500					-
	ROVIDER OR SUPPLIER	345569	B. WING	6	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	22/2019
NAME OF PI	ROVIDER OR SUPPLIER				95 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER	CLAYTON, NC 27520				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	∋ 102	F	835			
	#48's heels from the I	y failed to off-load Resident bed as recommended by the plemented by the physician.					
	Nurse on 02/19/19 at	vith the facility's Treatment 3:52 PM she stated ssments had not been					
	identified as a problem facility's quality assur assessment/performa	m to address through the					
	her work was more cl Assistant Director of I	losely supervised by the Nursing (ADON) as was ON accompanying her on					
	weekly wound rounds commented she thou	s. The Treatment Nurse ght this change was brought ne wound assessment					
	inconsistencies which management team.						
	(DON) on 02/19/19 at	vith the Director of Nursing t 4:18 PM she stated a					
	started on 01/24/19, a	mprovement plan (PIP) was and as part of that plan the ⁻ reatment Nurse would be					
	more closely supervis	sed by the ADON.					
	02/19/19 at 5:34 PM	erview with the DON on she stated that not all nurses					
	facility had received t the facility's wound P	ts currently employed by the he in-servicing outlined in IP. She shared the sign-in					
	on 02/19/19 only 16 r						COMPLETION
	nurses and 10 nursin	Nound Process, and only 16 g assistants had received sure Ulcer Prevention.					
		tions and nurse aide registry					

Facility ID: 100679

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345569	B. WING				_ 22/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REHA	ABILITATION CENTER			95 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	checks provided by the less than 50% of the seducated on the Wou Ulcer Prevention. In with the PIP in-service had not attended wou in the facility since 02 DON, because of staff departure of some mass staff the facility was not assessment education During an interview wo 02/22/19 at 9:21 AM H taken an opportunity for assessment and care PIP, but he was unaw involved in the PIP has reported there were se leadership team in the was challenging to ge changes the new lead During a follow-up into 02/22/19 at 10:46 AM not been included in the because the facility was agency staff out in the 2. F600: Free from A on observation, physis interview, and record 3 of 3 sampled reside #188) reviewed for pr complete initial and w for these residents.	the facility as a reference, staff in the facility had been and Process and Pressure comparing staffing sheets ing sign-in sheets, staff who and in-servicing had worked /08/19. According to the fing issues and the anagement/administrative ot able to complete wound in as outlined in their PIP. With the Administrator on the stated the facility had to improve on its of wounds by developing a vare that the in-servicing ad not been completed. He ome new members of the e facility, and sometimes it at all staff to embrace dership was advocating. erview with the DON on a she stated agency staff had he PIP wound in-servicing as planning on phasing e near future.	F	835			

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					FC	TED: 03/27/2019 DRM APPROVED
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) D	NO. 0938-0391 ATE SURVEY DMPLETED
		345569	B. WING			C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				195 SPRINGBROOK AVENUE		
SPRINGB	ROOK NURSING & REHA	BILITATION CENTER		CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 835	included measuremer wound bed, tunneling necrosis/infection, dra completed for Reside from 12/16/18, when i 01/08/19. The facility wound center consult documented as being 01/08/19 for a deep ti resident's right heel. dressing in accordanc care management of heel pressure ulcer. Resident #48's heels recommended by the implemented by the p pressure ulcer to Res presented with yellow and was painful. Whe at the wound clinic on to the resident's right documented was a D' wound, was identified pressure ulcer with ski wound bed and a mod No initial or weekly pr (which included meass of wound bed, tunneli necrosis/infection, dra completed for Reside when a blister opened her discharge from th 02/08/18 home health pressure ulcer to Res being a stage III wour centimeters (cm).	hts and descriptions of the or undermining, possible inage, odor, and pain) were nt #48's right heel ulcer t was identified, until neglected to expedite a for Resident #48 which was requested by the facility on ssue injury (DTI) to the The facility failed to apply a ewith the facility's wound DTIs to Resident #48's right The facility failed to off-load from the bed as wound center and hysician. On 01/08/19 the ident #48's wound /green purulent drainage, en Resident #48 was seen 01/30/19 the pressure ulcer heel, which the facility TI and then as stage II	F 83			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			
		345569	B. WING				C 22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	, <u> </u>	
SPRINGR	ROOK NURSING & REH	ABILITATION CENTER			195 SPRINGBROOK AVENUE		
SFRINGE	ROOK NORSING & REH	ADILITATION CENTER			CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	01/06/19 due to a pai resident's left heel. The was not completed for 01/16/19 when it was and was painful to tou During an interview we Nurse on 02/19/19 at wounds/wound assess identified as a problem facility's quality assumation assessment/performation processes. However her work was more of Assistant Director of the evidenced by the ADO weekly wound rounds commented she thoug about because of som inconsistencies which management team. During an interview we (DON) on 02/19/19 at wound performance in started on 01/24/19, at work of the facility's Timore closely supervise During a follow-up int 02/19/19 at 5:34 PM stant facility had received to the facility's wound PI sheets which docume on 02/19/19 only 16 r education about the Winurses and 10 nursing	nful stage II wound to the ne initial wound assessment r Resident #62 until found with dried drainage, uch and movement. with the facility's Treatment 3:52 PM she stated sements had not been m to address through the ance (QA) or quality once improvement (QAPI) , she reported that recently osely supervised by the Nursing (ADON) as was DN accompanying her on a. The Treatment Nurse ght this change was brought ne wound assessment ne were noticed by the with the Director of Nursing 4:18 PM she stated a mprovement plan (PIP) was and as part of that plan the freatment Nurse would be sed by the ADON. erview with the DON on she stated that not all nurses s currently employed by the he in-servicing outlined in IP. She shared the sign-in ented that prior to 4:18 PM	F	835			

Facility ID: 100679

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/27/20 FORM APPROVE OMB NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345569	B. WING		C 02/22/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE CLAYTON, NC 27520	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 835	Continued From page	a 106	F 835		
1 000		tions and nurse aide registry	F 030		
	0	ne facility as a reference,			
		staff in the facility had been			
		ind Process and Pressure			
		comparing staffing sheets			
		ing sign-in sheets, staff who			
		und in-servicing had worked			
	DON, because of sta	2/08/19. According to the			
		anagement/administrative			
	-	not able to complete wound			
	assessment education	n as outlined in their PIP.			
	During an interview				
	-	vith the Administrator on he stated the facility had			
	taken an opportunity	-			
		e of wounds by developing a			
		vare that the in-servicing			
		ad not been completed. He			
	-	some new members of the			
	-	e facility, and sometimes it			
		et all staff to embrace dership was advocating.			
	During a follow-up int	erview with the DON on			
		I she stated agency staff had			
		the PIP wound in-servicing			
		as planning on phasing			
F 867	agency staff out in the QAPI/QAA Improvem		F 867	7	3/18/19
	CFR(s): 483.75(g)(2)		1 007		0/10/19
00-L					
	SHOD. (C) Quality as	ssessment and assurance.			
	§483.75(g)(2) The qu	ality assessment and			
1		-			
	assurance committee	e must:			
	(ii) Develop and imple	emust: ement appropriate plans of tified quality deficiencies;			

Facility ID: 100679

If continuation sheet Page 107 of 114

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /	E SURVEY PLETED
			A. BUILDING	3		
		245500	B WINC			С
		345569	B. WING		02	/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE		
				CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 867	Continued From page	e 107	F 86	77		
		is not met as evidenced				
	by:					
		iew and staff interview the		The facility immediately put in me	easures	
		nplement a performance		to review and meet the requireme		
		IP) for wound assessment		providing a Quality assurance and		
	which the facility initia	ated on 01/24/19 and was to		performance improvement (QAPI)	
	have completed by 02	2/08/19. At the time of the		program in accordance to F865,		
	survey less than 50%	o of the nursing staff in the		483.75(a).		
	facility had been educ	cated on the Wound Process				
	and Pressure Ulcer P	Prevention by 02/08/19 as		The facility self-identified a need t	to review	
	outlined in the facility	's PIP. Findings included:		the wound process and implement		
				Performance Improvement Plan (
		s wound assessment		1/24/19 through the QAPI program		
		ment plan (PIP), which was		facility. The PIP initiated assess		
		revealed "On 01/24/19		resident wounds, documentation		
	100% in-service was			wound/skin issues, notification of		
		ses in regards to the Wound		physician and any necessary trea		
		I. Assessment of wounds:		The facility s PIP is an effective t		
	a. On admission with			improve wound/skin issues. The		
	wound/skin issues in			will continue to utilize the PIP to in		
		npletion of skin referral. b.		the facility s wound/skin program	is that	
		or skin issues. 2. MD/RR		was initiated on 1/24/19.		
		e party) notification. 3. Wound/Ulcer treatment.		QAPI plan for pressure wounds w	20	
		pleted by 02/08/19. After		reviewed to ensure it is ongoing,	103	
		Il be allowed to work until		comprehensive, and addresses the	ne full	
		ed." "On 02/01/19 100%		range of care and services provid		
		ed by the Staff Facilitator with		the facility. The QAPI program ad		
		g assistants in regards to		all systems of care and managem		
		ention to include but not		practices, includes clinical care, q		
	limited to turning and			life, and resident choice, utilizes t		
	•	prominences with pillows or		available evidence to define and r		
		de incontinent care, inspect		indicators of quality and facility go		
		priate staff of abnormal		reflect processes of care and facil		
		ositioning/protective devices		operations that have been shown	-	
	as need to protect su			predictive of desired outcomes for		
		e will be completed by		residents of a SNF or NF, and ref	lects the	
	02/08/19. After 02/08	3/19 no nurse or nursing		complexities, unique care, and se	rvices	
	assistant will be allow	ved to work until in-service is		that the facility provides.		

Facility ID: 100679

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 0	PPROVED
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		345569	B. WING		C 02/22/	2019
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE,	ZIP CODE	
SPRINGBI	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE		
				CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE C D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 867	Continued From page completed."	e 108	F 86			
	During an interview w Nurse on 02/19/19 at wounds/wound assess identified as a problem facility's quality assum assessment/performa processes. However her work was more of Assistant Director of I evidenced by the ADO weekly wound rounds commented she thou about because of som inconsistencies which management team. During an interview w (DON) on 02/19/19 at wound PIP was starts high volume of wound following and treating During a follow-up int 02/19/19 at 5:34 PM and nursing assistant facility had received t the facility's wound P sheets which docume on 02/19/19 only 16 r education about the V nurses and 10 nursin education about Pres	ssments had not been m to address through the ance (QA) or quality ance improvement (QAPI) s, she reported that recently losely supervised by the Nursing (ADON) as was ON accompanying her on s. The Treatment Nurse ght this change was brought ne wound assessment n were noticed by the with the Director of Nursing t 4:18 PM she stated a ed on 01/24/19 due to the ds that the facility was b. rerview with the DON on she stated that not all nurses ts currently employed by the he in-servicing outlined in IP. She shared the sign-in ented that prior to 4:18 PM nurses had received Wound Process, and only 16 g assistants had received usure Ulcer Prevention. tions and nurse aide registry		A QAPI meeting was h review the facility s sy compliance. A templat the QAPI programs pro- in-service to all QAPI r includes Nursing Home Director of Nursing, As Nursing, Unit Manager Nurse, Pharmacist Con Director, Activities, Son Dietary, and MDS Nurs 3/13/19 regarding requ (a) by the Nursing Hom All newly appointed stat in-serviced on the facil process. The QAPI committee r review and monitor pro- areas. The Nursing Hom is responsible for the O pressure wound and w times 4 weeks then mod during the scheduled O QAPI members will be re-trained by the audito areas of concern. The Executive QI com review the QI process months to determine is include continued mon	ystems and ensure te is used to track ogress. An members that e Administrator, ssistant Director of r(s), Wound Care nsultant, Medical cial Services, ses was held on uirements of 483.75 me Administrator. aff will be lity □ s QAPI meets monthly to ogress of identified ome Administrator QAPI plan for vill audit weekly onthly for 2 months QI meeting. The immediately or for any identified mittee will meet to monthly times 3 ssues and trend to	
	less than 50% of the educated on the Wou	ne facility as a reference, staff in the facility had been ind Process and Pressure comparing staffing sheets			If continuation about Data	

Facility ID: 100679

If continuation sheet Page 109 of 114

-						FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	345569	B. WING					_ 22/2019
R OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COI	DE		
NURSING & REH	ABILITATION CENTER						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BI		(X5) COMPLETION DATE
he PIP in-servici not attended would facility since 02 , because of staff rture of some match the facility was n ssment education g a follow-up intre 2/19 at 10:46 AM een included in the tion Prevention & s): 483.80(a)(1)(.80 Infection Corr acility must estaff ion prevention a ned to provide a portable environm opment and trar ses and infection and to provide a portable environm (am) acility must estaff ion prevention a ned to provide a portable environm (am) acility must estaff ion prevention a ned to provide a portable environm (am) (am) (a) Infection p (am) (am) (b) (b) (c)	ing sign-in sheets, staff who ind in-servicing had worked /08/19. According to the fing issues and the anagement/administrative ot able to complete wound in as outlined in their PIP. erview with the DON on I she stated agency staff had the PIP wound in-servicing as planning on phasing e near future. & Control (2)(4)(e)(f) htrol blish and maintain an ind control program is safe, sanitary and tent and to help prevent the issmission of communicable ins. orevention and control blish an infection prevention (IPCP) that must include, at <i>v</i> ing elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual						3/18/19
	R OR SUPPLIER SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I inued From page the PIP in-service not attended wou a facility since 02 , because of stat rture of some may the facility was n ssment educatio Ig a follow-up int 2/19 at 10:46 AW een included in the tion Prevention & (s): 483.80(a)(1)(1) .80 Infection Cor acility must estat tion prevention a pred to provide a ortable environm lopment and transistion prevention a pred to provide a prevention a pr	TOTION IDENTIFICATION NUMBER: 345569 R OR SUPPLIER NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Inued From page 109 the PIP in-servicing sign-in sheets, staff who not attended wound in-servicing had worked a facility since 02/08/19. According to the , because of staffing issues and the rture of some management/administrative the facility was not able to complete wound ssment education as outlined in their PIP. Ag a follow-up interview with the DON on 2/19 at 10:46 AM she stated agency staff had een included in the PIP wound in-servicing use the facility was planning on phasing cy staff out in the near future. tion Prevention & Control (s): 483.80(a)(1)(2)(4)(e)(f) .80 Infection Control facility must establish and maintain an tion prevention and control program and to provide a safe, sanitary and ortable environment and to help prevent the lopment and transmission of communicable uses and infections. .80(a) Infection prevention and control	RMEDICARE & MEDICAID SERVICES CHENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A BUILDIN 345569 B. WING_ R OR SUPPLIER 345569 B. WING_ NURSING & REHABILITATION CENTER D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG inued From page 109 F 8 the PIP in-servicing sign-in sheets, staff who not attended wound in-servicing had worked is facility since 02/08/19. According to the , because of staffing issues and the rurue of some management/administrative the facility was not able to complete wound ssment education as outlined in their PIP. F 8 ug a follow-up interview with the DON on 2/19 at 10:46 AM she stated agency staff had een included in the PIP wound in-servicing use the facility was planning on phasing cy staff out in the near future. tion Prevention & Control (s): 483.80(a)(1)(2)(4)(e)(f) F 8 80(a) Infection Control acility must establish and maintain an tion prevention and control program ined to provide a safe, sanitary and ortable environment and to help prevent the lopment and transmission of communicable ises and infections. 80(a)(1) A system for prevention prevention control program (IPCP) that must include, at imum, the following elements: .80(a)(1) A system for preventing, identifying, ting, investigating, and controlling infections communicable diseases for all residents, volunteers, visitors, and other individuals ding services under a contractual gement based upon the fa	RMEDICARE & MEDICAID SERVICES CIENCIES ICCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONST A. BUILDING 345569 B. WING R OR SUPPLIER STREET / NURSING & REHABILITATION CENTER ID PREFIX (CANTO CANTON OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Inued From page 109 F 867 the PIP in-servicing sign-in sheets, staff who not attended wound in-servicing had worked f acility since 02/08/19. According to the , because of staffing issues and the rurue of some management/administrative the facility was not able to complete wound ssment education as outlined in their PIP. F 867 ag a follow-up interview with the DON on 2/19 at 10:46 AM she stated agency staff had een included in the PIP wound in -servicing use the facility was planning on phasing cy staff out in the near future. F 880 tion Prevention & Control acility must establish and maintain an tion prevention and control program ined to provide a safe, sanitary and ortable environment and to help prevent the lopment and transmission of communicable ises and infections. S80(a)(1)(A system for prevention prevention sommunicable diseases for all residents, volunteers, visitors, and other individuals ding services under a contractual gement based upon the facility assessment	REDICARE & MEDICAID SERVICES SERVICES SERVICES SERVICES SCR SUPPLER NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Inued From page 109 the PIP in-servicing sign-in sheets, staff who to attended wound in-servicing had worked is facility was not able to complete wound ssment education as outlined in their PIP. gg a follow-up interview with the DON on 2/19 at 10.46 AM she stated agency staff had een included in the PIP wound in -servicing use the facility was not able to complete wound ssment education as outlined in their PIP. gg a follow-up interview with the DON on 2/19 at 10.46 AM she stated agency staff had een included in the PIP wound in -servicing use the facility was not able to complete wound ssment education as outlined in their PIP. gg a follow-up interview with the DON on 2/19 at 10.46 AM she stated agency staff had een included in the PIP wound in -servicing use the facility was not able to complete wound ssment education as control acility must establish and maintain an tion prevention and control program ined to provide a safe, sanitary and ortable environment and to help prevent the topment and transmission of communicable ises and infections. F 880 .80(a) Infection prevention and control am. .80(a) Infections prevention and control am. .80(a) Infections prevention, identifying, ting, investigating, and controlling infections communicable diseases for all residents, volunteers, visitors, and other individuals ding services under a contractual gement based upon the facility assessment ucted acacording to §483.70(e) and fo	AMEDICARE & MEDICAID SERVICES DERIOTES (X1) IDENTIFICATION NUMBER: A BULDING A BULDING A BULDING STREET ADDRESS. CITY, STATE, ZIP CODE NURSING & REHABILITATION CENTER STREET ADDRESS. CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD B REGULATORY OR LSC IDENTIFYING INFORMATION) PREIX Inued From page 109 F 867 he PIP in-servicing sign-in sheets, staff who tot attended wound in-servicing to the facility was not able to complete wound sament education as outlined in their PIP. F 867 training a planning on phasing cy staff had een included in the PIP wound in-servicing use the facility was not able to complete wound sament education as outlined on their PIP. F 880 staff out in the near future. F 880 sol Infection Control acility must establish and maintain an toin prevention & Control software and to help prevent the toppenent and transmission of communicable ses and infections. F 880 sol(a)(1)(2)(4)(e)(f) S0(a)(1) A system for prevention, identifying, ting, investigating, and controllaging services undre a contractual gement based upon the facility was sessment ucida essessment ucida (set) and following <td>OF HEALTH AND HUMAN SERVICES FORM NEDICARE & MEDICAD SERVICES OMB NO SIMEDICARE & MEDICAD SERVICES OMB NO CION (XI) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DITE COMB A BULDING </td>	OF HEALTH AND HUMAN SERVICES FORM NEDICARE & MEDICAD SERVICES OMB NO SIMEDICARE & MEDICAD SERVICES OMB NO CION (XI) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DITE COMB A BULDING

Facility ID: 100679

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345569	B. WING				22/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGBROOK NURSING & REHABILITATION CENTER					195 SPRINGBROOK AVENUE CLAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	2 110	F	880	D		
	procedures for the pro- but are not limited to: (i) A system of surveil possible communication infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco- resident; including bu (A) The type and dura- depending upon the in- involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in din §483.80(a)(4) A syste- identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand	lance designed to identify ole diseases or can spread to other in possible incidents of se or infections should be assission-based precautions ent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable kin lesions from direct is or their food, if direct ine disease; and procedures to be followed rect resident contact.					

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/27/20 MAPPROVE D. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345569	B. WING			C 02/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER			5 SPRINGBROOK AVENUE LAYTON, NC 27520		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 880	•	view. ıct an annual review of its	F	880			
	This REQUIREMENT by: Based on observatio interviews the facility a sanitary manner by of 2 sampled residen Resident #41). The f dirty linen in a sanitar Assistant (NA) was o dirty linen against her into the dirty linen roo Review of the Handlin 09/2014 revealed soi	The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced			The facility immediately put in measu to make prompt efforts to establish an maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections NA # 6, Nurse # 5 and Nurse # 6 were immediately re-educated and in-servic regarding infection control: handling o dirty linen. Dirty linen will be bagged to prevent contamination and removed to	d s. e all ced f	
	room for disposal. 1. A. In an observation at 11:14 AM soiled line between the wall and Resident #66's room. stated she had just prise and the linens on the had used. In an interview on 02. #5 indicated that NA is follow-up interview. In an interview on 02. stated that dirty linensity	on and interview on 02/18/19 hen was seen on the floor I the side of the bed in . Nursing Assistant (NA) #6 rovided care to the resident floor were the linens she /20/19 at 12:15 PM. Nurse #6 was unavailable for a /21/19 at 3:10 PM Nurse #4 s should be placed in a bag			soil utility room as soon as possible. The rooms of Resident #66 and #44 where the linen was temporarily place the floor during the delivery of residen care were immediately sanitized and cleaned by staff. A 100% in-service was initiated by the staff facilitator on 2/21/19 to include at staff to include RN s , LPN s and CNA s regarding following infection control policy specifically as it relates linen handling. In-service will be completed by 3/18/19.	d on t !	
		e floor. She indicated that vays available for NAs to put			Infection control process related to handling will be monitored by a QI infection control audit tool overseen by Assistant Director of Nursing, Unit	y the	

Facility ID: 100679

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	(X2) MULTIPLE CONSTRUCTION			
IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETE	ED			
		345569	B. WING		C 02/22/2	2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		2010	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		195 SPRINGBROOK AVENUE CLAYTON, NC 27520			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE CC	(X5) OMPLETION DATE	
F 880	In an interview on 02 Director of Nursing (I should be placed in a the room. She indica not be thrown on the because anything on transferred to the floo 1. B. In an observatia at 8:35 AM soiled line against the wall at the NA #7 was seen pick the floor and placing she should have plac a plastic bag and not stated she had a plas been in a hurry and h In an interview on 02 stated that dirty linen and not thrown on the plastic bags were alw the dirty linens in. In an interview on 02 Director of Nursing (I should be placed in a the room. She indica not be thrown on the because anything on transferred to the floo 2. In an observation #8 was seen walking up and unbagged soi touching her uniform. have placed the soile walking out of a resid	/22/19 at 9:14 AM the DON) stated that soiled linen a plastic bag and taken from ated that soiled linen should floor of resident's rooms the linen could be or. on and interview on 02/19/19 en was seen on the floor e foot of Resident #41's bed. ing up the soiled linen from it in a bag. She indicated the soiled linen directly in thrown it on the floor. She stic bag available but had had not used it. /21/19 at 3:10 PM Nurse #4 s should be placed in a bag e floor. She indicated that /ays available for NAs to put /22/19 at 9:14 AM the DON) stated that soiled linen a plastic bag and taken from thed that soiled linen should floor of resident's rooms the linen could be	F 88	Managers, or designee. Au utilized 3 times a week x 4 v weekly x 4 weeks, then mor month. Any staff member to RN s, LPN s and CNA s immediately be retrained an by the auditor for any identific concern. The Director of Nu designee is responsible and the Infection Control audit to completion to ensure all are were addressed weekly x s monthly x 1 month. The Executive QI committee review the Infection Control monthly x 3 months to deter and trends to include contin monitoring frequency.	veeks, then thly x 1 o include the will d re-educated ied areas of ursing or will review tools for as of concern as of concern as weeks and e will meet to audit tool mine issues		

Facility ID: 100679

If continuation sheet Page 113 of 114

	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 03/27/2019 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		. ,	E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		345569	B. WING			C 02/22/2019
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
SPRINGB	ROOK NURSING & REH	ABILITATION CENTER		95 SPRINGBROOK AVENUE CLAYTON, NC 27520	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 880	but she did not have of soiled linen from the r In an interview on 02/ stated that dirty linens plastic bag and not ca She indicated that pla available for NAs to p In an interview on 02/ Director of Nursing (D should be placed in a the room. She indica	one when she removed the room. (21/19 at 3:10 PM Nurse #4 is should be placed in a arried against the uniform. astic bags were always but the dirty linens in. (22/19 at 9:14 AM the DON) stated that soiled linen plastic bag and taken from ted that soiled linen should ged and against the uniform the linen could be	F 880			