STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING **01 - SPRINGBROOK NURSING & REHAB./CLAYTON** B. WING _____	**07/12/2016**

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
K 000	INITIAL COMMENTS A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. In the exit conference all deficiencies noted were discussed with administration. Stories: 1 Construction Type V (111) Constructed: 2015 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 100 Census - 41	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observations, on Tuesday 7/12/16 at approximately 8:15 AM onward, the following deficiencies were noted: The corridor doors were non-compliant, specific findings include: 1. The corridor doors to the Lobby and Therapy room were found wedged open at the time of the survey.	K 018	Upon discovery on 7/12/16 the corridor doors to the lobby and the therapy room were closed immediately. An audit of corridor doors was conducted on 7/12/16 by the maintenance director and the administrator in the remainder of the facility to ensure closure and no doors	7/29/16

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

Electronically Signed | 07/27/2016

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K 018	Continued From page 1 NFPA 101, 18.3.6. This deficiency affected one of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 018	were propped open. An in-service will be conducted by the administrator, staff facilitator, dietary manager, and maintenance director beginning on 07/25/16 to include 100% of staff to ensure that all staff are aware that corridor doors must remain closed. In addition, 100% of staff will be in-serviced on how to report problems with corridor doors to maintenance if necessary. Beginning on 7/27/16, the administrator, maintenance director, or Director of Nursing will conduct rounds to ensure corridor doors are closed properly three times a week for 4 weeks and once a week for 4 weeks. Results of the monitoring will be reported to the Executive QI Committee for Quality Assurance. Any issues of non-compliance will result in continued oversight.	
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is not met as evidenced by: Based on observations, and documentation review on 7/12/16 approximately 8:15AM onward, the following deficiencies were noted: The facility maintenance and inspection of the sprinkler system was non-compliant, specific findings include:	K 061	Upon discovery on 7/12/16 the sprinkler system vendor, Pye Barker, was contacted and the supervisory signal for the electronically supervised tamper alarm on the sprinkler control valve at the Fire Alarm Control Panel (FACP) was adjusted	7/12/16

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K 061	Continued From page 2 1. The supervisory signal for the electronically supervised tamper alarm on the sprinkler control valve at the Fire Alarm Control Panel (FACP) could be silenced permanently when the valve was in the closed position in the sprinkler riser room on the main riser for the facility. The facility must not have this condition on any supervised tamper alarms serving both buildings. Supervisory signals shall not be silenced permanently except by reopening/restoration of the valve to the normal operating position. This deficiency affects the entire facility. Ref: 2000 NFPA 101 Section 19.7.6; 9.7.2.1	K 061	so that it could not be silenced permanently. Following repairs on 7/12/16 the system was tested by the sprinkler system vendor, Pye Barker, to ensure the adjustment was effective. Beginning on 7/27/16, the Maintenance Director or the Administrator will conduct rounds three times a week for 4 weeks and once a week for 4 weeks to ensure the tamper valve is in the open position. Results of the monitoring will be reported to the Executive QI Committee for Quality Assurance. Any issues of non-compliance will result in continued oversight.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Tuesday 7/12/16 at approximately 8:15 AM onward, the following deficiencies were noted: The oxygen storage was corridor doors were non-compliant, specific	K 076	Upon discovery on 7/12/16 the oxygen cylinder was removed and stored properly. An audit was conducted in the remainder of the facility by the director of nursing on	7/29/16

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K 076	Continued From page 3 findings include: 1. An unsecured oxygen cylinder was found in the storage room next to the staff facilitator office. Oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] This deficiency affected one of six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 076	7/12/16 and all other oxygen cylinders were secured appropriately. An in-service was conducted by the staff facilitator, director of nursing, assistant director of nursing, quality assurance nurse including 100% of nursing staff beginning on 7/12/16 to ensure that all staff are aware of appropriate oxygen cylinder storage procedures. Additionally, an in-service will be conducted by the rehab manager to include 100% of rehab staff beginning on 7/25/16 to ensure that all staff are aware of appropriate oxygen cylinder storage procedures. Beginning on 7/27/16, the Administrator,DON, ADON, or QI Nurse will conduct rounds to ensure O2 cylinders are stored properly three times a week for 4 weeks and once a week for 4 weeks. Results of the monitoring will be reported to the Executive QI Committee for Quality Assurance. Any issues of non-compliance will result in continued oversight.	