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 04/07/2020

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on April 1-7, 2020. The facility was found to be in substanital compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart B Requirments for Long Term Care Facilities. The census was 99 (98 in house + 1 bed hold).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Survey was conducted from April 1 - 7, 2020. Event ID # E9JQ11 Two of the two complaint allegationswere substantiated resulting in deficiencies.	F 000		
F 880 SS=F	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	F 880		5/5/20

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

Electronically Signed | 04/19/2020

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F 880	Continued From page 1	F 880		

conducted according to §483.70(e) and following accepted national standards;

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

§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

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F 880	Continued From page 2 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, family, health department and Department of Social Services interview, the facility failed to implement social distancing among staff and screen individuals who had volunteered to take residents to medical appointments and discuss limiting the transport to the appointment only (Resident #1, 2, 3, 4 & 5). These failures occurred during a COVID-19 pandemic. Findings Included: 1. According to the facility's Influenza A/COVID-19 Validation Checklist, dated March 2020, employees should practice social distancing (6 feet) with other staff and patients when possible. Observation on 4/1/20 at 8:30 AM revealed more than one person entered the vestibule at the front of the nursing home at the same time and then entered the lobby area. A screening station was set up at the reception desk. It included a screening question document, an End of Life Critical Support Sign-in notebook, an Employee (Facility and Consultant) Daily Wellness Check Sheet notebook, hand sanitizer, a stand-up temperature machine, individual thermometers with disposable sleeves and a trash can. The visitor and employee sign in books were side by side on the reception counter. Individuals were grouped in the lobby and social distancing was not implemented at the screening station. No one was observed to try to correct the situation or	F 880	Springbrook Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Springbrook Nursing and Rehabilitation□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 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 proceeding. On 4/2/20, the Administrator made the decision to mark the floor of the front lobby to ensure social distancing of 6 feet is maintained. Only four people will be allowed to be screened in the lobby area at a time. Each person must stand on the marked area of the floor to include during	

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F 880	Continued From page 3 slow the entry of individuals. The surveyor signed in at 8:45 AM. On April 1, 2020, at 8:45 AM, four staff members also signed in at 8:45 AM on the (Employee Facility and Consultant) Daily Wellness Check Sheet. These employees included the Business Office Manager, Nurse Aide (NA) # 7, NA #8 and a Physical Therapy Assistant. Review of the Employee (Facility and Consultant) Daily Wellness Check Sheet notebook revealed a total of 7 employees signed in between 8:30 AM and 8:45 AM. On 4/3/20 at 4:10 PM, the Receptionist was interviewed by telephone regarding her duties related to screening. She said the front door was locked. No one came in unless authorized. For staff, - someone would open the door. The procedure was: use sanitizer, take temperature, ask screening questions, if answer was no, then they sign, date, answer questions, wash hands and proceed to work station. The nursing home did not allow visitors, except for end of life. The same process applied for visitors. Sanitize hands, take temperature, log time in and out. They ask questions. Someone escorted the visitor to wash hands. They are escorted to the room and escorted back and then, let them out. They try to keep 6 feet apart. They tried their best and kept some distancing. They received some guidance. On 4/3/20 at 4:38 PM, the Business Officer was interviewed by telephone. She said, "We have been getting directives from home office and administrator. We follow Centers for Disease Control (CDC) and Department of Health and Human Service (DHHS) guidelines. Now people	F 880	screening to ensure social distancing is maintained. A sign was posted on the door to the entrance of the front lobby for notification of the social distancing procedure upon entering the facility. On 4/02/20, the Administrator developed a letter for notification to 100% of families and residents to include resident #1, #2, #3, #4, and #5. The letter included (1) residents can only go out to essential appointments (2) residents will be transported by medical transport services only and (3) each medical transporter will be screened prior to transporting the resident. On 4/17/20, the Administrator initiated a second letter to include (1) at no time will families or volunteers be allowed to transport residents for any reason unless during discharge. The letter will be mailed by 5/5/20 to 100% of all residents and resident representatives to include residents #1, #2, #3, #4, and #5 by the receptionist and Administrative office staff. On 4/14/20, the Facility Consultant observed the front lobby area to include the screening station to ensure social distancing was maintained throughout the day. There were no concerns identified. 100% audit was completed by the Administrator, and transporter to ensure all upcoming appointments from 3/31/20 to 4/13/20 were essential (urgent and cannot be postponed). The Transporter contacted each residents physician to evaluate the urgency of the appointment with documentation in the clinical record. The Transporter ensured that medical	

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F 880	Continued From page 4 must wait until the next person is escorted in. We use social distancing. She was asked about social distancing on Wednesday, April 1, 2020 because she signed in at 8:45 AM. She said, "I give it a general time, because I round time up or down. We have a clock there, but it is not a digital clock." On 4/3/20 at 4:47 PM, NA #7 was interviewed by telephone. She said guidance comes through in-services, staff meetings, calls --many different ways. On Wednesday, April 1, 2020 she signed in at 8:45 AM. When asked about that date, she said on Wednesday she tried to stay away from others. She said the clock might have been 8:46 AM or 8:47 AM. "I keep my distances. We have been doing that mostly." On 4/3/20 at 5:46 PM, the Physical Therapy Assistant was interviewed by telephone. The guidance comes from in-services. She said she had no concerns at the visitor entrance. She said, "I try to stand back. New employees were being oriented that morning. It's normally not like that." On 4/3/20 at 6:38 PM, NA #8 was interviewed by telephone. She said she was an orientee. She thought the nursing home had good practices using sanitizer, taking temperatures, washing hands and questions. "There was a couple of people in there. I did not think it was that close." On 4/4/20 at 2:11 PM the administrator said, "since 4/2/20, we have put dots on the floor since you left to show 6 feet intervals. We are giving guidance - Don't crowd my dot. Daily logs have been going to the corporate office daily so they can help track."	F 880	transport services only were scheduled to transport residents to all identified essential appointments. All non-essential appointments were cancelled or rescheduled with approval from the physician and documented in the clinical record by the Transporter. An in-service was initiated on 4/13/20 with 100% of all current employees to include the Business office Manager, Nurse Aide (NA) #7, NA #8, the physical therapy Assistant, the receptionist, and agency staff regarding the importance of maintaining social distancing and the new procedure implemented at the front lobby to ensure social distancing is maintained to include at the screening station. All newly hired staff to include Business Office staff, NAs, physical therapy staff, and agency staff will be in-serviced by the Staff Facilitator during orientation in regards to Social Distancing. An in-service was initiated on 4/13/20 by the facility consultant with 100% of all nurses, the Administrator, the DON, and the appointment scheduler regarding residents are only allowed to leave the facility for essential appointments unless during discharge; residents are allowed to be transported to essential appointments by medical transport service only; all medical transport service personnel must be screened prior to taking a resident to an essential appointment; and families and volunteers are not allowed to transport residents for any reason unless during discharge from the facility. All newly hired nurses and agency nurses will	

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F 880	Continued From page 5 1. According to the Corporate Clinical Director via an email dated April 7, 2020, guidance on handling patients going to an outside physician appointment during restriction was addressed via a conference call on 3/20/20 with all company facilities including Springbrook. The policy addressed urgency of the appointment and indicated "We should take every step to limit exposure to our residents, due to the increasing number of confirmed COVID -19 cases throughout our state." The communication included four bullets, but none were about using volunteers to transport, screening volunteers or restricting activities other than going to the appointment and returning from the appointment. a. Resident #1 was admitted on 3/16/20. Physician's orders indicated he had orders for daily temperature checks and the physician (MD) was to be notified for a temperature greater than 100.4 degrees Fahrenheit (F) since 3/21/20. He had a Minimum Data Set (MDS) Admission assessment on 3/22/20. He had no cognitive problems. He had diagnoses including anemia, atrial fibrillation, diabetes, chronic obstructive pulmonary disease (COPD) and chronic pain syndrome. The diagnoses tab of the electronic medical record also indicated he had pneumonia due to other specified infectious organisms and acute kidney failure. On 4/1/20 at 8:46 AM, the Administrator said, "On 3/26/20 Resident #1 went out with his friend to a chronic pain appointment. After the appointment they drove through a fast food restaurant to get food." His temperatures were monitored and recorded in the electronic health record under the vital signs tab. None of the results met criteria for notifying the MD. New physician orders dated 3/31/2020 were for	F 880	receive the in-service by the Staff Facilitator during orientation. In-services will be completed by 5/5/20. The Activities Director, Social Workers, and/or Unit Manager will complete observations 3 x a week x 4 weeks then monthly x 1 month of staff on each area of the facility to include at the screening station to ensure social distancing is maintained. The observations will be documented on a Social Distancing Audit Tool. Staff will be retrained during the audit by the Director of Nursing, Unit Managers and/or Administrator for any identified areas of concern. The Administrator will review and initial the Social Distancing Audit Tool 3 x a week x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. All upcoming appointments will be reviewed weekly x 4 weeks then monthly x 1 month by the Supervisor and/or Unit Managers to ensure the physician has been contacted to review the urgency of the appointment with documentation in the clinical record and to ensure the medical transport company has been scheduled to transport the resident to the appointment. This will be documented on the Consult Tracking Audit Tool. The transporter will cancel or reschedule the appointment and/or contact medical transport services with retraining of the nurse and/or appointment scheduler during the audit for any identified areas of concern. The Director of Nursing will review and initial the Consult Tracking Audit Tool weekly x 4	

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F 880	Continued From page 6 Doxycycline Hyclate, an antibiotic, for the treatment of pneumonia and it was started on 3/31/20. On 4/1/2020 at 10:23 AM Resident #1 was observed sitting alone in the "Café". He said his friend picked him up for the appointment. "Took me across the street. That was it. I don't know if they screened him or asked him any questions." He said he did not wear a mask but performed good handwashing. According to the Daily Census dated 3/31/20 and printed 4/1/20, Resident #1 resided in a semi-private room, but had no roommate. b. Resident #2 was admitted on 3/14/20. She had an MDS Admission assessment on 3/20/20. She had no cognitive problems. She had diagnoses including fractures and multiple trauma, anemia, hypertension, diabetes, hyponatremia, and systemic lupus erythematosus. Physician's orders indicated she had orders for daily temperature checks and the MD was to be notified for a temperature greater than 100.4 degrees Fahrenheit (F) since 3/21/20. On 4/1/20 at 8:46 AM, the Administrator said, "On 3/25/20 Resident #2 went out with a family member. They went to a physician's appointment and then went through a fast food drive through. She had a surgical repair of a left humerous fracture. Her highest temperature was 99.5 on 3/24/20 and she has not had any symptoms." Her temperatures were monitored and recorded in the electronic health record under the vital signs tab. None of the results met criteria for notifying the MD. She had temperatures recorded two times every	F 880	weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the Social Distancing Audit Tool and the Consult Tracking Audit Tool to the Executive QA Committee monthly x 2. The Executive QA Committee will review the Social Distancing Audit Tool and the Consult Tracking Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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day. None of the results met criteria for notifying the MD.

On 4/1/20 at 11:31 Resident #2 was interviewed. She said, "I am a prime target (re virus)." She said a lot of appointments were cancelled because they were not critical. She went to the surgeon last week with her family member. The family member just came to the front door. Resident #2 was x-rayed, then they went to a drive through restaurant. They did not screen her family member, or she did not see it being done. They did not give her a mask.

On 4/3/20 at 6:12 PM Resident #2's family member was interviewed by telephone. She stated she was not given any instructions, was in the health field and was extremely cautious. The appointment was set for 3/25 - late. It was only her Mom and her. The car had been sprayed with disinfectant. They used hand sanitizer and it was with them. No one was in waiting room. They did not touch anything. In for a very short period, the x-rays were performed, and the MD was seen. They got food from a drive through window. She spoke to the MD's office beforehand. They needed to x-ray. She did all she knew to be safe.

According to the Daily Census dated 3/31/20 and printed 4/1/20, Resident #2 resided in a private room.

c. Resident #3 was admitted on 1/14/20. She had an MDS significant change assessment on 2/27/20. She had no cognitive problems. She had diagnoses including coronary artery disease, diabetes, multiple sclerosis, asthma and fractures. The 2/27/20 care plan included

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diabetes, ineffectual breathing pattern and chronic infection due to left elbow hardware.

On 4/1/20 at 8:46 AM, the Administrator said, "On 3/16/20 Resident #3 went out with 2 family members and a third person. They went to a post-surgical medical appointment for a displaced fracture. Her temperatures were monitored, and she had no respiratory issues. Her highest temperature in March was 98.7."

Physician's orders indicated she had orders for daily temperature checks and the MD was to be notified for a temperature greater than 100.4 degrees Fahrenheit (F) since 3/21/20. Prior to that order, she had her temperature taken twice on 3/16/20, once on 3/18/20. None of the results met criteria for notifying the MD. Her temperatures were monitored and recorded in the electronic health record under the vital signs tab. None of the results met criteria for notifying the MD.

On 4/1/20 at 11:39, Resident #3 was interviewed. She said, "I have my own mask." My [___] got it for me yesterday. I did not have a mask at the other appointment. They are checking temperature two times a day.

On 4/3/20 at 10:23 AM Resident #3's family member was interviewed. He said family was told there were no visitors a couple of weeks ago. On 3/16/20, two family members went to an MD appointment, but did not ride in van with Resident #3. They were in their personal vehicle. [_____ _____] was a medical transport driver from a medical transport company that was hired. The nursing home and MD office talked to us about social distancing. At the visit, family were very

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cautious. No one was around her. Advance communication from Springbrook was that no one could visit.

According to the Daily Census dated 3/31/20 and printed 4/1/20, Resident #3 resided in a private room.
d. #4 was admitted on 3/12/20 from an acute care hospital.
She had an admission MDS dated 3/16/20. She had no cognitive problems. She had diagnoses including traumatic ischemia of muscle, arthritis, cerebrovascular accident, non-Alzheimer's dementia and seizure disorder.

Physician orders dated 3/19/20 indicated she had a neurology consult per discharge summary from the hospital for middle cerebral artery stroke with left sided weakness. She also had MD ordered daily temperatures as of 3/21/20 and instructions to notify the MD if the temperature was >100.4.

On 4/1/20 at 8:46 AM, the Administrator said, "On 3/31/20, Resident #4 went out with her Social Worker to a neurologist for ischemia of muscles. Her highest temp since admission was 99.1 and she had no respiratory signs or symptoms."

Her temperatures were monitored and recorded in the electronic health record under the vital signs tab. She had temperatures monitored 2-3 times daily. Her highest temp since admission was 99.5. None of the results met criteria for notifying the MD.

On 4/6/20 at 8:11 AM the Department of Social Services Social Worker (DSS SW) was interviewed. She said this was an appointment she had scheduled with the neurologist about one

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month before. She called the nursing home in advance to speak to the facility social worker because she assumed they did not want anyone going in and out. The appointment was originally scheduled on 3/31/20 at 1:30 PM. She canceled the appointment on 3/30/20 around 3:00 PM because she had no follow up from the nursing home. Soon after she canceled the appt, NA #7 from transport called and said the therapist really wanted her to have the appointment. NA #7 rescheduled the appointment on 3/31/20 at 10:30 AM. When she spoke to NA #7, they had it worked out that she would transport and she would be there around 9:30 AM on Tuesday, March 31, 2020. The DSS SW reported when she arrived at the nursing home, the ladies at the door did not know she was taking Resident #4 to an appointment. No screening questions for COVID-19 or temperature check was done. They returned from the appointment between 12:00 PM and 12:30 PM. After the appointment she had a voice mail from SW #2. He wanted to know information from the visit for the care plan scheduled the next day. When she called back, she talked to the Administrator who was trying to figure out her role with Resident #4. He was concerned she was investigating the nursing home. Then SW #1 took the call and that is when they asked her if anyone was in the truck with them and who she had contact with. The DSS SW reported she had been fine and did not have a temperature. She said Resident #4 was not wearing a mask. DSS SW sprayed her truck with disinfectant and wiped seats with bleach wipes before Resident #4 got in.

According to the Daily Census dated 3/31/20 and printed 4/1/20, Resident #4 resided in a private room.

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	345569	A. BUILDING _____ B. WING _____	C 04/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

e. Resident #5 was admitted on 3/18/20 from an acute care hospital.
He had an admission MDS dated 3/24/20. He had no cognitive problems. He had diagnoses including anemia, coronary artery disease, heart failure, diabetes, malnutrition, adult failure to thrive, nonalcoholic steatohepatitis and thrombocytopenia.

His care plan dated 3/19/20 included problems for diabetes and ineffective breathing pattern relate to congestive heart failure.

Physician's orders indicated he had orders for daily temperature checks and the MD was to be notified for a temperature greater than 100.4 degrees Fahrenheit (F) since 3/21/20.

He had an MD order on 3/23/20 for paracentesis (a procedure to remove fluid or gas) weekly as needed due to ascites (an abnormal buildup of fluid in the abdomen) associated with hepatitis.

On 4/1/20 at 8:46 AM, the Administrator said, "[Resident #5] went out on 3/26/20 with a family member for a paracentesis. Afterwards, they went to a fast food drive through. He said he did not have any signs or symptoms of respiratory illness and his highest temperature was 97 degrees F." His temperatures were monitored and recorded in the electronic health record under the vital signs tab. None of the results met criteria for notifying the MD.
His temperatures were monitored and recorded in the electronic health record under the vital signs tab. None of the results met criteria for notifying the MD. He had daily temperature monitoring and his highest temperature was 98 degrees F.

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 04/07/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880		

On 4/3/20 at 10:57 AM Resident #5's family member was interviewed. He said he took Resident #5 to the hospital to have a procedure on Thursday, (3/26). He said he wore gloves and they both wore masks at the hospital. The gloves hurt Resident #5's hands, so he used hand sanitizer. The family member said he did not go inside the nursing home. He walked Resident #5 to the truck. When they got back, staff rolled a wheel chair to the truck. He said he did not hug Resident #5.

According to the Daily Census dated 3/31/20 and printed 4/1/20, Resident #5 resided in a private room.

Interview on 4/1/2020 at 10:17 AM with NA #7 who is responsible for transportation revealed they were having the first appointment via telehealth. She said a new procedure started this week. All families and residents were educated. This week there was a "crack down" on making sure appointments were essential.

On 4/3/2020 at 10:00 AM the representative from the health department was interviewed. She said when she talked to the administrator on April 1, 2020, they had already had 5 people go out to appointments. The nursing home confirmed the appointments were necessary. She stated the administrator made the best decision at the time. She added she would need to know what information was conveyed to the families. She said since they did not enter the building, it was okay they were not screened. They should have a better practice in place now. At that time, if no family was sick, it was okay that the resident did not wear a mask.