STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	04/07/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 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. 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 [DATE]. physician's orders [REDACTED]. He had a Minimum Data Set (MDS) Admission assessment on 3/22/20. He had no cognitive problems. He had [DIAGNOSES REDACTED]. The [DIAGNOSES REDACTED]. 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 [REDACTED]. On 4/1/2020 at 10:23 AM Resident #1 was observed sitting alone in the Caf. 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 [DATE]. She had an MDS Admission assessment on 3/20/20. She had no cognitive problems. She had [DIAGNOSES REDACTED]. physician's orders [REDACTED]. 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 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 ([MEDICAL CONDITION]). 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 [DATE]. She had an MDS significant change assessment on 2/27/20. She had no cognitive problems. She had [DIAGNOSES REDACTED]. The 2/27/20 care plan included 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 [REDACTED]. Prior to that order, she had her temperature taken twice on 3/16/20, once on

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	04/07/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) 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 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 [DATE] from an acute care hospital. She had an admission MDS dated [DATE]. She had no cognitive problems. She had [DIAGNOSES REDACTED]. Physician orders [REDACTED]. 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 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. e. Resident #5 was admitted on [DATE] from an acute care hospital. He had an admission MDS dated [DATE]. He had no cognitive problems. He had [DIAGNOSES REDACTED]. His care plan dated 3/19/20 included problems for diabetes and ineffective breathing pattern relate to [MEDICAL CONDITION]. physician's orders [REDACTED]. 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 [MEDICAL CONDITION]. 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. 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.