STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 2/18/19 through 2/22/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OUHB11.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint survey was conducted from 2/18/19 through 2/22/19. Substandard Quality of Care was identified at: CFR 483.12 at tag F600 at a scope and severity (H). CFR 483.25 at tag F686 at a scope and severity (H).	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		3/18/19

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

Electronically Signed | 03/18/2019

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F 580	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 (Resident #188) reviewed for pressure ulcers. On 02/08/19 home health services assessed the pressure ulcer to Resident #188's right heel as being a stage III wound measuring 2 x 2 x 0.5 cm with drainage. Findings included:	F 580	Springbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a	

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F 580	Continued From page 2 Resident #188 was admitted to the facility on 11/07/18 and had diagnoses of dementia without behaviors, insomnia and chronic kidney disease. Review of the Nursing Notes from 11/28/18 to 02/07/19 revealed no documentation of the physician being notified of Resident #188's heel wound. Review of the Flowsheet of Non-Ulcer Skin Conditions dated 11/28/18, completed by the nursing home's Wound Care Nurse (WCN), revealed Resident #188 had a pink ruptured right heel blister. There was no pain or infection present. There were no measurements of the wound and no description of the area surrounding the wound. The treatment was to apply betadine and a transparent film dressing every other day. There was no physician notification date on the form. Review of the Physician's Orders dated 11/28/18, written by the nursing home's WCN, revealed a verbal order to cleanse Resident #188's right heel with Normal Saline, apply betadine, and then cover with a transparent dressing with foam every other day for a ruptured blister. The order was initialed by the physician on 12/04/18. Review of the Care Plan initiated on 11/29/18 revealed a ruptured blister had been noted on Resident #188's right heel. The goal was for the ruptured blister to heal without complications through the next review. Interventions included to keep pressure off of the right heel and to perform treatments as ordered and to notify the physician of any changes.	F 580	written allegation of compliance. Springbrook Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Springbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. The facility immediately put in measures to inform the resident, consult with the resident□s physician, and notify the resident representative when there is a change in the resident□s status that requires such notification. A 100% audit of all nursing progress notes for the period of 2/15/19 through 3/15/19 was completed by 3/18/19 by the Staff Facilitator, Director of Nursing or designee. The audit identified any resident with a change in condition where the physician and responsible party were not consulted/notified. A 100% in-service to all licensed nurses and certified nursing assistants on notification of resident changes was initiated on 2/18/19 by the Staff Facilitator, Director of Nursing or designee and will be completed by 3/19/19. The in-service focused on changes in the resident□s status related to accidents resulting in	

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F 580	Continued From page 3 Review of the Physician Progress Note dated 12/04/18 revealed no mention of Resident #188's ruptured right heel blister. Review of the Physician Progress Note dated 12/12/18 revealed no mention of Resident #188's ruptured right heel blister. Review of the Flowsheet of Non-Ulcer Skin Conditions dated 01/03/19, completed by the nursing home's WCN, revealed Resident #188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and a transparent film dressing with foam every other day. There was no physician notification date on the form. Review of the Physician Progress Notes dated 01/17/19 revealed no mention of Resident #188's ruptured right heel blister. Review of the Flowsheet of Non-Ulcer Skin Conditions dated 01/23/19, completed by the nursing home's WCN, revealed Resident #188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and transparent film dressing with foam every other day. There was no physician notification date on the form. Review of the Physician Progress Notes dated 01/29/19 revealed no mention of Resident #188's ruptured right heel blister.	F 580	injury and has the potential to require physician intervention, significant changes in the resident□s physical, mental, or psychosocial status, a need to alter treatment significantly, and a decision to transfer/discharge a resident from the facility. All newly hired licensed nurses and certified nursing assistants will be in-serviced on notification of resident changes. Notification of resident change in status will be monitored through the facility□s Interdisciplinary Team (IDT) process using QI tools by the Assistant Director of Nursing, Unit Manager or designee. Progress notes, 24 hour sheets, IDT observations, and physician orders will be reviewed 3 times per week for 4 weeks for a total of ten residents, then 3 times per week for 4 weeks for a total of 5 residents, then monthly times 1 month for 5 residents. The licensed nurses and certified nursing assistants will be immediately re-trained by the auditor for any identified areas of concern. The Director of Nursing or designee is responsible and will review and initial the QI tool for completion to ensure all areas of concerns were addressed. The Executive QI committee will meet to review the notification of changes QI tool monthly times 3 months to determine issues and trend to include continued monitoring frequency.	

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F 580	Continued From page 4	F 580		

Review of the Flowsheet of Non-Ulcer Skin Conditions dated 01/31/19, competed by the nursing home's WCN revealed Resident #188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and transparent film dressing with foam every other day. There was no physician notification date on the form.

Record review revealed Resident #188 was discharged from the facility to home with Home Health on 02/07/19.

Review of the Home Health Comprehensive Adult Assessment dated 02/08/19 revealed Resident #188 had a stage 3 pressure wound on the right heel. The wound measured 2cm by 2cm and was 0.5cm deep. There was full thickness skin loss involving damage or necrosis of subcutaneous tissue. There was a small amount of thin, watery, pale, red/pink drainage from the wound. The wound bed was pink with less than 25% of the wound covered with epithelial tissue. The skin color surrounding the wound was normal for the resident.

In an interview on 02/20/19 at 1:55 PM the nursing home's WCN indicated Resident #188 had a fluid filled blister on the bottom of the right heel 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 but it was not there on admission. She indicated that a ruptured blister would be considered a stage 2 pressure wound.

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F 580	Continued From page 5	F 580		

The WCN 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 stated that she had not notified Resident #188's physician regarding the ruptured blister but she had begun a treatment using the standing orders. She indicated she did not perform a skin assessment when Resident #188 was discharged from the facility because she was not aware the resident was being discharged.

In an interview on 02/20/19 at approximately 1:20 PM the Assistant Director of Nursing (ADON) verified that she supervised the nursing home's WCN and indicated that she had started working at the facility on 01/02/19 which was after the wound was discovered and so she had not notified the physician of the wound.

In a telephone interview on 02/21/19 at 11:37 AM Physician #2 stated he was aware that Resident #188 had had a wound on the ankle but was unaware that there was a wound on the right heel. He indicated if the wound had started as a blister and then ruptured he would expect a weekly wound assessment with measurements. The physician indicated that the facility had not notified him of the wound and he did not remember initialing any orders for treatment.

In a follow-up interview on 02/21/19 at 1:45 PM the nursing home's WCN stated the physician's order that was written on 11/28/18 as a verbal order was actually from the standing orders and that she had not spoken to the physician regarding the heel wound at the time of the occurrence or when the blister first occurred

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F 580	Continued From page 6 because she did not know when that happened. However, she stated since the physician had initialed the order on 12/04/18 that served as 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.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		3/18/19

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F 585	Continued From page 7 to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to	F 585		

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F 585	Continued From page 8 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to complete a written grievance for 1 of 2 residents reviewed for grievances and failed to maintain written records of grievances completed for 1 of 2 resident	F 585	The facility immediately put in measures to make prompt efforts to complete and maintain a written record of grievances the resident may have and issue a grievance summary to the resident.	

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F 585	Continued From page 9 reviewed for grievances. (Resident #76 and Resident #189). Findings Included: 1). Resident # 76 was admitted to the facility on 8/21/17. Her diagnosis included; Kidney Failure, History of Falls, Muscle Weakness, and Dementia. The Minimum Data Set (MDS) dated 11/18/18 and coded as an annual assessment indicated Resident #76 had clear speech, with moderately impaired cognition. She exhibited no rejection of care. She required extensive two-person physical assist with bed mobility, transfers, and activities of daily living. An interview was conducted on 2/18/19 at 1:00 PM with Resident #76's family member. She stated she visited most days and if not her another family member would visit to assure care needs were being met. She voiced a concern with lack of staffing on the unit. She stated there were many incidents in which there was only one nursing assistant assigned on the unit. She stated she had voiced this concern with the Administrator, and with the Vice President over the phone, and the concerns were still ongoing. She stated she had received no resolution from the facility. A review of the facility grievance log from September 2018 through February 2019 revealed two grievances were filed for resident #76. On 1/28/19 a grievance was filed regarding a diet order and on 11/6/18 regarding a room change. No grievance was filed for resident #76 regarding insufficient staffing.	F 585	The facility completed a grievance form to record the grievance for resident #76 and shared results with family member expressing the concern. The facility completed a grievance form to record the grievance that was originally misplaced for resident #189. The grievance was placed in the grievance log and properly recorded. A 100% in-service to all staff on the grievance process was initiated on 2/26/19 by the Staff Facilitator and will be completed by 3/18/19. The in-service focused on ensuring that all grievances are completed on a grievance form, investigated, have results shared with the resident or residents representative, and have a written record in the grievance log. All newly hired staff will be in-serviced on the facility□s grievance policy and process for resolving. Resident grievances will be monitored through the facility□'s Interdisciplinary Team (IDT) process using the Resident Concern QI tools by the Social Services Directors, Director of Nursing, Assistant Director of Nursing, Unit Manager or designee. The Nursing Home Administrator will review the grievance QI tool for completion to ensure all areas of concerns were addressed weekly times 4 weeks and monthly times 2 months. The pertinent staff will be immediately re-trained by the auditor for any identified areas of concern.	

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F 585	Continued From page 10 An interview was conducted on 2/20/19 at 12:08 PM with the Director of Nursing. She stated she was aware of resident #76's concern regarding insufficient staffing. She stated she was not aware if a grievance was filed for the resident. An interview was conducted on 2/22/19 at 11:35 AM with the Administrator. He stated he was the facility grievance official. He stated many of the concerns voiced from family members he considered to be a conversation and therefore he didn't always document as an official grievance. He agreed that resident #76's family member had addressed concerns to him regarding lack of staffing on the unit and agreed that he didn't document the concern as an official grievance. He stated that he would follow up with the residents' family member immediately to resolve her concerns. 2) Resident #189 was admitted to the facility on 12/20/18. Her active diagnoses included fracture of the phalanx of the right little finger, and lymphedema. Review of Resident #189's minimum data set assessment dated 12/27/18 revealed the resident was assessed as cognitively intact. Review of the grievance log for the facility from September 2018 through February 2019 revealed there were no grievances logged by the facility for Resident #189. During an interview on 2/20/19 at 3:41 PM Nurse Aide #1 stated Resident #189 told him one day that some of the nurse aides were nasty to her.	F 585	The Executive QI committee will meet to review the notification of changes QI tool monthly times 3 months to determine issues and trend to include continued monitoring frequency.	

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F 585	Continued From page 11	F 585		

He further stated when he was informed of this he reported the concern to the on-staff nurse whom he could not remember who it was. Nurse Aide #1 stated he did not complete a grievance but reported it. He further stated the nurse then went to the Administrator who went and spoke with the resident about her concerns. He further stated within ten minutes of him being told by Resident #189 about the concern he saw the Administrator speak with Resident #189 about the concern.

During an interview on 2/21/19 at 8:06 AM the Administrator stated the grievance log had all the grievances he had received for all residents. He further stated he had no other grievances for Resident #189 that would not be listed on the grievance log and he was the grievance official for the facility.

During an interview on 2/21/19 at 10:08 AM the Administrator stated he was introduced to Resident #189 because the family member called and left a message on his phone requesting to meet with him with Resident #189. He further stated Resident #189 shared concerns with him about food preference. The Administrator stated he requested the dietary manager follow up on the concern and from that period forward there were no additional food preference concerns. He stated in addition she voiced a question about some moisture that had been coming from the air conditioning system. He offered her the opportunity to move but she preferred that unit and the staff on that unit. The moisture had probably come from condensation off the coils. He further stated he then had it checked out by maintenance and there were no issues identified. Resident #189 further informed him she saw an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 12	F 585		

ant and he asked where the ant was at and she said it was on the floor. The Administrator stated he saw no signs of pests, but the former maintenance guy treated the grounds and used an approved odorless ant bait outside on the grounds. The Administrator stated he called in a professional to treat around the building and there were no more concerns related to moisture or about ants in the facility. The Administrator stated her final concern was that at times it could take an extended period for staff to meet her needs. He further stated Resident #189 never told him how long it took to wait but only stated it took a long time for them to respond to her call bell. He further stated he asked if it happened all the time and she said it happened sometimes. Resident #189 informed him it was at random times and during meal times. He further stated he then told her on her unit at any given time there can be multiple people who require multiple needs, and sometimes she may be the first one and sometimes she may be the last one. The Administrator stated Resident #189 told him she understood that. He stated he did not complete a grievance form for Resident #189 once the family had contacted him about the concerns. He further stated with her multiple grievances he thought there was a grievance form completed. He concluded he did not know why her name was not on the grievance log as well.

Review of the grievance binder on 2/21/19 at 10:30 AM with the Administrator and Social Worker revealed there were no grievances for Resident #189.

During an interview on 2/21/19 at 10:37 AM Social Worker #1 stated grievance forms were completed and once they had been resolved the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 585	Continued From page 13 grievance forms went into the grievance binder. She concluded because the resident was now discharged, any grievances should have been in the grievance binder and did not know why there were none. She concluded she did not have a record of the grievances completed for Resident #189.	F 585		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, and record review the facility neglected 3 of 3 sampled residents (Resident #48, #62, and #188) reviewed for pressure ulcers by failing to complete initial and weekly wound assessments for these residents. No initial or weekly wound assessments (which included measurements and descriptions of the wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain) were	F 600	Residents #62 and #188 are discharged 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.	3/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14 completed for Resident #48's right heel ulcer from 12/16/18, when it was identified, until 01/08/19. The facility neglected to expedite a wound center consult for Resident #48 which was documented as being requested by the facility on 01/08/19 for a deep tissue injury (DTI) to the resident's right heel. The facility failed to apply a dressing in accordance with the facility's wound care management of DTIs to Resident #48's right heel pressure ulcer. The facility failed to off-load Resident #48's heels from the bed as recommended by the wound center and implemented by the physician. On 01/08/19 the pressure ulcer to Resident #48's wound presented with yellow/green purulent drainage, and was painful. When Resident #48 was seen at the wound clinic on 01/30/19 the pressure ulcer to the resident's right heel, which the facility documented was a DTI and then as stage II wound, was identified as an unstageable pressure ulcer with slough and eschar in the wound bed and a moderate amount of drainage. No initial or weekly pressure ulcer assessments (which included measurements and descriptions of wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain) were completed for Resident #188 from 11/28/18, when a blister opened on her right heel, through her discharge from the facility on 02/07/18. On 02/08/18 home health services assessed the pressure ulcer to Resident #188's right heel as being a stage III wound measuring 2 x 2 x 0.5 centimeters (cm). A skin referral was submitted for Resident #62 on 01/06/19 due to a painful stage II wound to the resident's left heel. The initial wound assessment was not completed for Resident #62 until	F 600	The facility initiated education on 2/20/19 for all nurses and aides regarding communication of changes in skin condition and notifying nursing. On 2/18/19 nurses were additionally educated that they must document changes to reflect change in cognition, behaviors and physical conditions. All education was completed by 3/18/19. On 3/13/19 the director of nursing, assistant director of nursing, staff facilitator, and quality improvement nurse completed a 100% skin audit to ensure all resident skin issues were identified, assessed, and with proper documentation and treatment/interventions were in place. 100% in-service to all staff, including licensed staff and certified nursing assistants, was initiated on freedom of neglect with a focus on treatment/services 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/neglect audit tool by the staff facilitator, unit manager, assistant director of nursing, or designee. The audit tool will be used three times a week for four weeks, then weekly for four weeks then monthly for one month. The director of nursing or designee will review and initial the audit tool for completion to ensure all areas of abuse/neglect concerns are addressed. The Executive QI committee will meet to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15 01/16/19 when it was found with dried drainage, and was painful to touch and movement. Findings included: 1. a. 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. A 12/16/18 skin referral form documented, "Description: necrotic area" and "Observer: staff." The form documented there was a necrotic area to the inner aspect of Resident #48's right heel. The staff member who created the skin referral was unable to be identified. On 12/20/18 the facility's Treatment Nurse documented on the skin referral form that Resident #48 had a "right heel DTI (deep tissue injury)". A 01/08/19 QA (Quality Assurance) Skin Wound Review documented the DTI to Resident #48's right heel measured 4.5 cm by 3.5 centimeters (cm), had yellow/green purulent drainage, and was painful. Orders were provided for a wound center consult. A 01/08/19 physician order started Resident #48 on Doxycycline (antibiotic) 100 milligrams twice daily (mg BID) x 7 days for right heel cellulitis (review of the resident's Medication Administration record revealed the antibiotic was administered as ordered). A 01/10/19 Wound Ulcer Flowsheet, completed by the facility's Treatment Nurse, documented Resident #48 had a suspected DTI to her right	F 600	review the abuse/neglect audit tool monthly for three months to identify issues and/or trends, including the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

heel which developed in the facility and measured 4.5 x 3.5 x 0.5 cm.

A 01/18/19 Wound Ulcer Flowsheet (the last facility assessment of Resident #48's right heel ulcer prior to being seen by the wound center) documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 4.5 x 3.5 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no tunneling or undermining, and no odor. The wound bed was described as purple/pink.

A 01/30/19 wound center consult documented Resident #48 presented to the clinic with an unstageable pressure ulcer on the right heel which measured 2.5 x 1.5 x 0.2 cm. The wound bed was described as tan/yellow with a mixture of slough and eschar and a moderate amount of drainage. The wound was debrided.

Wound Ulcer Flowsheets were completed by the facility's Treatment Nurse for Resident #48 on 01/31/19 and 02/08/19. They documented Resident #48 had a stage II pressure ulcer to her right heel which measured 4 x 3 x 0.5 cm, and presented with no drainage and no slough or eschar in the wound bed.

A 02/13/19 wound center consult documented Resident #48 presented to the clinic with an unhealed pressure ulcer on the right heel which measured 2 x 2 x 0.3 cm. The wound bed was described as yellow/pink with 76 - 100% slough and 1 - 25% granulation tissue. A moderate amount of yellow drainage was documented, and the wound was debrided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

A 02/13/19 physician order started Resident #48 on Keflex (antibiotic) 500 mg three times daily (TID) x 10 days for possible infection to the right heel ulcer.

A 02/18/19 Wound Ulcer Flowsheet documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 1.5 x 1 x 0.25 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no pain, no tunneling or undermining, and no odor. The wound bed was described as red/slough.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated she could not remember the size of the right heel wound when she viewed it on 12/20/18, but she commented the area was not necrotic. She reported that the wound presented as a DTI instead. She stated DTIs did not have depth, and were usually purple/burgundy in color. According to the WCN, she was supposed to document wound measurements, description of wound bed, and presence of drainage, odor, tunneling/undermining, pain, necrosis, and infection during her initial and weekly wound assessments, but she could not explain why it took until 01/10/19 for her to provide this documentation for Resident #48.

During an interview with the Director of Nursing (DON) on 02/19/19 at 4:18 PM she stated once a skin referral was received her expectation would be that the facility's Treatment Nurse assess that wound within 24 - 48 hours. She reported this assessment should include measurements,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

description of wound bed, drainage, odor, tunneling and undermining, pain, and possible necrosis or infections. She commented wounds should be assessed per the facility policy which was weekly and as needed.

On 02/20/19 at 10:34 AM an observation of Resident #48's right heel pressure ulcer was made with the facility's Treatment Nurse and Assistant Director of Nursing (ADON). The Treatment Nurse stated Silvasorb was currently being used to treat the resident's heel ulcer since it was an anti-microbial gel, and the resident was now on her second round of antibiotics to treat wound infection. The right heel wound bed was light pink to bright pink with a small amount of tan slough, and there was no odor. The Treatment Nurse stated she estimated measurements of the wound to be 1.5 x 1.2 x 0.2 cm.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated he expected wounds to be assessed, if not on the day they were found, no later than the next business day. He reported measurements and description of the wound bed were important pieces of information, but the most important thing was for the Treatment Nurse to use her expertise to diagnose what type of wound the resident had (such as a DTI, pressure wound, venous/stasis wound). He reported after the initial assessment the wound needed to be assessed every 7 - 10 days or more often if significant changes in the wound were noted. He stated he did his initial visit with the resident at the end of December (12/30/18). He commented if he remembered correctly he thought the wound presented as a DTI. On 01/09/19 Physician #1 stated Resident #48's right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

heel ulcer had changed, and he started the resident on an antibiotic due to purulent drainage. Physician #1 commented purulent drainage could develop quickly because infection could rise to the surface within even 24 hours. He reported he did not order wound cultures, and did not consider them to be a valid tool in treating wounds.

During a follow-up interview with the facility's Treatment Nurse on 02/22/19 at 9:08 AM she stated in her experience the development of slough and eschar was a gradual process, not one that occurred over night. She reported she saw no slough or eschar in Resident #48's wound before the resident's 01/30/19 wound consult, but commented she missed assessments of the wound between 12/20/18 and 01/10/19.

During a telephone interview on 2/22/19 at 11:50 AM Wound Center Nurse #1 stated slough and eschar did not develop in a 1 - 2 day period, but she had seen instances where small amounts of slough/eschar were removed from a wound bed one week, and when the patient returned a week later for a follow-up, there was slough in the wound bed again.

1. b. 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.

A 01/08/19 QA (Quality Assurance) Skin Wound Review documented the DTI to Resident #48's right heel measured 4.5 cm by 3.5 centimeters (cm), had yellow/green purulent drainage, and was painful. Orders were provided for a wound center consult.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

A 01/09/19 physician progress note written by Physician #1 documented, "Patient seen for heel decubitus. This continues to worsen and now needs surgical evaluation, patient confirms it is painful. Assessment and Plan: right heel ulcer: patient continues to worsen and now needs surgical evaluation. Will set up wound clinic referral."

A 01/10/19 Wound Ulcer Flowsheet documented under Comments, "wound clinic referral".

A 01/18/19 Wound Ulcer Flowsheet (the last facility assessment of Resident #48's right heel ulcer prior to being seen by the wound center) documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 4.5 x 3.5 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no tunneling or undermining, and no odor. However, it was documented the resident experienced pain with his dressing changes. The wound bed was described as purple/pink.

Resident #48's initial wound center consult on 01/30/19 documented she presented to the clinic with an unstageable pressure ulcer on the right heel which measured 2.5 x 1.5 x 0.2 cm. The wound bed was described as tan/yellow with a mixture of slough and eschar and a moderate amount of drainage. The wound was debrided.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated the facility primarily utilized one wound clinic for those patients who needed wound referrals to an outside source. She reported she usually got a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

resident seen at this wound clinic within a couple of days. She commented at the latest, if she could not get a resident into this wound center on the week the referral was made, she was able to set up an appointment early the following week. The Treatment Nurse was unable to explain why it took so long to get Resident #48 seen at the wound clinic, with a wound consult requested on 01/08/19 and the resident not seen until 01/30/19.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated when he observed the resident's right heel ulcer on 01/09/19 he thought the wound had changed. He explained he felt the purulent drainage was an indication of infection, and started the resident on an antibiotic. He commented he also recommended a surgical consult for debridement. 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. 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 from 12/21/18 until 01/30/19 the resident's treatment for the right heel pressure ulcer (classified as a DTI by the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

between 12/20/18 and 01/18/19 and documented as having no slough/eschar or drainage present between 01/18/19 and a 01/30/19 wound center consult) was calcium alginate applied topically every other day. (The facility's Wound Care Manual, version dated 05/22/18, documented treatment for a DTI was "1) Cleanse wound with normal saline solution or appropriate wound cleansing solution. Apply skin sealant and allow to dry thoroughly. Complete daily. 2) May also cover with a foam dressing after cleansing with normal saline solution or appropriate wound cleansing solution. Check dressing daily, change every other day and prn (as needed).") It was unclear who was responsible for ordering the calcium alginate to treat Resident #48's right heel wound.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she reported that the standing orders for DTI treatment included skin prep and protective booties to the heels. She was unable to explain why calcium alginate was used to treat Resident #48's right heel wound which was classified as a DTI between 12/21/18 and 01/18/19 and was documented as having no slough/eschar or drainage before the initial wound center consult on 01/30/19.

On 02/20/19 at 10:34 AM the Assistant Director of Nursing (ADON) stated she thought calcium alginate was used for debridement and was usually discontinued as the wound healed. She reported she did not think calcium alginate would be appropriate for treating a DTI.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated skin prep or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

betadine were the most frequently used treatments for DTIs. He also reported that calcium alginate had absorptive properties, and was typically utilized in wounds with drainage which contained slough. He commented he was unsure why the facility would have been using calcium alginate if a wound was truly a DTI and if a wound did not have slough or eschar in it.

1. d. 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.

A 12/16/18 skin referral form documented Resident #48 had a pressure ulcer to the inner aspect of her right heel, and the intervention was to "float heels on pillow".

A 01/08/19 QA (Quality Assurance) Skin Wound Review documented the wound to Resident #48's right heel measured 4.5 cm by 3.5 centimeters (cm), had yellow/green purulent drainage, and was painful. Foam booties were applied to bilateral heels, and the resident's heels were elevated on a pillow.

On 01/31/19 wound center recommendation for Resident #48 to "Keep heel off bed. Offload please!!" was implemented via physician order.

A 02/15/19 physician order documented, "Keep heel off loaded, float with no contact with bed."

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated there were many factors which entered into the unhealed status of Resident #48's heel ulcer which included difficulty keeping the protective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

booties on the resident's heels.

On 02/20/19 at 10:34 AM an observation of Resident #48's right heel pressure ulcer was made with the facility's Treatment Nurse and Assistant Director of Nursing (ADON). An attempt was made to engage the resident in meaningful conversation, but the resident was unable to participate. Resident #48 was found in bed with her right heel on the bed, resting on the sheet. The sheep skin bootie was not covering the resident's right heel, but was up around the resident's right ankle. A sheep skin bootie was covering the resident's left heel, and a fluffy sock covered the resident's left foot. There was no sock on the resident's right foot. There were no pillows in the bed or under the resident's legs for off-loading. As the ADON was leaving the resident's room, she picked up a pillow without a pillow case from furniture in the room, and stated that once a pillow case was applied, the pillow then needed to be placed under the resident's legs.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated the most important thing for treatment of a DTI on the heels was to off-load pressure exerted on the heels. He explained there could be things going on underneath the skin of a DTI so it was important to ensure a good blood supply to the wound by off-loading. He stated one of the most effective and easiest way to off-load pressure was to place a pillow behind the calves and apply bunny boots.

During an interview with Nursing Assistant (NA) #3 on 02/20/19 at 3:05 PM she stated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

#48 was supposed to have two pillows under her legs and fluffy socks and sheep skin boots on both feet to protect the heels. She commented she had not had a problem finding these interventions in place when she started her first shift rounds. According to NA #3, she had not seen a problem with the resident's heel booties coming off. She was unable to explain why Resident #48 was without some of these interventions when the wound observation was completed on 02/20/19 (she was assigned to care for the resident on first shift that morning).

During an observation 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 was a pillow with a pillow case which was at the bottom of the bed, but not under the resident's legs. The heels, covered by sheep skin booties, were on the bed. At this time NA #5 stated she worked third shift, but stayed over this morning. She commented she had been told by the nurse that the resident was supposed to have socks and booties on both feet, and a pillow was supposed to be under the resident's legs. She reported she could not say for sure but she felt like the resident had the pillow under her legs when she checked on her before 7:00 AM on 02/21/19. She stated the resident sometimes kicked the pillow out from under her legs.

During an interview with Nurse #4 on 02/21/19 at 8:52 AM she stated Resident #48 was supposed to have bunny boots on and a pillow under her legs, but the resident would not always tolerate the boots and pillow. She reported that if she explained to the resident why it is important to utilize these interventions the resident was more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26	F 600		

apt to comply.

During an interview with Nurse #8 on 02/21/19 at 4:51 PM she stated Resident #48 was to wear bunny boots all the time when in bed, although the resident did not always to keep them on because she did not like things touching her body. Nurse #8 stated the staff had to check on Resident #48 more frequently to make sure the booties stayed in placed.

During an observation on 02/22/19 at 8:14 AM Resident #48 was awake in bed. She had socks and booties on both feet. There was a pillow at the bottom of bed, but the resident's legs were not elevated by a pillow. The resident's feet were crossed with the right heel resting on top of the left foot.

During an interview with the DON on 02/22/19 at 10:46 AM she stated Resident #48 was supposed to have sheep skin boots covering her heels and pillows under her legs for off-loading. However, she commented keeping these interventions in place was difficult for this resident because of her compromised cognition, impulsiveness, and occasional combative behavior. She commented there were problems keeping the boots on the resident, but the resident had periods of alertness so she could be educated during these periods about the importance of keeping the boots on and keeping the pillows under her legs. The DON also remarked that the staff needed to check on the resident more frequently.

2. Resident #188 was admitted to the facility on 11/07/18 and had diagnoses of dementia without behaviors, insomnia and chronic kidney disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27	F 600		

Resident #188 was discharged home with Home Health on 02/07/19.

Review of the Physician's Orders dated 11/28/18 revealed a verbal order to cleanse Resident #188's right heel with Normal Saline, apply betadine, and then cover with a transparent dressing with foam every other day for a ruptured blister.

Review of the Flowsheets of Non-Ulcer Skin Conditions dated 11/28/18, 01/03/19, 01/23/19, and 01/31/19 revealed Resident #188 had a pink ruptured right heel blister. There was no pain or infection present. There were no measurements of the wound and no description of the area surrounding the wound. The treatment was to apply betadine and a transparent film dressing every other day. There was no physician notification date on the form.

Review of the Care Plan initiated on 11/07/18 and revised on 11/29/18 revealed Resident #188 was at risk for skin breakdown and the development of pressure wounds. The goal was for Resident #188 to not develop any skin breakdown or pressure wounds through the next review. Interventions included to encourage Resident #188 to change position frequently and to observe the skin daily for any abnormal changes.

Review of the Care Plan initiated on 11/29/18 revealed a ruptured blister had been noted on Resident #188's right heel. The goal was for the ruptured blister to heal without complications through the next review. Interventions included to keep pressure off of the right heel and to perform treatments as ordered and to notify the physician of any changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

Review of the quarterly Minimum Data Set (MDS) dated 02/01/19 revealed Resident #188 was at risk for but did not have a pressure wound. Resident #188 was cognitively intact and needed the extensive assistance of one person for bed mobility, dressing, and hygiene.

Review of the Home Health Comprehensive Adult Assessment Dated 02/08/19 revealed Resident #188 had a stage 3 pressure wound on the right heel. The wound measured 2cm by 2cm and was 0.5cm deep. There was full thickness skin loss involving damage or necrosis of subcutaneous tissue. There was a small amount of thin, watery, pale, red/pink drainage from the wound. The wound bed was pink with less than 25% of the wound covered with epithelial tissue. The skin color surrounding the wound was normal for the resident.

In an interview on 02/20/19 at 12:32 PM Physician #1 (Medical Director) stated that the most important thing for prevention of heel pressure wounds was to offload the heels and keep pressure off of them.

In an interview on 02/20/19 at 1:55 PM the Wound Care Nurse (WCN) indicated Resident #188 had a fluid filled blister on the bottom of the right heel 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 stated that a ruptured blister would be considered a stage 2 pressure wound. The WCN indicated that a pressure wound should be assessed weekly and should include measurements,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29	F 600		

staging, if there was drainage, any signs of infection, the presence of an 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. She stated that the floor nurses would do the treatments but would not perform the required assessments leaving them for her to do on her return to the WCN role. The WCN admitted there was missing documentation for Resident #188's wound. The WCN stated she knew there had been problems with the weekly assessment of wounds and she was now trying to be more proactive with the scheduling of assessments. She indicated she did not perform a skin assessment when Resident #188 was discharged from the facility because she was not aware the resident was being discharged. She indicated that if she had known about the discharge she would have written a note to the home health agency about the wound.

In an interview on 02/20/19 at approximately 2:20 PM the ADON stated she had only been working in the facility since 01/02/19. She verified that she supervised the WCN and stated that in an ideal world pressure wounds would be assessed and documented weekly.

In a telephone interview on 02/21/19 at 11:37 AM Physician #2 stated he was aware that Resident #188 had had a wound on the ankle but was unaware that there was a wound on the right heel. He indicated if the wound had started as a blister and then ruptured he would expect a weekly wound assessment with measurements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30	F 600		

In a follow-up interview on 02/21/19 at 1:45 PM the WCN stated the physician's order that was written on 11/28/19 as a verbal order was actually from the standing orders and that she had not spoken to the physician regarding the heel wound.

In an interview on 02/21/19 at 2:45 PM Nursing Assistant (NA) #2, who had worked with Resident #188, stated she was not sure when the resident developed the blister on the right heel. She indicated she looked at each resident's skin daily with care and reported any abnormal findings to the nurse. NA #2 indicated that after Resident #188 got the wound on her heel she wore a soft "bunny" boot on her right foot when she was in bed.

In an interview on 02/21/19 at 4:31 PM NA #9 indicated that when Resident #188 was first admitted she was only able to get up with therapy. She stated that in time Resident #188 progressed to being able to get up with two people and then one person. NA #9 indicated that Resident #188 wore a "bunny" boot on her right foot when she was in the bed and did not recall when the blister on her heel appeared or when it ruptured.

In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) indicated that she expected the assessment of a pressure wound to include measurements, a description of the wound bed, and if any signs of infection were noted such as purulent drainage or odor so that the facility could track if the wound was improving. She indicated she expected the wound to be assessed and documented weekly. She indicated she expected the WCN to notify the physician of any wounds a resident acquired in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31	F 600		

the facility so the physician could decide if standing orders were appropriate or if they wanted a different treatment.

3. Resident #62 was admitted to the facility on 1/4/19. His active diagnoses included displaced intertrochanteric fracture of the left femur, hypertension, heart failure, muscle weakness, and chronic obstructive pulmonary disease.

Review of Resident #62 ' s admission skin assessment and referral form dated 1/4/19 revealed Resident #62 had a left hand and left knee cap skin tear as well as a left hip wound. There were no pressure ulcers to Resident #62 ' s left heel identified upon admission. This skin referral was locked on 1/10/19 and signed as reviewed by the Wound Care Nurse.

Review of a nurse's note dated 1/6/19 revealed the nurse noted a pressure ulcer noted to Resident #62's left heel. A skin referral was completed and new orders for bunny boots while in bed and to keep left heel elevated on pillows.

Review of a physician's progress note dated 1/6/19 revealed the physician documented Resident #62 had a left heel pressure ulcer and he wished to have the wound care nurse provide a consult and avoid pressure to the heel.

Review of a skin referral form dated 1/6/19 revealed the nurse documented a new ulcer to the left heel. A new order was made for bunny boots to the left heel and elevate the heel in bed. This skin referral was locked (meaning the referral would no long be on reports run by the Wound Care Nurse) on 1/6/19 and not signed as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 32	F 600		

reviewed by the Wound Care Nurse.

Review of a physician's order dated 1/6/19 revealed the physician ordered for the wound care nurse to evaluate a stage II pressure ulcer to Resident #62's left heel.

There were no wound assessments documented between 1/6/19 and 1/16/19.

Review of a nurse practitioner progress note dated 1/7/19 revealed Resident #62 had bilateral bunny boots in place and had heel pain. The left heel pain was greater than the right heel pain.

Review of a physician ' s progress note dated 1/9/19 revealed Resident #62 had bilateral bunny boots in place and had heel pain with the left heel pain greater than the right heel pain.

Review of a nurse practitioner progress note dated 1/14/19 revealed Resident #62 had bilateral bunny boots in place and bilateral heel pain. The left heel pain was greater than right heel pain. Left heel stage II pressure ulcer noted with old drainage noted to the inside of the bunny boot. The wound was painful to the touch and with minimal movement. The plan was for the stage II pressure ulcer to continue being followed by the wound nurse and pain controlled with as needed pain medication.

Review of a physician ' s progress note dated 1/16/19 reveled Resident #62 had bilateral bunny boots in place. The left heel was noted to have a stage II pressure ulcer with old drainage noted to the inside of the bunny boot. Pain was present to the ulcer with movement and to touch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 33	F 600		

Review of the physician orders revealed on 1/16/19 Resident #62 was ordered betadine and adhesive dressing with foam every other day to the stage II pressure ulcer on the left heel.

Review of a wound flowsheet dated 1/16/19 revealed the resident had an in-house stage II pressure ulcer to his left heel which measured 3 centimeters by 1 centimeter. The ordered treatment was to apply betadine and an adhesive dressing with foam every other day.

Review of Resident #62's January 2019 treatment record revealed Resident #62's order for betadine and adhesive dressing with foam was not initialed as being performed until 1/19/19.

Review of the Resident #62 ' s care plan dated 1/17/19 revealed the resident was care planned for a pressure ulcer to his left heel. The interventions included to provide medications for wound healing as ordered, observe for changes in skin integrity or skin impairment such as signs or symptoms of infection and pain, specialty boots or pressure relieving boots to both feet, and provide treatments as ordered.

Review of Resident #62 ' s minimum data set assessment dated 2/1/19 revealed the resident was assessed as cognitively intact. He required extensive assistance with bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. He required supervision with eating. Resident #62 had one unhealed stage II pressure ulcer which was not present upon admission.

Review of a wound flowsheet dated 2/1/19 revealed Resident #62 had a stage II pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 34	F 600		

ulcer to his left heel which measured 3 centimeters long and 1.5 centimeters wide with no depth.

Review of a wound flowsheet dated 2/5/19 revealed Resident #62 had a stage II pressure ulcer to his left heel which measured 3 centimeters long, 2 centimeters wide, and 0.5 centimeters deep.

Review of a wound flowsheet dated 2/18/19 revealed Resident #62 had a stage II pressure ulcer to his left heel which measured 1.5 centimeters long, 1.5 centimeters wide, and less than 0.25 centimeters deep.

During an interview on 2/18/19 at 1:26 PM Resident #62 and his family member stated he had a pressure ulcer to his left heel. They further stated the nurses had missed some of his treatments and they were not sure when he developed it. He concluded care was better now but at first not all his dressing changes were being done.

During observation on 2/18/19 at 2:58 PM the Wound Care Nurse was observed providing wound care to Resident#62. No concerns were identified with the wound care. The wound was measured to be 1.5 centimeters long, 1.5 centimeters wide, and less than 0.25 centimeters deep.

During an interview on 2/19/19 at 2:15 PM the Wound Care Nurse stated upon admission she would receive a skin referral from the nurse if something is identified. She further stated Resident #62 did not have any pressure ulcers upon admission. The Wound Care Nurse stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 35	F 600		

another skin referral would be issued for newly identified concerns. She further stated she usually sees new referrals within the first 24 hours but if it's the weekend she would then go and assess the resident the next work week day. She further stated she would have done all new skin referrals on 1/7/19 which was the first work week day following the 1/6/19 when the referral was made and would have been the day following the skin referral. She further stated the nurse who placed the referral form in the system for the newly identified stage II pressure ulcer on 1/6/19 closed the referral on 1/6/19 which meant the referral never made it to her when she came back to work on 1/7/19. She further stated she saw Resident #62 on 1/7/19 for his surgical incision but was not aware of any other new skin conditions at that time. The Wound Care Nurse stated staff were not supposed to close out newly identified skin referrals because it would not show in her report and was how she knew when there were newly identified skin conditions. She continued stated if they did close them out they should slide a copy under the door and that was not done. The Wound Care Nurse stated she was first made aware of the pressure ulcer on 1/16/19 when someone from the management team showed her the referral order placed on 1/6/19. She further stated it was her expectation that the wound be brought to her attention as soon as it was identified, and it was not done due to the nurse closing the referral which caused the referral to not appear in her report. The Wound Care Nurse stated it was too long of a gap from the identification of the wound to her being notified and she did not know what state the wound was in on the 6th, however the physician documented it as a stage II and it had not increased in stage and had decreased in size

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 36	F 600		

between her last two measurements. She further stated on 1/16/19 when she was made aware of the pressure ulcer and performed her first assessment on that day with the physician there was no dressing on the wound but bunny boots at that point and then treatment was initiated on that day for betadine with an adhesive foam dressing on the pressure ulcer with the physician. She further stated she did not know why the treatment was not initialed as completed until 1/19/19 on the treatment record because she had placed the first dressing on 1/16/19 when she was first aware of the wound. She concluded from January 6th through January 16th there were no wound assessments or measurements performed on Resident #62's stage II pressure ulcer.

During an interview on 2/19/19 at 3:21 PM the Director of Nursing stated it was her expectation with newly identified pressure ulcers that the wound care nurse would perform an initial assessment and measure and document that status of the wound within 24 to 48 hours of identification. She further stated it was not acceptable to allow a wound to go ten days without having an assessment performed following its identification. The Director of Nursing stated skin referrals were not to be closed prior to the Wound Care Nurse signing off on the referral and Nurse #1 should not have closed the referral form before the Wound Care Nurse could sign off that she had received.

During an interview on 2/19/19 at 4:03 PM Physician #1 stated it was his expectation the Wound Care Nurse do a wound assessment and measurements within the next business day of the request for a wound care nurse referral order and not a delay of ten days. He further stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 600	Continued From page 37 did not feel that there had been any deterioration in the wound between 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 #1 stated skin referrals were not to be locked until the wound care nurse was aware of the issue. She further stated the skin referral she completed on 1/6/19 was completed and locked by her on 1/6/19 before the Wound Care Nurse could see it. She further stated the family had stated they believed the wound had been there since the resident entered the facility on 1/4/19 so the Wound Care Nurse already knew about it and was why she closed it and did not inform the Wound Care Nurse.	F 600		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		3/18/19

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 623	Continued From page 38	F 623		

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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F 623	Continued From page 39 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of discharge	F 623	The facility immediately put in measures to notify the resident and the resident□s	

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F 623	Continued From page 40 to the resident or resident representative for a facility initiated discharge to the hospital for 1 of 1 residents reviewed for hospitalization (Resident # 90). The findings included: Resident #90 was admitted to the facility on 11/13/18 with diagnoses that included coronary artery disease and hypertension. Review of a nurse's note dated 11/16/18 revealed Resident #90 was sent to the hospital for evaluation of chest pain. Review of a nurse's note dated 11/20/18 revealed Resident #90 was readmitted to the facility from the hospital on 11/20/18. A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's hospital transfer on 11/16/18. During an interview with the Social Worker on 2/21/19 at 1:55 PM she indicated she did not send written notice of discharge to the resident or resident's representative for emergent hospital transfers. She reported the Administrator contacted the ombudsman regarding facility-initiated discharges. During an interview with the Administrator on 2/21/19 at 2:08 PM he stated he was unaware written notice of discharge was to be sent to the resident or resident's representative with a copy forwarded to the ombudsman. He stated the facility would begin sending these written notices as required by regulations for emergent hospital	F 623	representative of the resident□s transfer or discharge from the facility and the reasons for the move in writing and send a copy to the Office of the State Long Term Care Ombudsman. All residents discharged from the facility will receive the notice of transfer or discharge form. Resident #90 no longer resides in the facility. An in-service used the notice of transfer form as the template to educate all social services and accounts receivable staff on the transfer and discharge process was initiated on 3/12/19 by the Nursing Home Administrator and will be completed by 3/12/19. The in-service focused on the facility permitting each resident to remain in the facility, and not transfer or discharge the resident from the facility unless (A) The transfer or discharge is necessary for the resident□s welfare and the resident□s needs cannot be met in the facility, (B) The transfer or discharge is appropriate because the resident□s health has improved sufficiently so the resident no longer needs the services provided by the facility, (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, (D) The health of individuals in the facility would otherwise be endangered, (E) The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility, or (F) The facility ceases to operate. All newly hired staff will be in-serviced on the facility□s transfer and discharge process.	

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F 623	Continued From page 41 transfers.	F 623	Resident transfers and discharges will be monitored through the facility□s Interdisciplinary Team process by the Accounts Receivable, Social Services, or designee. The Nursing Home Administrator will be responsible for the QI tools and will audit weekly times 4 weeks then monthly times 2 months. The pertinent staff will be immediately re-trained by the auditor for any identified areas of concern. The Executive QI committee will meet to review the discharge QI tool monthly times 3 months to determine issues and trend to include continued monitoring frequency.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code a pressure wound on a Minimum Data Set (MDS) for 1 of 3 sampled residents (Resident #188) reviewed for pressure ulcers. Findings included: Resident #188 was admitted to the facility on 11/07/18 and had diagnoses of dementia without behaviors, insomnia and chronic kidney disease. Review of Resident #188's medical record revealed a Flowsheet of Non-Ulcer Skin Conditions sheet, completed by the Wound Care	F 641	The facility immediately put in measures 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 current assessment of the resident is accurate. Resident #188 no longer resides in the facility. A 100 % audit of the last completed MDS assessment, section M, for all residents	3/18/19

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 641	Continued From page 42 Nurse (WCN) dated 01/31/19 that specified Resident #188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and transparent film dressing with foam every other day. Review of the quarterly Minimum Data Set (MDS) dated 02/01/19 revealed Resident #188 was at risk for but did not have a pressure wound. Resident #188 needed the extensive assistance of one person for bed mobility, dressing, and hygiene. In an interview on 02/20/19 at 1:55 PM the Wound Care Nurse (WCN) indicated Resident #188 had a fluid filled blister on the bottom of the right heel, which was not identified until it ruptured on 11/28/18, which 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, instead relying on the Nursing Assistants (NAs) to inform the nurses daily of any change in a resident's skin. 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 so that other staff would know Resident #188 actually had a pressure wound. She indicated she did not know why she had documented on the non-ulcer assessment sheet. She indicated she did not perform a skin	F 641	was initiated on 3/15/19 by the MDS nurses, Director of Nursing, Assistant Director of Nursing, Wound Care Nurse and Staff Facilitator to ensure the most recent MDS assessment accurately reflects the residents current condition to include coding of pressure wounds to be completed by 3/18/19. For all areas of concern identified, a modification or significant correction of prior assessment (Quarterly/Comprehensive) will be completed by the MDS nurses as indicated by the Resident Assessment Instrument (RAI) manual by 3/18/19. On 3/15/19, an in- service was initiated for the Care Plan Team to include MDS Nurses, Activities, Social Services, Dietary, and the Director of Nursing by the Staff Facilitator, corporate consultant or designee regarding proper coding of the MDS assessments per the Resident Assessment Instrument (RAI) Manual, and was completed by 3/18/19. When coding the MDS assessment, the MDS Nurse and the Care Plan Team to include Activities, Social Services and Dietary will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the residents current condition. An audit of completed Minimum Data Set (MDS) assessments will be reviewed 3 times per week for 4 weeks for a total of ten residents, then 3 times per week for 4 weeks for a total of 5 residents, then monthly times 1 month for 5 residents. The audits will be conducted by the MDS	

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F 641	Continued From page 43 assessment when Resident #188 was discharged from the facility. In an interview on 02/20/19 at approximately 1:20 PM the ADON stated she had only been working in the facility since 01/02/19. She verified that she supervised the WCN and stated that in an ideal world pressure wounds would be documented on the correct assessment forms so the information would be available to all staff. In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) indicated that she expected wounds to be documented on the correct form so the correct information was available to everyone.	F 641	Nurse, Director of Nursing or designee to ensure compliance and accuracy of the MDS to include coding for pressure wounds utilizing a MDS Audit Tool. All Identified areas of concern will be addressed immediately by the Director of Nursing or designee through retraining and by modification or significant correction of the MDS Assessment by the MDS Nurse to accurately reflect the resident□s current condition. The results of the MDS Audit tool will be reviewed by the Administrator weekly. The Director of Nursing or designee will take audit results to the Quality Improvement Executive Committee will review all audit results monthly for 3 months for further recommendations, take action as appropriate, and to monitor continued compliance.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.	F 660		3/18/19

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F 660	Continued From page 44	F 660		

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 660	Continued From page 45 limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and implement an effective discharge planning process that allowed an effective transition to post-discharge care in the area of pressure ulcers for 1 of 3 residents (Resident #188) whose discharge was reviewed. Findings included: Resident #188 was admitted to the facility on 11/07/18 and had diagnoses of dementia without behaviors, insomnia and chronic kidney disease. Review of the last Flowsheet of Non-Ulcer Skin Conditions assessment dated 01/31/19 revealed Resident #188 had a pink ruptured right heel blister (the ruptured heel blister was discovered 11/28/18) that was improving. The area surrounding the wound was intact. There was no	F 660	The facility immediately put in measures to ensure a discharge planning process 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 resident discharges. The appropriate parties (social worker, MDS, activities, dietary, therapy, and wound nurse when applicable) will be notified during interdisciplinary team meetings (IDT) held in the morning and afternoon and/or clinical meetings.	

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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F 660	Continued From page 46 pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and transparent film dressing with foam every other day. Review of the quarterly Minimum Data Set (MDS) dated 02/01/19 revealed Resident #188 was at risk for but did not have a pressure wound. Resident #188 was cognitively intact and needed the extensive assistance of one person for bed mobility, dressing, and hygiene. Review of the Discharge Instructions and Plan of Care dated 02/06/19 revealed Resident #188 was to be discharged home with Home Health on 02/07/19. A follow-up appointment with a Nurse Practitioner had been made for 02/28/19 at 9:50 AM and orders for a treatment to the right heel were included. Resident #188 was to receive a regular diet with a dietary shake supplement twice each day. The name of the Home Health Service along with the name and telephone number of a contact person were provided. Review of the Patient Discharge Instructions dated 02/07/19 revealed a list of routine medications and prn (as needed) medications. Review of the Discharge Summary dated 02/07/19 directed the reader to "see chart" for admission diagnoses. For recent labwork and pertinent clinical findings relevant to discharge "see chart" was listed. Resident 188's condition was listed as stable and she was discharged home with home health by Nurse #4 on 02/07/19 at 10:35 AM. In an interview on 02/20/19 at 1:55 PM the Wound Care Nurse (WCN) indicated Resident	F 660	An in-service to all licensed nursing staff, social services, and medical director on the discharge planning process and required elements was initiated on 3/8/19 by the Staff Development Coordinator and Director of Nursing and was completed by 3/18/19. The in-service focused on the use of discharge planning forms and to document pressure ulcer vs non pressure skin condition, interest in receiving information regarding returning to community and if d/c to community is unfeasible, documentation of who made determination and why. All newly hired licensed nursing staff, social services, and medical directors will be in-serviced on the facility□s discharge planning process. Each resident□s discharge planning process will be monitored by the facility'□s Interdisciplinary Team (IDT) process. The QI tools will be reviewed by the social services directors three times per week for four weeks for a total of ten residents, then three times per week for four weeks for a total of five residents, then monthly for one month for five residents. The Executive QI Committee will meet to review the discharge planning process monthly times three months to determine issues and trends to include the need for continued monitoring.	

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F 660	Continued From page 47	F 660		

#188 had a fluid filled blister on the bottom of the right heel 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 heel 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 during Resident #188's stay in the facility. The WCN 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 there had been problems with the weekly assessment of wounds and she was now trying to be more proactive with the scheduling of assessments. She indicated she did not perform a skin assessment when Resident #188 was discharged from the facility because she was not aware the resident was being discharged. She indicated that if she had known about the discharge she would have written a note to the home health agency about the wound.

In an interview on 02/21/19 at 3:10 PM Nurse #4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 660	Continued From page 48	F 660		

stated when she discharged Resident #188 she provided a copy of the medication list and a copy of the Discharge Instructions and Plan of Care to the family member that came to take Resident #188 home. She indicated she had not performed a skin assessment prior to Resident #188's discharge.

In an interview on 02/21/19 at 4:16 PM Social Worker (SW) #1 stated discharge plans were talked about from the time of admission. She indicated there were multiple discussions with Resident #188's family about the planned discharge. SW #1 indicated that home health was aware of Resident #188's heel wound and its treatment. She stated that discharge instructions and a medication list had been provided to Resident #188's family at discharge.

Review of the Home Health Comprehensive Adult Assessment dated 02/08/19 revealed Resident #188 had a stage 3 pressure wound on the right heel. The wound measured 2cm by 2cm and was 0.5cm deep. There was full thickness skin loss involving damage or necrosis of subcutaneous tissue. There was a small amount of thin, watery, pale, red/pink drainage from the wound. The wound bed was pink with less than 25% of the wound covered with epithelial tissue. The skin color surrounding the wound was normal for the resident.

In a telephone interview on 02/22/19 at 1:46 PM the Home Health Manager confirmed that when Resident #188 was assessed at home on 02/08/19 the wound on the right heel presented as a stage 3 pressure wound. She indicated there was no odor and there were no signs of infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 661 SS=C	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a recapitulation of the facility stay for 2 of 3 residents reviewed for a planned discharge from the facility to the community (Resident #188 and Resident #61). Findings included:	F 661	Residents #188 and #61 no longer reside in the facility. The facility immediately put in measures to provide a discharge summary to residents in accordance to F661, 483.21 (c)(2) Discharge Summary.	3/18/19

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 661	Continued From page 50 1. Review of the medical record revealed Resident #188 was admitted to the facility on 11/07/18 with diagnoses of dysphagia, chronic kidney disease and insomnia. Review of the quarterly Minimum Data Set (MDS) dated 02/01/19 revealed Resident #188 was cognitively intact and needed the extensive assistance of one person for bed mobility, dressing and hygiene. There was an active return to the community discharge plan in place for Resident #188. Review of the medical record revealed Resident #188 was discharged home on 02/07/19. Further review revealed the facility did not complete a recapitulation of Resident #188's stay in the facility. In an interview on 02/21/19 at 11:50 AM the Director of Nursing (DON) indicated that no recapitulation of Resident #188's stay had been completed. She stated the facility had not been completing a recapitulation for the resident's at discharge. In an interview on 02/22/19 at 9:10 AM the facility Administrator stated that the facility was not completing a recapitulation of any resident's stay because he was unaware that a recapitulation of the facility stay for residents needed to be completed. He stated that from then on Utilization Review, the MDS team, and the Social Services Department would work together to make sure the recapitulation was completed. 2. Resident #61 was admitted to the facility on 01/25/19 with the diagnoses that included cerebral infarction (CVA), schizophrenia, benign prostatic hyperplasia (BPH), and seizures.	F 661	An in-service to all licensed nursing staff, social services and providers on the discharge summary required elements was initiated on 3/8/2019 by the Staff Development Coordinator and Director of Nursing and will be completed by 3/19/19. The in-service focused on providing residents a discharge summary that includes a recapitulation of the resident's stay. Each resident discharge summary will be monitored through the facility□s Interdisciplinary Team process by the Social Services Directors, Assistant Director of Nursing, and Unit Managers. The Director of Nursing will be responsible for the QI tools that will be reviewed 3 times per week for 4 weeks for a total of ten residents, then 3 times per week for 4 weeks for a total of 5 residents, then monthly times 1 month for 5 residents. The pertinent staff will be immediately re-trained by the auditor for any identified areas of concern. The Executive QI committee will meet to review the discharge summary audit tool monthly times 3 months to determine issues and trend to include continued monitoring frequency.	

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F 661	Continued From page 51	F 661		

Resident #61's 14 day Minimum Data Set (MDS) dated 02/08/19 indicated that resident had severe cognitive impairments, and needed extensive to total assistance with all activities of daily living (ADL)

Review of Resident #61's closed record revealed he was discharged to another skilled facility on 02/14/19. Further review of the closed records revealed the facility failed to complete a recapitulation of Resident #61's stay in the facility.

A nursing note dated 02/14/19 at 11:25 AM by the Director of Nursing (DON) for Resident #61 revealed a discharge summary; stated, "resident #61 discharged with family member and transport to another facility. All his belongings were accounted for. His vitals stable at time of discharge."

An interview on 02/22/19 at 8:40 AM with the Director of Nursing (DON) revealed she was not aware that the facility should have completed a "Recapitulation of Stay": A concise summary of Resident #61's stay and course of treatment in the facility per regulation, at the time of discharge from the facility, and did not. She stated the discharge recapitulation was not completed on Resident #61, and that it was her expectation, going forward, that she complete the discharge recapitulation prior to a resident's anticipated discharge.

An interview was completed with the Administrator on 02/22/19 at 8:50 AM. He stated it was his expectation that the facility should have completed a "Recapitulation of Stay": A concise summary of Resident #61's stay and course of

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F 661	Continued From page 52 treatment in the facility per regulation, at the time of discharge from the facility, and did not.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident and staff, a facility nurse failed to communicate with another nurse that she had already administered two medications for hypertension and muscle spasms to Resident #52, putting 1 of 1 sampled resident at risk of receiving duplicate medication doses. Findings included: Resident # 52 was admitted to the facility on 1/16/19. Her diagnoses included: Polyneuropathy, and Hypertension. The Minimum Data Set (MDS) dated 1/23/19 and coded as an admission assessment indicated Resident #52 had clear speech and was cognitively intact. She exhibited no rejection of care. A review of the Physician orders dated 1/16/19 showed an order in place for Carvedilol Tablets	F 684	The facility immediately put in measures to ensure that residents receive treatment and care in accordance with professional standards of practice. Resident #52 did not receive a duplicate administration of medication. Patient #52 has received medication in accordance with physician orders. Facility ensured the safe and accurate administration of medications for all other residents by: 1) on 2/19/19, the staff facilitator immediately educated Nurse # 9 and #5 on following the proper communication channels necessary when exchanging responsibility for a medication cart and 2) A 100% in-service was initiated on 2/19/19 by the Staff Facilitator to all	3/18/19

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F 684	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 sign the medications off on the MAR (Medication Administration Record), and stated they should have communicated with each other regarding what medications had already been administered at the time that Nurse #5 returned to the cart.	F 684	licensed nurses with a completion date of 3/18/19. The in-service focused on quality of care related to medication pass errors regarding (a) proper hand off of keys during a medication pass to the nurse accepting responsibility of the cart (b) documentation of e-MARs immediately following a medication pass (c) communication with resident when administering a medication and (d) giving medications per MD order. All newly hired licensed nurses will be in-serviced on preventing medication errors. Free from medication errors will be monitored by utilizing a QI audit tool for Medication Administration by the Staff Facilitator, Unit Manager, Assistant Director of Nursing, or Director of Nursing. Audit tool will be used 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The licensed nurses will be immediately re-trained by the auditor for any identified areas of concern. The Director of Nursing or designee is responsible and will review and initial the Medication Pass Audit Tool for completion to ensure all areas of concern were addressed. The Executive QI committee will meet to review the Medication Administration QI tool monthly times 3 months to determine issues and trends to include continued monitoring frequency.	

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F 684	Continued From page 54 A follow up interview was conducted on 2/20/19 at 5:15 PM with Nurse #5, and the Director of Nursing. Nurse #5 stated she was working the hall and was pulled away for an admission, and Nurse #9 took over her medication cart when the admission came in. Nurse #5 stated upon return to the medication cart the MAR was still highlighted yellow, so she pulled the medications and took it to the resident. She stated she did not communicate with Nurse #9 as she should have regarding what medications had been given. She stated she pulled the residents medications and took them into the resident ' s room to give them. An interview was conducted on 02/22/19 11:30 AM with the Director of Nursing. She stated her expectation is that all nurses are administering the correct medications, at the correct times, and active communication is expected between all nurses.	F 684		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		3/18/19

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F 686	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, wound center interview, home health interview, and staff interview the facility failed to conduct initial and weekly wound assessments which included measurements and descriptions of the wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain for 3 of 3 sampled residents (Resident #48, #62, and #188) with pressure ulcers. No initial or weekly wound assessments were completed for Resident #48's right heel ulcer from 12/16/18, when it was identified, until 01/08/19 when a Quality Assurance (QA) Skin Wound Review documented the 4.5 x 3.5 centimeter (cm) ulcer to the resident's right heel was painful and presented with yellow/green purulent drainage. No initial or weekly pressure ulcer assessments which included measurements and descriptions of wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain were completed for Resident #188 from 11/28/18, when a blister opened on her right heel, through her discharge from the facility on 02/07/18. On 02/08/18 home health services assessed the pressure ulcer to Resident #188's right heel as being a stage III wound measuring 2 x 2 x 0.5 cm with drainage. A skin referral was submitted for Resident #62 on 01/06/19 due to a painful stage II wound. However, an initial wound assessment was not completed for the resident until 01/16/19 when it was determined Resident #62 had a stage II pressure ulcer to the left heel. This ulcer was found with dried drainage, and the wound was painful to touch and movement. In addition, the facility failed to expedite a wound center consult for Resident #48 which was	F 686	On 3/12/19, the administrator directed the initiation of a 100% head-to-toe skin audit to ensure all residents are accurately assessed and have assessments completed. On 3/13/19 through 3/14/19, the director of nursing, assistant director of nursing, staff facilitator, and QI nurse competed a 100% skin audit of current residents. The wound care nurse and other licensed nurses were proactively educated on following the wound/skin policies and procedures and physician orders. Residents #48 and #62 were immediately assessed and had a chart audit completed to ensure proper treatments were in place. Resident #188 was discharged home from the facility. Pressure relieving mattresses are in use for all residents and Resident #48 has an air mattress. The facility initiated education on 2/20/19 for all nurses and aides regarding communication of skin conditions and notifying nursing on any changes on skin. On 2/28/19 nurses were additionally educated that they must document changes to reflect change in cognition, behaviors and physical conditions. All education was completed by 3/18/19. Beginning 3/18/19, the staff facilitator, unit manager, assistant director of nursing, and/or director of nursing will use a quality	

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F 686	Continued From page 56 documented as being requested by the facility on 01/08/19 for a deep tissue injury (DTI) to the resident's right heel. The wound center consult did not occur until 01/30/19 at which time the heel wound presented as an unstageable pressure ulcer with slough and eschar in the wound bed and a moderate amount of drainage. In addition, based on facility documentation, the facility inappropriately applied calcium alginate, designed to absorb excess fluid and promote natural debridement via enzymes, to Resident #48's right heel ulcer from 12/21/18 until 01/30/19. The facility documented this wound as being a DTI from 12/20/18 until 01/18/19 and as being free from slough/eschar and drainage from 01/18/19 until a wound center consult on 01/30/19. In addition, the facility failed to off-load Resident #48's heels from the bed as recommended by the wound center and implemented by the physician. Findings included: 1. a. 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. A 11/11/18 scale for predicting pressure ulcer risk documented Resident #48 was at high risk for pressure ulcer development. Factors documented as entering into this risk included the resident being in fair physical condition, being alert, being chairbound, having very limited mobility, being incontinent of bowel and bladder, having a diagnosis of hypertension, and receiving five or more medications which placed the	F 686	improvement monitoring tool. The audit tool will be used three times a week for four weeks, then weekly for four weeks then monthly for one month. The director of nursing or assistant director of nursing will review and initial the QI audit tool to ensure all areas of concern are addressed. The Executive QI Committee will meet to review the QI audit tool monthly for three months to determine issues and trends to include the need for continued monitoring.	

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 686	Continued From page 57	F 686		

resident at risk for skin integrity issues.

A 12/16/18 skin referral form documented, "Description: necrotic area" and "Observer: staff." The form documented there was a necrotic area to the inner aspect of Resident #48's right heel.

On 12/20/18 the facility's Treatment Nurse documented on the skin referral form that Resident #48 had a "right heel DTI (deep tissue injury)".

A 12/30/18 physician progress note written by Physician #1 (not found in the resident's electronic medical record or paper chart, but printed off from the physician's own electronic system documented, "...she has a right heel ulcer. Assessment and Plan: right heel ulcer: continue aggressive wound care and preventative strategies."

A 01/08/19 QA (Quality Assurance) Skin Wound Review documented the DTI to Resident #48's right heel measured 4.5 cm by 3.5 centimeters (cm), had yellow/green purulent drainage, and was painful.

A 01/08/19 physician order started Resident #48 on Doxycycline (antibiotic) 100 milligrams twice daily (mg BID) x 7 days for right heel cellulitis (review of the resident's Medication Administration record revealed the antibiotic was administered as ordered).

A 01/09/19 physician progress note written by Physician #1 documented, "Patient seen for heel decubitus. This continues to worsen and now needs surgical evaluation, patient confirms it is

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F 686	Continued From page 58	F 686		

painful. Assessment and Plan: right heel ulcer: patient continues to worsen and now needs surgical evaluation...."

On 01/09/19 Resident #48's care plan identified the following problem: "Ulceration or interference with structural integrity of layers of skin related to right heel pressure ulcer." Interventions to this problem included "treatment as ordered by physician to right heel pressure ulcer."

A 01/10/19 Wound Ulcer Flowsheet documented Resident #48 had a suspected DTI to her right heel which developed in the facility and measured 4.5 x 3.5 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with yellow/green drainage, no infection, no necrosis, no pain, no tunneling or undermining, and no odor.

A 01/18/19 Wound Ulcer Flowsheet (the last facility assessment of Resident #48's right heel ulcer prior to being seen by the wound center) documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 4.5 x 3.5 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no tunneling or undermining, and no odor. However, it was documented the resident experienced pain with his dressing changes. The wound bed was described as purple/pink.

Resident #48's 01/23/19 annual minimum data set (MDS) documented the resident's cognition was moderately impaired, she exhibited no behaviors including resistance to care, she required moderate assistance to being totally dependent on staff for her activities of daily living,

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F 686	Continued From page 59	F 686		

she weighed 91 pounds, her weight was stable, and she had one stage II unhealed pressure ulcer which was not present on admission or re-entry.

A 01/30/19 wound center consult documented Resident #48 presented to the clinic with an unstageable pressure ulcer on the right heel which measured 2.5 x 1.5 x 0.2 cm. The wound bed was described as tan/yellow with a mixture of slough and eschar and a moderate amount of drainage. The wound was debrided.

On 01/31/19 wound center recommendation for the application of "Silvasorb gel, 4 x 4, Kling tape and net and change 3 x a week" was implemented via physician order.

A 01/31/19 Wound Ulcer Flowsheet documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 4 x 3 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no pain, no tunneling or undermining, and no odor. The wound bed was described as pink.

A 02/08/19 Wound Ulcer Flowsheet documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 4 x 3 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no pain, no tunneling or undermining, and no odor. The wound bed was described as purple/maroon.

A 02/13/19 wound center consult documented Resident #48 presented to the clinic with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 60	F 686		

unhealed pressure ulcer on the right heel which measured 2 x 2 x 0.3 cm. The wound bed was described as yellow/pink with 76 - 100% slough and 1 - 25% granulation tissue. A moderate amount of yellow drainage was documented, and the wound was debrided.

A 02/13/19 physician order started Resident #48 on Keflex (antibiotic) 500 mg three times daily (TID) x 10 days for possible infection to the right heel ulcer.

A 02/15/19 physician order documented, "Apply Silvasorb gel, 4 x 4, Kling and net and change 3 x/week to right heel, stage II."

A 02/18/19 Wound Ulcer Flowsheet documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 1.5 x 1 x 0.25 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no pain, no tunneling or undermining, and no odor. The wound bed was described as red/slough.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated she could not remember which staff member brought Resident #48's wound to the facility's attention on 12/16/18 by completing a skin referral. She reported she could not remember the size of the right heel wound when she viewed it on 12/20/18, but she commented the area was not necrotic. She remarked that the wound presented as a DTI instead. She stated DTIs did not have depth, and were usually purple/burgundy in color. According to the Treatment Nurse, she usually documented wound measurements, description of wound bed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 61	F 686		

and presence of drainage, odor, tunneling/undermining, pain, necrosis, and infection during her initial wound assessment, but she not sure why this did not occur for Resident #48. The Treatment Nurse reported she completed weekly wound assessments on Thursdays. She commented that she and the Assistant Director of Nursing (ADON) completed wound rounds together on Tuesdays and Wednesdays. According to the Treatment Nurse, wounds were to be assessed on a weekly basis and should include measurements, staging, drainage, infection, odor, wound bed description, and peri-wound bed description. The Treatment Nurse was unable to explain why she did not assess Resident #48's right heel wound for all these components until 01/10/19. According to the facility's Treatment Nurse, a second round of antibiotics was begun for Resident #48 on 02/13/18 when a small green/yellow area was found in the right heel wound bed, and there was a "mild" odor and small amount of drainage. The Treatment Nurse also reported that there was a small amount of slough in the wound bed on 02/18/19 so she should have probably staged the pressure ulcer as stage III wound.

During an interview with the Director of Nursing (DON) on 02/19/19 at 4:18 PM she stated once a skin referral was received her expectation would be that the facility's Treatment Nurse assess that wound within 24 - 48 hours. She reported this assessment should include measurements, description of wound bed, drainage, odor, tunneling and undermining, pain, and possible necrosis or infections. She commented wounds should be assessed per the facility policy which was weekly and as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 62	F 686		

On 02/20/19 at 10:34 AM an observation of Resident #48's right heel pressure ulcer was made with the facility's Treatment Nurse and Assistant Director of Nursing (ADON). An attempt was made to engage the resident in meaningful conversation, but the resident was unable to participate. The Treatment Nurse stated the wound developed because of sheering, with the resident digging her heels into the bed. She stated Silvasorb was currently being used to treat the resident's heel ulcer since it was an anti-microbial gel, and the resident was now on her second round of antibiotics. The right heel wound bed was light pink to bright pink with a small amount of tan slough, and there was no odor. The Treatment Nurse stated she estimated measurements of the wound to be 1.5 x 1.2 x 0.2 cm.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated he expected wounds to be assessed, if not on the day they were found, no later than the next business day. He reported measurements and description of the wound bed were important pieces of information, but the most important thing was for the facility's Treatment Nurse to use her expertise to diagnose what type of wound the resident had (such as a DTI, pressure wound, venous/stasis wound). He reported after the initial assessment the wound needed to be assessed every 7 - 10 days or more often if significant changes in the wound were noted. He stated he did his initial visit with the resident at the end of December (12/30/18). He commented if he remembered correctly he thought the wound presented as a DTI. On 01/09/19 Physician #1 stated Resident #48's right heel ulcer had changed, and he thought there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 63	F 686		

might be cellulitis or an abscess. He reported on closer examination he felt the purulent drainage was more of an indication of an infection, and started the resident on an antibiotic. Physician #1 commented purulent drainage could develop quickly because infection could rise to the surface within even 24 hours. He reported he did not order wound cultures, and did not consider them to be a valid tool in treating wounds.

During a follow-up interview with the facility's Treatment Nurse on 02/22/189 at 9:08 AM she stated in her experience the development of eschar was a gradual process, but establishing a definite time frame was difficult because factors such as nutritional status and co-morbidities entered into the time frame. She reported she saw no slough or eschar in Resident #48's wound before the resident's 01/30/19 wound consult, but commented she missed assessments of the wound between 12/20/18 and 01/10/19.

During a telephone interview on 2/22/19 at 11:50 AM Wound Center Nurse #1 stated slough and eschar did not develop in a 1 - 2 day period, but she had seen instances where small amounts of slough/eschar were removed from a wound bed one week, and when the patient returned a week later for a follow-up, there was slough in the wound bed again.

1. b. 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.

A 01/08/19 QA (Quality Assurance) Skin Wound Review documented the DTI to Resident #48's right heel measured 4.5 cm by 3.5 centimeters

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 64	F 686		

(cm), had yellow/green purulent drainage, and was painful. Orders were provided for a wound center consult.

A 01/09/19 physician progress note written by Physician #1 documented, "Patient seen for heel decubitus. This continues to worsen and now needs surgical evaluation, patient confirms it is painful. Assessment and Plan: right heel ulcer: patient continues to worsen and now needs surgical evaluation. Will set up wound clinic referral."

On 01/09/19 Resident #48's care plan identified the following problem: "Ulceration or interference with structural integrity of layers of skin related to right heel pressure ulcer." Interventions to this problem included "wound clinic referral for right heel pressure ulcer."

A 01/10/19 Wound Ulcer Flowsheet documented under Comments, "wound clinic referral".

A 01/18/19 Wound Ulcer Flowsheet (the last facility assessment of Resident #48's right heel ulcer prior to being seen by the wound center) documented Resident #48 had a stage II pressure ulcer to her right heel which developed in the facility and measured 4.5 x 3.5 x 0.5 cm. The facility's Treatment Nurse documented the wound presented with no drainage, no infection, no necrosis, no tunneling or undermining, and no odor. However, it was documented the resident experienced pain with his dressing changes. The wound bed was described as purple/pink.

Resident #48's 01/23/19 annual minimum data set (MDS) documented the resident's cognition was moderately impaired, she exhibited no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 65	F 686		

behaviors including resistance to care, she required moderate assistance to being totally dependent on staff for her activities of daily living, she weighed 91 pounds, her weight was stable, and she had one stage II unhealed pressure ulcer which was not present on admission or re-entry.

Resident #48's initial wound center consult on 01/30/19 documented she presented to the clinic with an unstageable pressure ulcer on the right heel which measured 2.5 x 1.5 x 0.2 cm. The wound bed was described as tan/yellow with a mixture of slough and eschar and a moderate amount of drainage. The wound was debrided.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated the facility primarily utilized one wound clinic for those patients who needed wound referrals to an outside source. She reported she usually got a resident seen at this wound clinic within a couple of days. She commented at the latest, if she could not get a resident into this wound center on the week the referral was made, she was able to set up an appointment early the following week. The Treatment Nurse was unable to explain why it took so long to get Resident #48 seen at the wound clinic, with a wound consult requested on 01/08/19 and the resident not seen until 01/30/19.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated when he observed the resident's right heel ulcer on 01/09/19 he thought the wound had changed. He explained he felt the purulent drainage was an indication of infection, and started the resident on an antibiotic. He commented he also recommended a surgical consult for debridement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. 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 from 12/21/18 until 01/30/19 the resident's treatment for the right heel pressure ulcer (classified as a DTI by the facility between 12/20/18 and 01/18/19 and documented as having no slough/eschar or drainage present between 01/18/19 and a 01/30/19 wound center consult) was calcium alginate applied topically every other day. (The facility's Wound Care Manual, version dated 05/22/18, documented treatment for a DTI was "1) Cleanse wound with normal saline solution or appropriate wound cleansing solution. Apply skin sealant and allow to dry thoroughly. Complete daily. 2) May also cover with a foam dressing after cleansing with normal saline solution or appropriate wound cleansing solution. Check dressing daily, change every other day and prn (as needed).")

On 01/09/19 Resident #48's care plan identified the following problem: "Ulceration or interference with structural integrity of layers of skin related to right heel pressure ulcer." Interventions to this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 67	F 686		

problem included "treatment as ordered by physician to right heel pressure ulcer."

Resident #48's 01/23/19 annual minimum data set (MDS) documented the resident's cognition was moderately impaired, she exhibited no behaviors including resistance to care, she required moderate assistance to being totally dependent on staff for her activities of daily living, she weighed 91 pounds, her weight was stable, and she had one stage II unhealed pressure ulcer which was not present on admission or re-entry.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she reported that the standing orders for DTI treatment included skin prep and protective booties to the heels. She was unable to explain why calcium alginate was used to treat Resident #48's right heel wound which was classified as a DTI between 12/21/18 and 01/18/19 and was documented as having no slough/eschar or drainage before the initial wound center consult on 01/30/19.

On 02/20/19 at 10:34 AM the Assistant Director of Nursing (ADON) stated she thought calcium alginate was used for debridement and was usually discontinued as the wound healed. She reported she did not think calcium alginate would be appropriate for treating a DTI.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated skin prep or betadine were the most frequently used treatments for DTIs. He also reported that calcium alginate had absorptive properties, and was typically utilized in wounds with drainage which contained slough. He commented he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 68	F 686		

unsure why the facility would have been using calcium alginate if a wound was truly a DTI and if a wound did not have slough or eschar in it.

1. d. 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.

A 12/16/18 skin referral form documented Resident #48 had a pressure ulcer to the inner aspect of her right heel, and the intervention was to "float heels on pillow".

A 01/08/19 QA (Quality Assurance) Skin Wound Review documented the wound to Resident #48's right heel measured 4.5 cm by 3.5 centimeters (cm), had yellow/green purulent drainage, and was painful. Foam booties were applied to bilateral heels, and the resident's heels were elevated on a pillow.

On 01/09/19 Resident #48's care plan identified the following problem: "Ulceration or interference with structural integrity of layers of skin related to right heel pressure ulcer." Interventions to this problem included "off-load heels when in bed."

Resident #48's 01/23/19 annual minimum data set (MDS) documented the resident's cognition was moderately impaired, she exhibited no behaviors including resistance to care, she required moderate assistance to being totally dependent on staff for her activities of daily living, she weighed 91 pounds, her weight was stable, and she had one stage II unhealed pressure ulcer which was not present on admission or re-entry.

On 01/31/19 wound center recommendation for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 69	F 686		

Resident #48 to "Keep heel off bed. Offload please!!" was implemented via physician order.

A 02/15/19 physician order documented, "Keep heel off loaded, float with no contact with bed."

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated there were many factors which entered into the unhealed status of Resident #48's heel ulcer which included difficulty keeping the protective booties on the resident's heels.

On 02/20/19 at 10:34 AM an observation of Resident #48's right heel pressure ulcer was made with the facility's Treatment Nurse and Assistant Director of Nursing (ADON). An attempt was made to engage the resident in meaningful conversation, but the resident was unable to participate. Resident #48 was found in bed with her right heel on the bed, resting on the sheet. The sheep skin bootie was not covering the resident's right heel, but was up around the resident's right ankle. A sheep skin bootie was covering the resident's left heel, and a fluffy sock covered the resident's left foot. There was no sock on the resident's right foot. There were no pillows in the bed or under the resident's legs for off-loading. As the ADON was leaving the resident's room, she picked up a pillow without a pillow case from furniture in the room, and stated that once a pillow case was applied, the pillow then needed to be placed under the resident's legs.

On 02/20/19 at 12:35 PM the facility's Medical Director, who was Resident #48's primary physician (Physician #1), stated the most important thing for treatment of a DTI on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 70	F 686		

heels was to off-load pressure exerted on the heels. He explained there could be things going on underneath the skin of a DTI so it was important to ensure a good blood supply to the wound by off-loading. He stated one of the most effective and easiest way to off-load pressure was to place a pillow behind the calves and apply bunny boots.

During an interview with Nursing Assistant (NA) #3 on 02/20/19 at 3:05 PM she stated Resident #48 stayed fairly still in bed, occasionally shifting a little on her side to see out her window. She reported the resident was supposed to have two pillows under her legs and fluffy socks and sheep skin boots on both feet to protect the heels. She commented she had not had a problem finding these interventions in place when she started her first shift rounds. According to NA #3, she had not seen a problem with the resident's heel booties coming off. She was unable to explain why Resident #48 was without some of these interventions when the wound observation was completed on 02/20/19 (she was assigned to care for the resident on first shift that morning).

During an observation 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 was a pillow with a pillow case which was at the bottom of the bed, but not under the resident's legs. The heels, covered by sheep skin booties, were on the bed. At this time NA #5 stated she worked third shift, but stayed over this morning. She commented she had been told by the nurse that the resident was supposed to have socks and booties on both feet, and a pillow was supposed to be under the resident's legs. She reported she could not say

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 71	F 686		

for sure but she felt like the resident had the pillow under her legs when she checked on her before 7:00 AM on 02/21/19. She stated the resident sometimes kicked the pillow out from under her legs.

During an interview with Nurse #4 on 02/21/19 at 8:52 AM she stated Resident #48 was supposed to have bunny boots on and a pillow under her legs, but the resident would not always tolerate the boots and pillow. She reported that if she explained to the resident why it is important to utilize these interventions the resident was more apt to comply. She commented that she had done dressing changes on Resident #48 when the facility's Treatment Nurse was not in the building or not available. According to Nurse #4, Resident was eventually followed by the wound clinic, and the resident's pressure ulcer to her right heels was supposed to be assessed weekly.

During an interview with Nurse #8 on 02/21/19 at 4:51 PM she stated she had done the dressing changes for Resident #48 when the facility's Treatment Nurse was not available. She reported the wound had not had odor or drainage when she did the dressing changes. She commented the resident was to wear bunny boots all the time when in bed, although the resident did not always to keep them on because she did not like things touching her body. Nurse #8 stated the staff had to check on Resident #48 more frequently to make sure the booties stayed in placed. According to Nurse #8, she was not sure if there were any other interventions to use when the resident was in bed to lessen pressure to the resident's heels, but she would go to the care guide to check.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 72 During an observation on 02/22/19 at 8:14 AM Resident #48 was awake in bed. She had socks and booties on both feet. There was a pillow at the bottom of bed, but the resident's legs were not elevated by a pillow. The resident's feet were crossed with the right heel resting on top of the left foot. During an interview with the DON on 02/22/19 at 10:46 AM she stated Resident #48 was supposed to have sheep skin boots covering her heels and pillows under her legs for off-loading. However, she commented keeping these interventions in place was difficult for this resident because of her compromised cognition, impulsiveness, and occasional combative behavior. She commented there were problems keeping the boots on the resident, but the resident had periods of alertness so she could be educated during these periods about the importance of keeping the boots on and keeping the pillows under her legs. The DON also remarked that the staff needed to check on the resident more frequently. 2. Resident #188 was admitted to the facility on 11/07/18 and had diagnoses of dementia without behaviors, insomnia and chronic kidney disease. Resident #188 was discharged home with Home Health on 02/07/19. Review of the Physician's Orders dated 11/28/18 revealed a verbal order to cleanse Resident #188's right heel with Normal Saline, apply betadine, and then cover with a transparent dressing with foam every other day for a ruptured blister.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 686	Continued From page 73	F 686		

Review of the Care Plan revised on 11/29/18 revealed Resident #188 was at risk for skin breakdown and the development of pressure wounds. The goal was for Resident #188 to not develop any skin breakdown or pressure wounds through the next review. Interventions included to encourage Resident #188 to change position frequently and to observe the skin daily for any abnormal changes.

Review of the Care Plan initiated on 11/29/18 revealed a ruptured blister had been noted on Resident #188's right heel. The goal was for the ruptured blister to heal without complications through the next review. Interventions included to keep pressure off of the right heel and to perform treatments as ordered and to notify the physician of any changes.

Review of the Flowsheet of Non-Ulcer Skin Conditions dated 11/28/18 revealed Resident #188 had a pink ruptured right heel blister. There was no pain or infection present. There were no measurements of the wound and no description of the area surrounding the wound. The treatment was to apply betadine and a transparent film dressing every other day. There was no physician notification date on the form.

Review of the Physician Progress Note dated 12/04/18 revealed no mention of Resident #188's ruptured right heel blister.

Review of the Physician Progress Note dated 12/12/18 revealed no mention of Resident #188's ruptured right heel blister.

Review of the Flowsheet of Non-Ulcer Skin Conditions dated 01/03/19 revealed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 686	Continued From page 74	F 686		

#188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and a transparent film dressing with foam every other day. There was no physician notification date on the form.

Review of the Quality Assurance- Skin/Wound Review dated 01/08/19 revealed Resident #188 had a ruptured blister on the right heel that measured approximately 2 cm (centimeters) by 1 cm. The wound was healing and pink. The wound was cleaned and betadine and a dressing were applied. There was no indication of how the area surrounding the wound appeared.

Review of the Quality Assurance- Skin/Wound Review dated 01/16/19 revealed Resident #188 had a ruptured blister to the right heel that was healing well. The skin was pink and healthy without signs or symptoms of infection or worsening breakdown. There were no measurements of the wound or any indication of how the area surrounding the wound appeared.

Review of the Physician Progress Notes dated 01/17/19 revealed no mention of Resident #188's ruptured right heel blister.

Review of the Flowsheet of Non-Ulcer Skin Conditions dated 01/23/19 revealed Resident #188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and transparent film dressing with foam every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 686	Continued From page 75	F 686		

other day.
There was no physician notification date on the form.

Review of the Physician Progress Notes dated 01/29/19 revealed no mention of Resident #188's ruptured right heel blister.

Review of the Flowsheet of Non-Ulcer Skin Conditions dated 01/31/19 revealed Resident #188 had a pink ruptured right heel blister that was improving. The area surrounding the wound was intact. There was no pain or infection present. There were no measurements of the wound. The treatment was to continue betadine and transparent film dressing with foam every other day. There was no physician notification date on the form.

Review of the quarterly Minimum Data Set (MDS) dated 02/01/19 revealed Resident #188 was at risk for but did not have a pressure wound. Resident #188 was cognitively intact and needed the extensive assistance of one person for bed mobility, dressing, and hygiene.

Review of the Home Health Comprehensive Adult Assessment Dated 02/08/19 revealed Resident #188 had a stage 3 pressure wound on the right heel. The wound measured 2cm by 2cm and was 0.5cm deep. There was full thickness skin loss involving damage or necrosis of subcutaneous tissue. There was a small amount of thin, watery, pale, red/pink drainage from the wound. The wound bed was pink with less than 25% of the wound covered with epithelial tissue. The skin color surrounding the wound was normal for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 686	Continued From page 76	F 686		

In an interview on 02/20/19 at 1:55 PM the Wound Care Nurse (WCN) indicated Resident #188 had a fluid filled blister on the bottom of the right heel 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, instead relying on the Nursing Assistants (NAs) to inform the nurses daily of any change in a resident's skin. 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. The WCN 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. She stated that the floor nurses would do the treatments but would not perform the required assessments leaving them for her to do on her return to the WCN role. The WCN admitted there was missing documentation for Resident #188's wound but that she would provide all that she had. She stated that the Assistant Director of Nursing (ADON) reviewed all the wound care data that was collected weekly for pressure ulcers and also visualized the wound. A Quality Assurance Skin/Wound note would then be written. The WCN stated she knew there had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 77	F 686		

been problems with the weekly assessment of wounds and she was now trying to be more proactive with the scheduling of assessments. She indicated she did not perform a skin assessment when Resident #188 was discharged from the facility because she was not aware the resident was being discharged. She indicated that if she had known about the discharge she would have written a note to the home health agency about the wound.

In an interview on 02/20/19 at approximately 1:20 PM the ADON stated she had only been working in the facility since 01/02/19. She verified that she supervised the WCN and stated that in an ideal world pressure wounds would be documented on the correct assessment forms and that assessments would be done weekly.

In a telephone interview on 02/21/19 at 11:37 AM Physician #2 stated he was aware that Resident #188 had had a wound on the ankle but was unaware that there was a wound on the right heel. He indicated if the wound had started as a blister and then ruptured he would expect a weekly wound assessment with measurements.

In a follow-up interview on 02/21/19 at 1:45 PM the WCN stated the physician's order that was written on 11/28/19 as a verbal order was actually from the standing orders and that she had not spoken to the physician regarding the heel wound.

In an interview on 02/21/19 at 2:45 PM NA #2, who had worked with Resident #188, stated she was not sure when the resident developed the blister on the right heel. She indicated she looked at each resident's skin daily with care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 686	Continued From page 78	F 686		

reported any abnormal findings to the nurse.

In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) indicated that she expected the assessment of a pressure wound to include measurements, a description of the wound bed, and if any signs of infection were noted such as purulent drainage or odor so that the facility could track if the wound was improving. She indicated she expected the wound to be documented on the correct form weekly. She indicated she expected the WCN to notify the physician of any wounds a resident acquired in the facility so the physician could decide if standing orders were appropriate or if they wanted a different treatment.

In a telephone interview on 02/22/19 at 1:46 PM the Home Health Manager confirmed that when Resident #188 was assessed on 02/08/19 the wound on the right heel presented as a stage 3 pressure wound. She indicated there was no odor and there were no signs of infection.

3. Resident #62 was admitted to the facility on 1/4/19. His active diagnoses included displaced intertrochanteric fracture of the left femur, hypertension, heart failure, muscle weakness, and chronic obstructive pulmonary disease.

Review of Resident #62 ' s admission skin assessment and referral form dated 1/4/19 revealed Resident #62 had a left hand and left knee cap skin tear as well as a left hip wound. There were no pressure ulcers to Resident #62 ' s left heel identified upon admission. This skin referral was locked on 1/10/19 and signed as reviewed by the Wound Care Nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 686	Continued From page 79	F 686		

Review of a nurse's note dated 1/6/19 revealed the nurse noted a pressure ulcer noted to Resident #62's left heel. A skin referral was completed and new orders for bunny boots while in bed and to keep left heel elevated on pillows.

Review of a physician's progress note dated 1/6/19 revealed the physician documented Resident #62 had a left heel pressure ulcer and he wished to have the wound care nurse provide a consult and avoid pressure to the heel.

Review of a skin referral form dated 1/6/19 revealed the nurse documented a new ulcer to the left heel. A new order was made for bunny boots to the left heel and elevate the heel in bed. This skin referral was locked (meaning the referral would no long be on reports run by the Wound Care Nurse) on 1/6/19 and not signed as reviewed by the Wound Care Nurse.

Review of a physician's order dated 1/6/19 revealed the physician ordered for the wound care nurse to evaluate a stage II pressure ulcer to Resident #62's left heel.

There were no wound assessments documented between 1/6/19 and 1/16/19.

Review of a nurse practitioner progress note dated 1/7/19 revealed Resident #62 had bilateral bunny boots in place and had heel pain. The left heel pain was greater than the right heel pain.

Review of a physician ' s progress note dated 1/9/19 revealed Resident #62 had bilateral bunny boots in place and had heel pain with the left heel pain greater than the right heel pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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F 686	Continued From page 80	F 686		

Review of a nurse practitioner progress note dated 1/14/19 revealed Resident #62 had bilateral bunny boots in place and bilateral heel pain. The left heel pain was greater than right heel pain. Left heel stage II pressure ulcer noted with old drainage noted to the inside of the bunny boot. The wound was painful to the touch and with minimal movement. The plan was for the stage II pressure ulcer to continue being followed by the wound nurse and pain controlled with as needed pain medication.

Review of a physician ' s progress note dated 1/16/19 reveled Resident #62 had bilateral bunny boots in place. The left heel was noted to have a stage II pressure ulcer with old drainage noted to the inside of the bunny boot. Pain was present to the ulcer with movement and to touch.

Review of the physician orders revealed on 1/16/19 Resident #62 was ordered betadine and adhesive dressing with foam every other day to the stage II pressure ulcer on the left heel.

Review of a wound flowsheet dated 1/16/19 revealed the resident had an in-house stage II pressure ulcer to his left heel which measured 3 centimeters by 1 centimeter. The ordered treatment was to apply betadine and an adhesive dressing with foam every other day.

Review of Resident #62's January 2019 treatment record revealed Resident #62's order for betadine and adhesive dressing with foam was not initialed as being performed until 1/19/19.

Review of the Resident #62 ' s care plan dated 1/17/19 revealed the resident was care planned

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 81	F 686		

for a pressure ulcer to his left heel. The interventions included to provide medications for wound healing as ordered, observe for changes in skin integrity or skin impairment such as signs or symptoms of infection and pain, specialty boots or pressure relieving boots to both feet, and provide treatments as ordered.

Review of Resident #62 ' s minimum data set assessment dated 2/1/19 revealed the resident was assessed as cognitively intact. He required extensive assistance with bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. He required supervision with eating. Resident #62 had one unhealed stage II pressure ulcer which was not present upon admission.

Review of a wound flowsheet dated 2/1/19 revealed Resident #62 had a stage II pressure ulcer to his left heel which measured 3 centimeters long and 1.5 centimeters wide with no depth.

Review of a wound flowsheet dated 2/5/19 revealed Resident #62 had a stage II pressure ulcer to his left heel which measured 3 centimeters long, 2 centimeters wide, and 0.5 centimeters deep.

Review of a wound flowsheet dated 2/18/19 revealed Resident #62 had a stage II pressure ulcer to his left heel which measured 1.5 centimeters long, 1.5 centimeters wide, and less than 0.25 centimeters deep.

During an interview on 2/18/19 at 1:26 PM Resident #62 and his family member stated he had a pressure ulcer to his left heel. They further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 82	F 686		

stated the nurses had missed some of his treatments and they were not sure when he developed it. He concluded care was better now but at first not all his dressing changes were being done.

During observation on 2/18/19 at 2:58 PM the Wound Care Nurse was observed providing wound care to Resident #62. No concerns were identified with the wound care. The wound was measured to be 1.5 centimeters long, 1.5 centimeters wide, and less than 0.25 centimeters deep.

During an interview on 2/19/19 at 2:15 PM the Wound Care Nurse stated upon admission she would receive a skin referral from the nurse if something is identified. She further stated Resident #62 did not have any pressure ulcers upon admission. The Wound Care Nurse stated another skin referral would be issued for newly identified concerns. She further stated she usually sees new referrals within the first 24 hours but if it's the weekend she would then go and assess the resident the next work week day. She further stated she would have done all new skin referrals on 1/7/19 which was the first work week day following the 1/6/19 when the referral was made and would have been the day following the skin referral. She further stated the nurse who placed the referral form in the system for the newly identified stage II pressure ulcer on 1/6/19 closed the referral on 1/6/19 which meant the referral never made it to her when she came back to work on 1/7/19. She further stated she saw Resident #62 on 1/7/19 for his surgical incision but was not aware of any other new skin conditions at that time. The Wound Care Nurse stated staff were not supposed to close out newly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 83	F 686		

identified skin referrals because it would not show in her report and was how she knew when there were newly identified skin conditions. She continued stated if they did close them out they should slide a copy under the door and that was not done. The Wound Care Nurse stated she was first made aware of the pressure ulcer on 1/16/19 when someone from the management team showed her the referral order placed on 1/6/19. She further stated it was her expectation that the wound be brought to her attention as soon as it was identified, and it was not done due to the nurse closing the referral which caused the referral to not appear in her report. The Wound Care Nurse stated it was too long of a gap from the identification of the wound to her being notified and she did not know what state the wound was in on the 6th, however the physician documented it as a stage II and it had not increased in stage and had decreased in size between her last two measurements. She further stated on 1/16/19 when she was made aware of the pressure ulcer and performed her first assessment on that day with the physician there was no dressing on the wound but bunny boots at that point and then treatment was initiated on that day for betadine with an adhesive foam dressing on the pressure ulcer with the physician. She further stated she did not know why the treatment was not initialed as completed until 1/19/19 on the treatment record because she had placed the first dressing on 1/16/19 when she was first aware of the wound. She concluded from January 6th through January 16th there were no wound assessments or measurements performed on Resident #62's stage II pressure ulcer.

During an interview on 2/19/19 at 3:21 PM the Director of Nursing stated it was her expectation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 84 with newly identified pressure ulcers that the wound care nurse would perform an initial assessment and measure and document that status of the wound within 24 to 48 hours of identification. She further stated it was not acceptable to allow a wound to go ten days without having an assessment performed following its identification. The Director of Nursing stated skin referrals were not to be closed prior to the Wound Care Nurse signing off on the referral and Nurse #1 should not have closed the referral form before the Wound Care Nurse could sign off that she had received. During an interview on 2/19/19 at 4:03 PM Physician #1 stated it was his expectation the Wound Care Nurse do a wound assessment and measurements within the next business day of the request for a wound care nurse referral order and not a delay of ten days. He further stated he did not feel that there had been any deterioration in the wound between 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 #1 stated skin referrals were not to be locked until the wound care nurse was aware of the issue. She further stated the skin referral she completed on 1/6/19 was completed and locked by her on 1/6/19 before the Wound Care Nurse could see it. She further stated the family had stated they believed the wound had been there since the resident entered the facility on 1/4/19 so the Wound Care Nurse already knew about it and was why she closed it and did not inform the Wound Care Nurse.	F 686		
F 732	Posted Nurse Staffing Information	F 732		3/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732 SS=C	Continued From page 85 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 732	Continued From page 86 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to update the staff posting with the actual number of Nursing Aides on the evening shift for 1 of 1 daily nurse staffing forms reviewed. Findings included: Review of the Daily Nursing Staff Posting dated 02/19/19 revealed that on evening shift there were 14 Nursing Aides (NA) that should have been working. On 02/19/19 at 4:20 PM a tour was conducted throughout the facility. There were nine NAs working in the four neighborhoods of the facility. In an interview on 02/19/19 at 4:25 PM Nurse #5 indicated that she did admissions, staffing, and scheduling and also worked as a floor nurse if needed. She stated it was not her responsibility to update the daily staff posting and believed it was the responsibility of the receptionist. Nurse #5 verified that there were nine NAs working on the evening shift that day. In an interview on 02/19/19 at 4:56 PM with the Administrator and the Director of Nursing (DON), the Administrator stated that the process for the staff posting began at midnight when the night shift nurse filled out the staffing form with the projected staff for the following day from the schedule. He indicated it was the responsibility of the scheduler to update the staff posting but that the facility did not have a scheduler at that time. The DON stated she expected the daily staffing to be updated within one hour of the start of the shift. She indicated that since the facility did not have a current scheduler the responsibility for	F 732	The facility immediately put in measures to ensure the facility updates the staff posting with actual number of nursing aides and licensed nurses. The daily nursing staffing sheets are located in the front lobby and are updated in a timely manner at the beginning of each shift to reflect accurate staffing numbers/census. A 100% in-service initiated by the Staff Facilitator to all licensed nursing staff on 3/12/19 and is to be completed by 3/19/19. The education is focused on the process of including the following information on the staffing sheet: facility name, date, current census, total number of actual hours worked by categories of nursing staff directly responsible for resident care per shift □ RN□s, LPN□s, CNA□s. Staffing posting sheets are filled out nightly by 11-7 shift on Flowers neighborhood and posted. Clinical staff are educated to highlight/initial staffing sheets at the time clock as they arrive daily for their assignment to better facilitate tracking of staff. Nurses on Clayton neighborhood and/or scheduler will then timely update the daily staffing sheets at the beginning of each shift: 7-3; 3-11; 11-7. Monitoring will include QI audit tool for	

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F 732	Continued From page 87 updating the posting was hers and that she had not updated the posting. She stated the daily staff posting should accurately reflect the number of staff that was providing care to the residents.	F 732	daily nurse staffing sheets and will be monitored by the Staff Facilitator or designee. Audit tool will be used 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The RN□s and LPN□s will immediately be retrained and re-educated by the auditor for any identified areas of concerns. The Director of Nursing or designee is responsible and will review and initial the audit tool for completion to ensure all areas of concern were addressed. The Executive QI committee will meet to review the nurse staffing posting QI tool monthly X□s 3 months to determine issues and trends to include continued monitoring frequency.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to maintain a medication administration error rate of less than 5% when a nurse failed to prime and hold the insulin pen against the skin for 5 seconds and failed to administer Aspirin as ordered by the physician. This resulted in an error rate of 8% for 2 of 25 opportunities observed for 2 of 5 residents during medication pass. (Resident #88 and Resident #31)	F 759	The facility immediately put in measures to ensure the administration of medications has an error rate of less than 5%. Nurse # 2 was immediately educated on following the insulin pen manufacturer□s recommendations and Nurse # 3 was immediately educated to administer medications per MD order.	3/18/19

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F 759	Continued From page 88 Findings include: 1. Review of the manufacturer ' s recommendations for the Humalog insulin pen used by the facility dated 1/6/17 revealed the insulin pen was to be primed before each injection. (Priming an insulin pen means to remove the air from the needle and cartridge and ensures the pen is working correctly). To prime the insulin pen, the user was to turn the dose knob to select 2 units, hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and push the dose knob in until it stopped and read 0 on the dose window. The user should see the insulin at the tip of the needle. If insulin was not observed at the tip of the needle the steps were to be repeated no more than 4 times. If there was still no insulin observed at the top of the needle, the needle would need to be replaced. To administer the medication, the user was to dial to the desired dosage in the dose window, insert the needle into the skin and push the knob all the way in. The user was then to hold the dose knob in and keep the needle in the skin for 5 seconds. Resident #88 was admitted to the facility on 2/18/19. Her active diagnoses included diabetes mellitus. Review of Resident #88 ' s physician ' s order dated 2/20/19 revealed the resident was ordered Humalog Pen for sliding scale insulin one time. Review of the sliding scale revealed for a blood sugar of 351 to 499, the resident was to receive 12 units of Humalog. During observation on 2/20/19 at 4:26 PM, Nurse	F 759	Medical Director in building and verbally notified at the time. No additional orders provided. Facility ensured the safe and accurate administration of medications for all other residents. Resident #88 and #31 have received medication in accordance with manufacturer□s recommendations and physician orders. The administrative nurses (director of nursing, assistant director of nursing, staff facilitator, quality improvement nurse) ensured all other residents, including residents receiving aspirin and insulin received the appropriate medication using the six rights. Corporate facility consultants also initiated medication pass audits. A 100% in-service was initiated on 3/12/19 by the Staff Facilitator to all licensed nurses with a completion date by 3/19/19. The focus of the education is decreasing medication errors to include following manufacturer□s instructions and giving medications per MD order. All newly hired licensed nurses will be in-serviced on preventing medication errors. Free from medication errors will be monitored by utilizing a QI audit tool for Medication Administration by the Staff Facilitator, Unit Manager, Assistant Director of Nursing, or Director of Nursing. Audit tool will be used 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The licensed nurses will be immediately	

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F 759	Continued From page 89 #2 was observed to check Resident #88 ' s blood sugar. The blood sugar result was 380. During observation on 2/20/19 at 4:56 PM, Nurse #2 was observed to place the needle on the Humalog insulin pen and turned the dial to 12 units. She then entered the resident ' s room and administered the 12 units of insulin to Resident #88 ' s abdomen. The nurse held the insulin pen against the resident ' s skin for 1 second, removed the insulin pen from the skin, and a drop of insulin was observed to drip from the administration site. The nurse did not prime the needle prior to administration. During an interview on 2/20/19 at 4:56 PM, Nurse #2 stated she never primed insulin pens prior to administering insulin via insulin pens. She further stated she usually held the insulin pens for one to two seconds following insulin pen administration. She concluded she only held the pen at the site for a second but Resident #88 did not have much fat which was why some insulin dripped from the injection site. During an interview on 2/21/19 at 9:30 AM, the Director of Nursing stated it was her expectation nurses follow the manufacturer ' s recommendations for insulin pens. She further stated the nurse should have primed the insulin pen prior to administration of the medication as well as held the insulin pen against the injection site for five seconds to insure the appropriate dosage was administered. She concluded this was a medication error. 2. Resident #31 was admitted to the facility on 10/1/17. His active diagnoses included atherosclerotic heart disease of native coronary	F 759	re-trained by the auditor for any identified areas of concern. The Director of Nursing or designee will review and initial the Medication Pass Audit Tool for completion to ensure all areas of concern were addressed. The Executive QI committee will meet to review the Medication Administration QI tool monthly times 3 months to determine issues and trends to include continued monitoring frequency.	

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F 759	Continued From page 90 artery. Review of Resident #31 ' s orders revealed on 12/5/18 the resident was ordered chewable Aspirin 81 milligrams by mouth one time a day. During observation on 2/19/19 at 8:27 AM, Nurse #3 was observed performing a medication administration pass for Resident #31. The nurse was observed to administer enteric coated ("enteric coated" Aspirin means the Aspirin does not dissolve until it is in the small intestines to protect the stomach) Aspirin 81 milligrams by mouth. During an interview on 2/21/19 at 8:05 AM, Nurse #3 stated she administered enteric coated Aspirin instead of the chewable aspirin which was a mistake. She concluded it was a medication error. During an interview on 2/21/19 at 9:30 AM, the Director of Nursing stated it was her expectation nurses follow the physicians ' orders. She concluded by giving the enteric coated aspirin instead of the chewable aspirin it was a medication error by the nurse.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		3/18/19

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F 761	Continued From page 91 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 3 of 5 medication carts observed and failed to keep an unattended medication secured by leaving it on top of a medication cart for 1 of 5 medication carts observed. (100 - 200 Hall Medication Cart, 300 - 400 Hall Medication Cart, and 500 Hall Medication Cart) Findings included: 1. During observation on 2/21/19 at 1:30 PM the 100 - 200 hall medication cart was observed to be at the nurse's station and unlocked. One resident was observed in the common area near the nurse's station approximately 20 feet away from the open door to the nurse's station. There were no nurses at the nurse's station or in line of sight of the medication cart. At 1:31 PM a therapy staff	F 761	The facility immediately put in measures to ensure unattended medications are stored in a locked medication cart. The facility also immediately put in measures to ensure that all medication carts are locked when not supervision by a licensed nurse. Nurse #1, #6, #7 were immediately in-serviced on keeping their carts locked while not under supervision and keeping all medications locked while the cart is unattended. A 100% audit all of medication and treatment carts was completed on 2/22/19 by the Director of Nursing and Assistant Director of Nursing. A 100% in-service was initiated on 2/21/19	

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F 761	Continued From page 92	F 761		

member was observed to walk passed the unlocked medication cart. At 1:31 PM a dietary staff member was observed to walk passed the unlocked medication cart. At 1:32 PM a nurse aide was observed to walk passed the unlocked medication cart. At 1:32 PM the Director of Nursing approached the surveyor.

Upon observation of the unlocked medication cart with the surveyor on 2/21/19 at 1:32 PM the Director of Nursing stated medication carts were always to remain locked when they were unattended. She concluded the medication cart was unlocked and should have been locked. The Director of Nursing then locked the medication cart.

During an interview on 2/21/19 at 1:34 PM Nurse #1 stated she thought she had locked the medication cart and did not know it was unlocked.
2. A. In an observation on 02/21/19 beginning at 6:02 AM a medication cart was outside and to the left of the closed door of room 501. The drawers and the lock of the medication cart were facing into the hallway. The lock of the medication cart did not appear to be engaged. A continuous observation of the medication cart was conducted until 6:05 AM when Nurse #6 opened the door of room 501 and stepped into the hallway. During the three minutes of the continuous observation no other staff members or residents were seen on the hall.

In an interview on 02/21/19 at 6:06 AM Nurse #6 verified that the medication cart was unlocked. She stated the medication cart should always be locked especially if the cart was out of her direct line of sight. Nurse #6 indicated that if not kept locked, anyone could open the cart and take

by the Staff Facilitator to all licensed nurses with a completion date by 3/18/2019. The focus of the education is appropriate storage of drugs and biologicals. All newly hired licensed nurses will be in-serviced on the same and best practice/guidelines.

Drug storage will be monitored by utilizing a QI audit tool by the Staff Facilitator, Unit Manager, Assistant Director of Nursing, or designee. Audit tool will be used 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 1 month. The licensed nurses will be immediately re-trained by the auditor for any identified areas of concern. The Director of Nursing or designee is responsible and will review and initial the audit tool for completion to ensure all areas of concern were addressed.

The Executive QI committee will meet to review the locked medication cart QI tool monthly X□s 3 months to determine issues and trends to include continued monitoring frequency.

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F 761	Continued From page 93	F 761		

medications out.

In an interview on 02/22/19 at 9:55 AM the Director of Nursing (DON) stated she expected medication carts to be locked at all times. She indicated that if the medication carts were not locked anyone could gain access to the carts and it became a safety issue.

B. In an observation on 02/21/19 at 6:08 AM a small white box which appeared to hold medications was seen on top of the locked 300 hall medication cart. No staff or residents were seen on the hall but Nurse #7 approached the cart within approximately 30 seconds.

In an interview on 02/21/19 at 6:09 AM Nurse #7 confirmed that the white box on top of the medication cart contained a medication called Boniva with a dosage of 150 milligrams. There was one dose left in the box. She indicated medications should always be kept secured inside the locked medication cart and not on top of it.

In an interview on 02/22/19 at 9:55 AM the DON stated she expected that medications be secured at all times and not left on top of the medication carts. She indicated that if medications were left on top of the carts anyone could remove them.
3. A continuous observation conducted on 02/21/19 from 5:00 PM to 5:05 PM revealed the medication cart for the 300-400 hall was left unsupervised and unlocked. The med cart was located at the end of the hallway near an exit door. A resident was sitting by the med cart in her wheelchair and stated she was waiting for the nurse to come. On 2/21/19 at 5:05 PM the nurse assigned to the unlocked medication cart was

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F 761	Continued From page 94 observed to exit from a residents ' room which had its door closed and return to the medication cart. An interview was conducted on 2/21/19 at 5:05 PM with the assigned nurse (Nurse #2) upon her return to the medication cart. She stated that she thought she had locked the cart before entering the residents ' room, and that it was an error on her part. She stated she typically double checks to make sure she has locked the cart before leaving it unattended, and this time failed to do so. An interview was conducted on 02/22/19 at 2:42 PM with the Director of Nursing. She stated it ' s her expectation that all medications carts are always kept locked when unattended.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		3/18/19

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F 812	Continued From page 95 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry items of kitchenware before stacking them on top of one another in storage, and failed to monitor dish machine gauges which resulted in kitchenware not being sanitized during the final rinse cycle. The facility also failed to remove grease from stove filters and remove food debris and dust/dirt from behind kitchen equipment and racks along the kitchen perimeter. The facility also failed to label and date opened and repackaged food items in storage areas. Findings included: 1. During initial tour of the kitchen, beginning at 11:03 AM on 02/18/19, 13 of 16 tray pans, stacked directly on top of one another, had moisture trapped between them. During an interview with the Dietary Manager (DM) on 02/21/19 at 10:28 AM she stated about six months ago the dietary staff received in-servicing about the importance of air drying kitchenware before it was stacked in storage. She reported moisture trapped between tray pans provided an environment in which bacteria could grow. She commented this bacteria had the potential for making residents sick. During an interview with Dietary Employee #1 on 02/21/19 at 11:04 AM she stated there were racks designated in the kitchen/dish machine room for air drying kitchenware. She reported dietary staff were educated that kitchenware should be completely dry and free of dried food particles before placing it in storage. She commented that	F 812	The facility immediately put in measures to comply with F812, 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. A complete audit of the kitchen was completed immediately by Director of Dietary Services following the inspection by surveyor on 2/20/19. All food items were properly dated and labeled, pans were separated to prevent wet nesting, stove filters were cleaned, and the kitchen was cleaned of dust and debris from behind equipment and along kitchen perimeter. A professional cleaning vendor was brought onsite to clean stove filters. The dishwasher sensor was replaced by the manufacturer□s representative during the survey. An in-service to all dietary staff on kitchen sanitation including the proper procedures to store, prepare, distribute and serve food in accordance with professional standards for food service safety process was initiated on 2/18/19 by the Director of Dietary Services and will be completed by 3/18/19. All newly hired staff will be in-serviced on the facility□s storage, preparation, distribution, and serving processes. The filters, food labeling, and	

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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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F 812	Continued From page 96 "wet nesting" could cause bacterial growth in kitchenware which could cross-contaminate food that was being stored in it. 2. An observation of the dish machine process was made on 02/20/19 between 9:58 AM and 10:24 AM. The dietary employees participating in the process were not watching the wash or final rinse gauges on the dish machine. At 10:09 AM on 02/20/19 a rack of kitchenware exited the dish machine with the final rinse gauge registering 174 degrees Fahrenheit. Dietary Employee #2 placed this kitchenware on a drying rack. At 10:18 AM on 02/20/19 a rack of kitchenware exited the dish machine with the final rinse gauge registering 176 degrees Fahrenheit. Dietary Employee #2 placed this kitchenware on a drying rack. During an interview with Dietary Employee #2 on 02/20/19 at 10:22 AM she stated she checked the dish machine gauges when the dish machine process first started up after meals. She reported the final rinse temperature was supposed to be 165 degrees Fahrenheit. During an interview with the Dietary Manager (DM) on 02/21/19 at 10:28 AM she stated dietary staff had been in-serviced that the minimum final rinse temperature necessary to sanitize kitchenware via the dish machine was 180 degrees Fahrenheit. She reported it was the responsibility of the employee collecting kitchenware that was exiting the dish machine to monitor the wash and final rinse gauges. She commented if the final rinse temperature did not reach 180 degrees Fahrenheit the kitchenware was to be run back through the dish machine, and if the required temperature was still not reached, she was to be notified so she could	F 812	drying of pans were added to a weekly audit tool managed by the Director of Dietary Services. The kitchen sanitation audit tool will be monitored by the Food Service Consultant or designee for QI purposes. The Nursing Home Administrator is responsible for the QI tools and will review 3 times per week for 8 weeks then monthly times 1 month. The pertinent staff will be immediately re-trained by the auditor for any identified areas of concern. The Executive QI committee will meet to review the notification of changes QI tool monthly times 3 months to determine issues and trend to include continued monitoring frequency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 97	F 812		

involve the maintenance department and/or the contracted service technician. According to the DM, since the 02/20/19 dish machine observation a dish machine part was replaced which was compromising the ability of the final rinse cycle to kick in consistently and efficiently.

During an interview with Dietary Employee #1 on 02/21/19 at 11:04 AM she stated she had attended multiple in-services during which it was emphasized that when operating the dish machine the wash gauge needed to register at least 150 degrees Fahrenheit and the final rinse gauge needed to register at least 180 degrees in order to sanitize kitchenware. She reported if those temperatures were not met dietary staff was supposed to notify the DM so she could get the problem fixed. She commented that residents could get sick eating off kitchenware that was not sanitized.

3. During initial tour of the kitchen, beginning at 11:03 AM on 02/18/19, five filters in the hood system located above the stove and oven had rivulets of grease on them. There was also grease on the back splash behind the stove and ovens. Food debris, dust/dirt, condiment packets, paper, and kitchenware were found along the perimeter kitchen walls, behind equipment and racks.

At 9:17 AM on 02/20/19, during a follow-up tour of the kitchen, five filters in the hood system located above the stove and oven had rivulets of grease on them. There was also grease on the back splash behind the stove and ovens. Food debris, dust/dirt, condiment packets, paper, and kitchenware were found along the perimeter kitchen walls, behind equipment and racks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 98	F 812		

During an interview with the Dietary Manager (DM) on 02/21/19 at 10:28 AM she stated at one time the filters in the hood system were cleaned every three months by a contracted service, but that frequency had been changed to every six months. She reported grease on the filters posed a possible fire hazard, and the debris along the floor boards of the kitchen and dish room increased the chance of pest problems. She commented the perimeter floors were supposed to be cleaned daily, but she was not sure that was happening.

During an interview with Dietary Employee #1 on 02/21/19 at 11:04 AM she stated the dietary department had some employees who were out of work so she thought the center of the kitchen floors were being mopped and swept twice a day, but she commented it might have been awhile since employees had time to clean in behind equipment and racks. She commented grease and food debris could breed rodents and pests, and dust/dirt could grow bacteria and mold.

4. During initial tour of the kitchen, beginning at 11:03 AM on 02/18/19, opened food items found in the dry storage room were without labels and dates. These items included two 1-pound bags of light brown sugar, a bag of potato pearls (instant potatoes), a 5-pound box of quick grits, two bags of rotini noodles, and a bag of egg noodles. In the walk-in refrigerator an opened 5-pound bag of shredded mozzarella cheese, an opened 8-pound 10-ounce container of salsa, opened gallon containers of Cole slaw dressing and mayonnaise, and an opened gallon container of barbeque sauce were without labels and dates. In the walk-in freezer an opened bag of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 812	Continued From page 99 strawberries did not have a label and date on it. On 02/20/19 at 9:28 AM, during a follow-up observation of the kitchen, there was an opened bag of pepperoni in the walk-in freezer without a label and date on it. During an interview with the Dietary Manager (DM) on 02/21/19 at 10:28 AM she stated food items which were resealed and repackaged should all have labels and dates on them. She reported her staff was taught that anyone who opened food items and placed them in a storage container or resealed them was responsible for placing labels and dates on them. She commented that she and her assistant tried to monitor all storage areas daily to make sure labeling and dating was done. During an interview with Dietary Employee #1 on 02/21/19 at 11:04 AM she stated labeling and dating opened and repackaged food items was important so that residents could be served the freshest food possible. She explained dating and labeling was a vital element in the FIFO (first in, first out) system. She reported either the DM or her assistant tried to monitor all storage areas daily for labeling and dating, but sometimes that was difficult to do.	F 812		
F 835 SS=H	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 835		3/18/19

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F 835	Continued From page 100 This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, wound center interview, home health interview, staff interview, and record review the facility administration failed to provide effective leadership and oversight in the implementation of wound care policies and procedures to ensure that 3 of 3 sampled residents (Resident #48, #62, and #188) reviewed for pressure ulcers received initial and weekly wound assessments and were free from neglect. The administration also failed to provide guidance to ensure that facility staff expedited a wound consult, administered an appropriate wound treatment, and implemented pressure-reducing interventions for 1 of 3 sampled residents (Resident #48) reviewed for pressure ulcers. Findings included: This tag is cross-referenced to: 1. F686: Treatment/Services to Prevent/Heal Pressure Ulcers: Based on observation, physician interview, wound center interview, home health interview, and staff interview the facility failed to conduct initial and weekly wound assessments which included measurements and descriptions of the wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain for 3 of 3 sampled residents (Resident #48, #62, and #188) with pressure ulcers. No initial or weekly wound assessments were completed for Resident #48's right heel ulcer from 12/16/18, when it was identified, until 01/08/19 when a Quality Assurance (QA) Skin Wound Review documented the 4.5 x 3.5 centimeter (cm) ulcer to the resident's right heel was painful and presented with yellow/green purulent drainage.	F 835	On 3/13/19, the regional vice president (RVP) and the corporate clinical director met with the administrator and director of nursing to review the Performance Improvement Plan (PIP) initiated for wound/skin care to ensure the ongoing completion of the plan. On 3/13/19, the corporate clinical director addressed the use of the interdisciplinary team (IDT) to review the wound care program. Corporate (RVP, clinical director, and/or facility consultants) is providing off-site and on-site review of the electronic health record for nursing progress notes and wound care documentation. On 3/13/19, the administrative team determined key focus areas can be improved through the use of: 1) a newly added structured daily standup meeting using the IDT process, 2) newly structured daily clinical meeting, 3) end of day follow-up IDT meeting, 4) review of the 24 hour report sheets, 5) administrative rounds, 6) care plan reviews, 7) medication pass audits, 8) wound rounds by the director of nursing/assistant director of nursing, 9) notification to resident representatives/family members in regards to wound status and treatment plans, 10) physician notification procedures, 11) continued use of the QAPI process. On 3/12/19, the administrator directed the	

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F 835	Continued From page 101 No initial or weekly pressure ulcer assessments which included measurements and descriptions of wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain were completed for Resident #188 from 11/28/18, when a blister opened on her right heel, through her discharge from the facility on 02/07/18. On 02/08/18 home health services assessed the pressure ulcer to Resident #188's right heel as being a stage III wound measuring 2 x 2 x 0.5 cm with drainage. A skin referral was submitted for Resident #62 on 01/06/19 due to a painful stage II wound. However, an initial wound assessment was not completed for the resident until 01/16/19 when it was determined Resident #62 had a stage II pressure ulcer to the left heel. This ulcer was found with dried drainage, and the wound was painful to touch and movement. In addition, the facility failed to expedite a wound center consult for Resident #48 which was documented as being requested by the facility on 01/08/19 for a deep tissue injury (DTI) to the resident's right heel. The wound center consult did not occur until 01/30/19 at which time the heel wound presented as an unstageable pressure ulcer with slough and eschar in the wound bed and a moderate amount of drainage. In addition, based on facility documentation, the facility inappropriately applied calcium alginate, designed to absorb excess fluid and promote natural debridement via enzymes, to Resident #48's right heel ulcer from 12/21/18 until 01/30/19. The facility documented this wound as being a DTI from 12/20/18 until 01/18/19 and as being free from slough/eschar and drainage from 01/18/19 until a wound center consult on 01/30/19.	F 835	initiation of a 100% head-to-toe skin audit to ensure all residents are accurately assessed and have assessments completed. The audit was completed on 3/18/19. On 3/13/19, the nursing home administrator initiated an in-service was for the interdisciplinary team to include MDS nurses, activities, social services, dietary, and the director of nursing. An audit of completed assessments will be reviewed three times per week for four weeks for a total of ten residents, then three times per week for four weeks for a total of five residents, then monthly for one month for five residents. The audits will be conducted by the assistant director of nursing, unit managers, director of nursing or designee to ensure compliance, communication and accuracy of the facilities process improvement initiatives. The results of the audit tool will be reviewed by the administrator weekly. The director of nursing or designee will take audit results to the Quality Improvement Executive Committee monthly for three months for further recommendations and determine need for continued monitoring.	

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

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F 835	Continued From page 102	F 835		

In addition, the facility failed to off-load Resident #48's heels from the bed as recommended by the wound center and implemented by the physician.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated wounds/wound assessments had not been identified as a problem to address through the facility's quality assurance (QA) or quality assessment/performance improvement (QAPI) processes. However, she reported that recently her work was more closely supervised by the Assistant Director of Nursing (ADON) as was evidenced by the ADON accompanying her on weekly wound rounds. The Treatment Nurse commented she thought this change was brought about because of some wound assessment inconsistencies which were noticed by the management team.

During an interview with the Director of Nursing (DON) on 02/19/19 at 4:18 PM she stated a wound performance improvement plan (PIP) was started on 01/24/19, and as part of that plan the work of the facility's Treatment Nurse would be more closely supervised by the ADON.

During a follow-up interview with the DON on 02/19/19 at 5:34 PM she stated that not all nurses and nursing assistants currently employed by the facility had received the in-servicing outlined in the facility's wound PIP. She shared the sign-in sheets which documented that prior to 4:18 PM on 02/19/19 only 16 nurses had received education about the Wound Process, and only 16 nurses and 10 nursing assistants had received education about Pressure Ulcer Prevention. Using license verifications and nurse aide registry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 835	Continued From page 103	F 835		

checks provided by the facility as a reference, less than 50% of the staff in the facility had been educated on the Wound Process and Pressure Ulcer Prevention. In comparing staffing sheets with the PIP in-servicing sign-in sheets, staff who had not attended wound in-servicing had worked in the facility since 02/08/19. According to the DON, because of staffing issues and the departure of some management/administrative staff the facility was not able to complete wound assessment education as outlined in their PIP.

During an interview with the Administrator on 02/22/19 at 9:21 AM he stated the facility had taken an opportunity to improve on its assessment and care of wounds by developing a PIP, but he was unaware that the in-servicing involved in the PIP had not been completed. He reported there were some new members of the leadership team in the facility, and sometimes it was challenging to get all staff to embrace changes the new leadership was advocating.

During a follow-up interview with the DON on 02/22/19 at 10:46 AM she stated agency staff had not been included in the PIP wound in-servicing because the facility was planning on phasing agency staff out in the near future.

2. F600: Free from Abuse and Neglect: Based on observation, physician interview, staff interview, and record review the facility neglected 3 of 3 sampled residents (Resident #48, #62, and #188) reviewed for pressure ulcers by failing to complete initial and weekly wound assessments for these residents.

No initial or weekly wound assessments (which

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F 835	Continued From page 104	F 835		

included measurements and descriptions of the wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain) were completed for Resident #48's right heel ulcer from 12/16/18, when it was identified, until 01/08/19. The facility neglected to expedite a wound center consult for Resident #48 which was documented as being requested by the facility on 01/08/19 for a deep tissue injury (DTI) to the resident's right heel. The facility failed to apply a dressing in accordance with the facility's wound care management of DTIs to Resident #48's right heel pressure ulcer. The facility failed to off-load Resident #48's heels from the bed as recommended by the wound center and implemented by the physician. On 01/08/19 the pressure ulcer to Resident #48's wound presented with yellow/green purulent drainage, and was painful. When Resident #48 was seen at the wound clinic on 01/30/19 the pressure ulcer to the resident's right heel, which the facility documented was a DTI and then as stage II wound, was identified as an unstageable pressure ulcer with slough and eschar in the wound bed and a moderate amount of drainage.

No initial or weekly pressure ulcer assessments (which included measurements and descriptions of wound bed, tunneling or undermining, possible necrosis/infection, drainage, odor, and pain) were completed for Resident #188 from 11/28/18, when a blister opened on her right heel, through her discharge from the facility on 02/07/18. On 02/08/18 home health services assessed the pressure ulcer to Resident #188's right heel as being a stage III wound measuring 2 x 2 x 0.5 centimeters (cm).

A skin referral was submitted for Resident #62 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 105	F 835		

01/06/19 due to a painful stage II wound to the resident's left heel. The initial wound assessment was not completed for Resident #62 until 01/16/19 when it was found with dried drainage, and was painful to touch and movement.

During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated wounds/wound assessments had not been identified as a problem to address through the facility's quality assurance (QA) or quality assessment/performance improvement (QAPI) processes. However, she reported that recently her work was more closely supervised by the Assistant Director of Nursing (ADON) as was evidenced by the ADON accompanying her on weekly wound rounds. The Treatment Nurse commented she thought this change was brought about because of some wound assessment inconsistencies which were noticed by the management team.

During an interview with the Director of Nursing (DON) on 02/19/19 at 4:18 PM she stated a wound performance improvement plan (PIP) was started on 01/24/19, and as part of that plan the work of the facility's Treatment Nurse would be more closely supervised by the ADON.

During a follow-up interview with the DON on 02/19/19 at 5:34 PM she stated that not all nurses and nursing assistants currently employed by the facility had received the in-servicing outlined in the facility's wound PIP. She shared the sign-in sheets which documented that prior to 4:18 PM on 02/19/19 only 16 nurses had received education about the Wound Process, and only 16 nurses and 10 nursing assistants had received education about Pressure Ulcer Prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 835	Continued From page 106 Using license verifications and nurse aide registry checks provided by the facility as a reference, less than 50% of the staff in the facility had been educated on the Wound Process and Pressure Ulcer Prevention. In comparing staffing sheets with the PIP in-servicing sign-in sheets, staff who had not attended wound in-servicing had worked in the facility since 02/08/19. According to the DON, because of staffing issues and the departure of some management/administrative staff the facility was not able to complete wound assessment education as outlined in their PIP. During an interview with the Administrator on 02/22/19 at 9:21 AM he stated the facility had taken an opportunity to improve on its assessment and care of wounds by developing a PIP, but he was unaware that the in-servicing involved in the PIP had not been completed. He reported there were some new members of the leadership team in the facility, and sometimes it was challenging to get all staff to embrace changes the new leadership was advocating. During a follow-up interview with the DON on 02/22/19 at 10:46 AM she stated agency staff had not been included in the PIP wound in-servicing because the facility was planning on phasing agency staff out in the near future.	F 835		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		3/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 107 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to fully implement a performance improvement plan (PIP) for wound assessment which the facility initiated on 01/24/19 and was to have completed by 02/08/19. At the time of the survey less than 50% of the nursing staff in the facility had been educated on the Wound Process and Pressure Ulcer Prevention by 02/08/19 as outlined in the facility's PIP. Findings included: Review of the facility's wound assessment performance improvement plan (PIP), which was initiated on 01/24/19, revealed "On 01/24/19 100% in-service was initiated by the Staff Facilitator with all nurses in regards to the Wound Process to include: 1. Assessment of wounds: a. On admission with documentation of wound/skin issues in Nursing Admission Assessment with completion of skin referral. b. With all new wounds or skin issues. 2. MD/RR (physician/responsible party) notification. 3. Treatment orders. 4. Wound/Ulcer treatment. In-service will be completed by 02/08/19. After 02/08/19 no nurse will be allowed to work until in-service is completed." "On 02/01/19 100% in-service was initiated by the Staff Facilitator with all nurses and nursing assistants in regards to Pressure Ulcer Prevention to include but not limited to turning and positioning residents frequently, pad bony prominences with pillows or foam products, provide incontinent care, inspect skin and notify appropriate staff of abnormal changes and using positioning/protective devices as need to protect susceptible areas from breakdown. In-service will be completed by 02/08/19. After 02/08/19 no nurse or nursing assistant will be allowed to work until in-service is	F 867	The facility immediately put in measures to review and meet the requirements of providing a Quality assurance and performance improvement (QAPI) program in accordance to F865, 483.75(a). The facility self-identified a need to review the wound process and implemented a Performance Improvement Plan (PIP) 1/24/19 through the QAPI program of the facility. The PIP initiated assessment of resident wounds, documentation of wound/skin issues, notification of physician and any necessary treatment. The facility□s PIP is an effective tool to improve wound/skin issues. The facility will continue to utilize the PIP to improve the facility□s wound/skin programs that was initiated on 1/24/19. QAPI plan for pressure wounds was reviewed to ensure it is ongoing, comprehensive, and addresses the full range of care and services provided by the facility. The QAPI program addresses all systems of care and management practices, includes clinical care, quality of life, and resident choice, utilizes the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF, and reflects the complexities, unique care, and services that the facility provides.	

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	345569	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 867	Continued From page 108 completed." During an interview with the facility's Treatment Nurse on 02/19/19 at 3:52 PM she stated wounds/wound assessments had not been identified as a problem to address through the facility's quality assurance (QA) or quality assessment/performance improvement (QAPI) processes. However, she reported that recently her work was more closely supervised by the Assistant Director of Nursing (ADON) as was evidenced by the ADON accompanying her on weekly wound rounds. The Treatment Nurse commented she thought this change was brought about because of some wound assessment inconsistencies which were noticed by the management team. During an interview with the Director of Nursing (DON) on 02/19/19 at 4:18 PM she stated a wound PIP was started on 01/24/19 due to the high volume of wounds that the facility was following and treating. During a follow-up interview with the DON on 02/19/19 at 5:34 PM she stated that not all nurses and nursing assistants currently employed by the facility had received the in-servicing outlined in the facility's wound PIP. She shared the sign-in sheets which documented that prior to 4:18 PM on 02/19/19 only 16 nurses had received education about the Wound Process, and only 16 nurses and 10 nursing assistants had received education about Pressure Ulcer Prevention. Using license verifications and nurse aide registry checks provided by the facility as a reference, less than 50% of the staff in the facility had been educated on the Wound Process and Pressure Ulcer Prevention. In comparing staffing sheets	F 867	A QAPI meeting was held on 2/27/19 to review the facility□s systems and ensure compliance. A template is used to track the QAPI programs progress. An in-service to all QAPI members that includes Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Wound Care Nurse, Pharmacist Consultant, Medical Director, Activities, Social Services, Dietary, and MDS Nurses was held on 3/13/19 regarding requirements of 483.75 (a) by the Nursing Home Administrator. All newly appointed staff will be in-serviced on the facility□s QAPI process. The QAPI committee meets monthly to review and monitor progress of identified areas. The Nursing Home Administrator is responsible for the QAPI plan for pressure wound and will audit weekly times 4 weeks then monthly for 2 months during the scheduled QI meeting. The QAPI members will be immediately re-trained by the auditor for any identified areas of concern. The Executive QI committee will meet to review the QI process monthly times 3 months to determine issues and trend to include continued monitoring frequency.	

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F 867	Continued From page 109 with the PIP in-servicing sign-in sheets, staff who had not attended wound in-servicing had worked in the facility since 02/08/19. According to the DON, because of staffing issues and the departure of some management/administrative staff the facility was not able to complete wound assessment education as outlined in their PIP. During a follow-up interview with the DON on 02/22/19 at 10:46 AM she stated agency staff had not been included in the PIP wound in-servicing because the facility was planning on phasing agency staff out in the near future.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		3/18/19

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F 880	Continued From page 110 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 111 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to handle dirty linen in a sanitary manner by placing it on the floor for 2 of 2 sampled residents (Resident #66 and Resident #41). The facility also failed to handle dirty linen in a sanitary manner when a Nursing Assistant (NA) was observed carrying unbagged dirty linen against her chest down the hallway and into the dirty linen room. Findings included: Review of the Handling of Linen policy dated 09/2014 revealed soiled linen should be held away from the uniform and the body. Soiled linen should be bagged and carried to a soiled utility room for disposal. 1. A. In an observation and interview on 02/18/19 at 11:14 AM soiled linen was seen on the floor between the wall and the side of the bed in Resident #66's room. Nursing Assistant (NA) #6 stated she had just provided care to the resident and the linens on the floor were the linens she had used. In an interview on 02/20/19 at 12:15 PM. Nurse #5 indicated that NA #6 was unavailable for a follow-up interview. In an interview on 02/21/19 at 3:10 PM Nurse #4 stated that dirty linens should be placed in a bag and not thrown on the floor. She indicated that plastic bags were always available for NAs to put the dirty linens in.	F 880	The facility immediately put in measures to make prompt efforts to establish and 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 all immediately re-educated and in-serviced regarding infection control: handling of dirty linen. Dirty linen will be bagged to prevent contamination and removed to soil utility room as soon as possible. The rooms of Resident #66 and #44 where the linen was temporarily placed on the floor during the delivery of resident care were immediately sanitized and cleaned by staff. A 100% in-service was initiated by the staff facilitator on 2/21/19 to include all staff to include RN□s , LPN□s and CNA□s regarding following infection control policy specifically as it relates to linen handling. In-service will be completed by 3/18/19. Infection control process related to handling will be monitored by a QI infection control audit tool overseen by the Assistant Director of Nursing, Unit	

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F 880	Continued From page 112 In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) stated that soiled linen should be placed in a plastic bag and taken from the room. She indicated that soiled linen should not be thrown on the floor of resident's rooms because anything on the linen could be transferred to the floor. 1. B. In an observation and interview on 02/19/19 at 8:35 AM soiled linen was seen on the floor against the wall at the foot of Resident #41's bed. NA #7 was seen picking up the soiled linen from the floor and placing it in a bag. She indicated she should have placed the soiled linen directly in a plastic bag and not thrown it on the floor. She stated she had a plastic bag available but had been in a hurry and had not used it. In an interview on 02/21/19 at 3:10 PM Nurse #4 stated that dirty linens should be placed in a bag and not thrown on the floor. She indicated that plastic bags were always available for NAs to put the dirty linens in. In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) stated that soiled linen should be placed in a plastic bag and taken from the room. She indicated that soiled linen should not be thrown on the floor of resident's rooms because anything on the linen could be transferred to the floor. 2. In an observation on 02/19/19 at 7:45 AM NA #8 was seen walking down the hallway with rolled up and unbagged soiled linens in her arms touching her uniform. She indicated she should have placed the soiled linen in a bag prior to walking out of a resident's room and down the hallway. She stated plastic bags were available	F 880	Managers, or designee. Audit tool will be utilized 3 times a week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. Any staff member to include the RN□s, LPN□s and CNA□s will immediately be retrained and re-educated by the auditor for any identified areas of concern. The Director of Nursing or designee is responsible and will review the Infection Control audit tools for completion to ensure all areas of concern were addressed weekly x□s 8 weeks and monthly x 1 month. The Executive QI committee will meet to review the Infection Control audit tool monthly x 3 months to determine issues and trends to include continued monitoring frequency.	

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F 880	Continued From page 113	F 880		

but she did not have one when she removed the soiled linen from the room.

In an interview on 02/21/19 at 3:10 PM Nurse #4 stated that dirty linens should be placed in a plastic bag and not carried against the uniform. She indicated that plastic bags were always available for NAs to put the dirty linens in.

In an interview on 02/22/19 at 9:14 AM the Director of Nursing (DON) stated that soiled linen should be placed in a plastic bag and taken from the room. She indicated that soiled linen should not be carried unbagged and against the uniform because anything on the linen could be transferred to the uniform.