	-	ND HUMAN SERVICES			FOF	RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ´		(X3) DAT	NO. 0938-0391 TE SURVEY MPLETED
		345143	B. WING		1	C 0/22/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SILER CIT	Y CENTER			000 W DOLPHIN STREET BILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 000			
F 278 SS=D	complaint investigatio 483.20(g) - (j) ASSE	e cited as a result of the on Event ID #4R8Y11. SSMENT DINATION/CERTIFIED	F 278			11/18/15
	The assessment mus resident's status.	st accurately reflect the				
	A registered nurse m each assessment wit participation of health					
	A registered nurse m assessment is compl	ust sign and certify that the eted.				
		completes a portion of the n and certify the accuracy of sessment.				
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than essment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each				
	Clinical disagreemen material and false sta	t does not constitute a atement.				
	by:	Γ is not met as evidenced				
	Based on record rev	iew and staff interview, the		1. Modifications were made to t	he	
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					11/12/2015

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.

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED		
					С		
		345143	B. WING		10/22/201		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET				
SILER CIT	TY CENTER						
				SILER CITY, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLI		
F 278	Continued From page	e 1	F 27	8			
		rately code the Minimum		Minimum Data Set for Resident #4	l2 and		
		essment for pressure ulcer		Resident #25 on 10/21/2015. The			
		or hydration (Resident #42)		modification for Resident #42 inclu			
		residents reviewed. Findings		changing the dehydration status fr to no and the modification for Res			
	included:			#25 was changed from present on			
	1. Resident #42 was	admitted to the facility on		admission to in-house acquired.			
		rly Minimum Data Set (MDS)					
	assessment dated 9/	21/15 indicated that		2. Director of Nursing, Assistant D	irector		
		evere cognitive impairment		of Nursing and Clinical Reimburse	ment		
	and was dehydrated.			Coordinator completed audit on			
	last notes dated 9/4/	s notes were reviewed. The		11/10/2015 of Minimum Data Set 1 residents who were coded for deh			
	dehydration.			and pressure ulcers. Audits reveal	-		
	-	ere reviewed. The notes		Minimum Data Sets were coded			
	dated 9/18/15 at 3:08	3 AM indicated that Resident		incorrectly for pressure ulcers.			
		Tylenol (fever reducer) for		Modifications were completed on			
	at 5:52 PM, the resid			11/10/2015 by Clinical Reimburser Coordinator.	ment		
	,	for increased congestion					
		notes dated 9/19/15 at 1:00		3. Regional Clinical Reimburseme			
		icated that the resident's food e adequate. The notes		Coordinator will provide re-educat Clinical Reimbursement Coordinat			
		PM indicated that the		MDS accuracy 11/16/2015. The			
		quid intake were adequate.		Interdisciplinary Team, including D	virector		
		PM, the MDS Nurse was		of Nursing, Clinical Reimbursemen			
		ted that she had not seen		Coordinator, Recreation Director,			
	-	n the records to indicate that		Worker and Register Dietitian will			
		hydration. She added that licated that		Minimum Data Set for accuracy pr transmission on 100% of residents			
		quid intake so the MDS		weeks then 50% of residents x 4 v			
	Nurse acknowledge	-		then 25% of residents x 4 weeks a			
	hydration was inaccu	irate.		of residents quarterly thereafter.			
				4. The center Clinical Reimbursen	nent		
				Coordinator will present the result			
		readmitted to the facility on		audit for accuracy for the entire M			
	9/7/15 status post be	low the knee amputation of		Data Set that was completed prior	to		
		arterly Minimum Data Set		submission monthly to the Perforn			

Facility ID: 923120

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		MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		E SURVEY IPLETED
						С
		345143	B. WING		10)/22/2015
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
SILER CIT	Y CENTER			900 W DOLPHIN STREET SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 278	Continued From page 2		F 27	78		
	(MDS) dated 10/5/15 indicated that Resident #25's cognition was intact and she had an			Improvement meeting for 3 quarterly.	months then	
	unstageable pressure ulcer that was present on admission. The nursing admission assessment dated 9/7/15					
	indicated that the resident was admitted with skin impairment on the buttock/sacrum and right stump. The records indicated that Resident #25 was admitted with a stage II pressure ulcer on the buttock/sacrum and the pressure ulcer healed up on 9/27/15.					
	dated 9/15/15 at 11 A	ere reviewed. The notes M indicated that an area t inner knee and it appeared brace.				
	an unstageable press on the right medial kr	integrity report indicated that sure ulcer was first identified nee. The ulcer had 90% pulation measuring 1.5 () 5.3 cm.				
	clean the right media cleanser), apply nicke agent) to wound bed,	s a physician's order to I knee with vashe (wound el size santyl (debriding cover with foam, wrap with it daily and as needed.				
	interviewed. After rev MDS Nurse stated the coded incorrectly. The ulcer had developed	AM, the MDS Nurse was viewing the records, the at the pressure ulcer was he unstageable pressure in house and was not				
F 281	present on admission 483.20(k)(3)(i) SERV		F 28			11/18/15

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STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	D. 0938-039 SURVEY PLETED
		345143	B. WING			C 10/22/2015	
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
SILER CIT	Y CENTER				00 W DOLPHIN STREET ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 281 SS=E			F	281			
		d or arranged by the facility nal standards of quality.					
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the				1. Physician notified of medication		
	as ordered by the phy Administration Recor #30) of 5 sampled res				transcription error and ordered to co with current order for Senna for Res #30 10/21/2015. Director of Nursin re-educated Nurse #1 on process for	sident g or	
	Resident # 30 was ad	tions. Findings included: dmitted to the facility on ses including constipation.			medication order transcription and a of Senna versus Senna Plus on 10/21/2015.	action	
	The annual Minimum assessment dated 10 Resident #30 had set The physician's order Resident #30 had an	Data Set (MDS) 0/5/15 indicated that vere cognitive impairment. rs were reviewed. On 3/2/15, order for Senna Plus (a			2. Director of Nursing, Assistant Dir of Nursing and designated licensed nurses will complete audit of curren residents physician orders from 01/01/2015 to 11/13/2015. The aud	l it dit of	
	bedtime for constipat Review of the resider September and Octo	r) two tablets by mouth at ion. nt's MARs for August, ber, 2015 revealed that scribed as Senna Lax (a			 physician orders was completed on November 13, 2015. 3. Nurse Practice Educator (NPE) v re-educate licensed nurses, includii 	will	
	laxative) to the MAR. On 10/21/15 at 2:20 I was interviewed. Afte	PM, administrative staff #1 er reviewing the records,			weekend and prn licensed nurses b 11/18/2015, concerning Monthly Physician/Mid-level Provider Order	у	
	incorrectly transcriber MAR. She added that started in March, 201	1 indicated that Nurse #1 d the Senna Plus to the at the incorrect transcription 5 when the order was e staff #1 confirmed that			Review and Transcription of Orders Licensed nurses (including weeken prn) will complete return demonstra transcribing and correctly entering physician order into center training	d and ation of	
	Resident #30 incorre- instead of Senna Plus On 10/21/15 at 2:40 I	ctly received Senna Laxative s from 03/02/15 to 10/20/15.			11/18/2015. Director of Nursing, As Director of Nursing and/or RN Supe will conduct checks of physician or received prior day, will be review a	ssistant ervisor ders	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/19/20 FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345143	B. WING		C 10/22/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SILER CIT	Y CENTER			900 W DOLPHIN STREET SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO	
F 281 F 314	resident's March 201	g the Senna Plus to the 5 MAR.	F 28 ⁻ F 314	 reconcile with handwritten orders (if applicable) and will check Medicatio Administration Record (MAR)/Treatr Administration Record (TAR) for transcription accuracy in Clinical Sta 5 days/week indefinitely. 4. Director of Nursing will report the findings of audits to the Performance Improvement meeting monthly times months then quarterly. 	n nent indup	
SS=G	resident, the facility n who enters the facility does not develop pre- individual's clinical co they were unavoidabl pressure sores receive	chensive assessment of a nust ensure that a resident y without pressure sores ssure sores unless the ondition demonstrates that le; and a resident having yes necessary treatment and nealing, prevent infection and				
	by: Based on record rev and resident interview monitor the skin and against a knee brace development of an ur the right medial knee	is not met as evidenced iew, observation and staff v, the facility failed to closely protect the skin from rubbing which resulted in the instageable pressure ulcer to for 1 (Resident #25) of 2 th pressure ulcers. Findings		1. Residents #25 is currently receive treatment for right medial knee wour follows: Cleanse right medial knee w with DWC, apply Aquacel to wound h then apply foam dressing and wrap w Kerlix q day until healed. Physician family are aware. Resident #25 wou improving with treatment.	nd as vound bed, with and	
		admitted to the facility on low the knee amputation of		2. Director of Nursing and Assistant Director of Nursing completed an au		

Facility ID: 923120

							IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
			A. BUILDIN	G			
		345143	B. WING			10/22/2015	
	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1	0/22/2015
			900 W DOLPHIN STREET				
SILER CIT	Y CENTER				ER CITY, NC 27344		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIC	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETIC
F 314	Continued From page	e 5	F 3	14			
	10	arterly Minimum Data Set			residents who have brace(s), splint(s	;),	
		ated 10/5/15 indicated that			immobilizer(s) and prosthetic devices		
		tion was intact and she had			10/22/2015. Physician orders were		
	an unstageable press	sure ulcer.			obtained for those residents who have	-	
	The nursing admissio			adaptive equipment and their Treatm			
		ident was admitted with skin			Administration Records were update		
	impairment to the right	nt stump.			11/12/2015. Director of Nursing com		
	The regident's pureat	a notes from 0/7/15 through			full body assessments on those resid	ients	
	9/18/15 were reviewe	s notes from 9/7/15 through			identified as having braces, splints, immobilizers and/or prosthetic device	e on	
		Resident #25 was wearing a			10/23/2015. No new skin integrity	.5 011	
		or the skin surrounding the			concerns were identified.		
		pnitored for skin breakdown					
	-	dated 9/15/15. The notes			3. Physician orders were obtained for	or	
	dated 9/15/15 at 11:0	0 AM indicated that an			residents that use braces, splints,		
		e right inner knee and it			immobilizers and prosthetic devices		
	appeared to be from	the resident's stump brace."			include when to be applied and remo	oved.	
					The physician s orders also include		
		/ skin checks were reviewed.			inspection of skin integrity prior to		
		ks were conducted on the 7: ift every Monday. The skin			applying the device. The licensed nu will document the application, skin	lise	
	checks completed on				inspection and remove on the treatm	ent	
		t the resident had previously			record according to the physician s	Cint	
		nd. The checks did not			order. Director of Nursing, Assistant		
	indicate that the resid				Director of Nursing, Nurse Practice		
	breakdown.				Educator and RN Supervisors will		
					re-educate licensed nurses (including	9	
		/ skin integrity reports were			weekend and prn licensed nurses),		
		t indicated that on 9/18/15,			certified nursing assistants (including		
		ted to have an unstageable			weekend and prn nursing assistants)		
	-	right medial knee. The nand 10% granulation			therapy staff on policy and procedure braces, splints, immobilizers and		
	-	neter (cm) x (by) 5.3 cm. On			prosthetic devices. The Director of		
		ndicated that the ulcer on			Nursing, Assistant of Nursing and RN	١	
		edial knee had 80% slough			Supervisor will audit Treatment		
	-	measuring 1 cm x 5 cm.			Administration Record that is comple	ted	
					by the medication nurse, as well as		
		as a physician's order to			assess those residents who have		
	clean the resident's ri	ight medial knee with a			adaptive equipment 2 x per week x 4		

Facility ID: 923120

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED	
		345143	B. WING		C 10/22/201	15
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0
				900 W DOLPHIN STREET		
SILER CIT	Y CENTER			SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPL THE APPROPRIATE DA	K5) LETIOI ATE
F 314	Continued From page	e 6	F 31	4		
		ly calcium alginate to the		weeks then 1 x per week x	2 months.	
	wound bed, cover with foam, wrap with kerlix and			The audit of splints, immob	ilizers, braces	
	to change it daily and as needed. On 10/20/15 at 2:15 PM, interview with administrative staff #1 was conducted. She			and prosthetic devices will		
				device is applied/removed a skin integrity is monitored.	as ordered and	
				skin integrity is monitored.		
	stated that Resident #	#25 had developed an		4. Director of Nursing will r	eport the	
		e ulcer on the right medial		findings of audits to the Per		
		that the pressure ulcer was		Improvement meeting mon	thly times 3	
		ee brace. Administrative esident #25 was re-admitted		months then quarterly.		
		5 with a brace to her right				
	leg to support the stu	-				
	conducted. Nurse #1 change. The pressure medial knee had slow was cleaned with woo	tesident #25's right knee was performed the dressing e ulcer on the resident's right igh in the center. The ulcer und cleaner, calcium alginate bund bed, covered with a				
	re-admitted on 9/7/15	AM, Nurse #1 was icated that Resident #25 was 5 status post below the knee ht leg. The resident was				
	the stump. The resid	e on her right leg to support ent had to wear the brace at that she noticed the redness				
	the dressing to the st	t knee and she thought that ump was too tight that				
		Later on, she realized that the resident's knee brace				
		kin so she removed the				
		ent's leg. Nurse #1 described				
	the brace as a hard p	lastic material.				
		lastic material. AM, Resident #25 was				

Facility ID: 923120

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/19/2015 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345143	B. WING		_	(10/:) 22/2015
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SILER CIT	Y CENTER			00 W DOLPHIN STREET SILER CITY, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	made of a clear white added that the end of back of her knee but s was an open area at t On 10/22/15 at 10:15 was interviewed. She breakdown that Resid knee from the use of t been avoided. She inter resident was admitted called the physician a use of the knee brace and when to apply the the application and th resident's skin should documented in the resident's skin should documented in the resident's skin should documented in the resident's brace was observed. made of a hard plastic the brace that was pro- was padded but the re- padding on it. On 10/22/15 at 10:50 interviewed. She stat should have been obt admission for the use instruction on how an- stated that the applicat resident's skin to prev- breakdown should ha and documented in the records.	ed that her knee brace was , hard plastic material. She the brace was rubbing the she didn't know that there he back of her knee. AM, administrative staff #1 e stated that the skin ent #25 experienced on her the knee brace could have dicated that when the 1, the nurse should have nd obtained an order for the and the instruction on how e brace. She also indicated e monitoring of the have been done and sident's medical records. AM, the resident's knee The brace was white and c material. The front part of otecting the resident's stump est of the brace had no AM, Nurse #1 was ed that a doctor's order ained for Resident #25 on of the brace including the d when to apply it. She also ation and observation of the rent the skin from ve been completed by staff e resident's medical	F 314				
F 323 SS=D	483.25(h) FREE OF A HAZARDS/SUPERVI		F 323				11/18/15

Facility ID: 923120

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345143	B. WING				_ 22/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
	VOENTER			9	00 W DOLPHIN STREET		
SILER CIT	Y CENTER			S	SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	8	F	323			
	as is possible; and ea	as free of accident hazards					
	by: Based on record revi interviews and observ follow the policy on sr	is not met as evidenced ew, resident interview, staff vations, the facility failed to moking for one of three 133) reviewed for smoking.			1. Resident #133 voluntary acknowledged to Administrator he wou like to go to another center that would allow him to keep not only his cigarette but his lighter too. Center has found alternate placement for resident.		
	Patients will not be all lighter fluid or matche	evised 4/1/15 stated " lowed to maintain their own s. " Smoking List included			 Administrator, Director of Nursing ar Social Work interviewed current smoke to ensure that they did not have materi for lighting cigarettes in their possession No resident had lighting material in the 	ers al on.	
	Resident #133 was ad multiple diagnoses ind	dmitted on 3/14/15 with cluding dementia. Il Minimum Data Set dated			possession on 10/26/2015. Director of Nursing and/or Licensed Nurse reassessed and updated each residen Smoking Assessment on 11/05/2015. Administrator and both Social Workers	f t	
		resident was assessed as ct. The resident was			held a meeting on 11/06/2015 with residents who currently smoke. Administrator discussed and reviewed centers Smoking Policy with emphasis	the	
	resident may smoke i assessment. The inte	ed 10/8/15 indicated the ndependently per smoking rventions included the of smoking materials in a			lighting materials and where they are to be stored. Each resident received a co of the Smoking Policy and signed a Smoking Acknowledgement Form.		
					3. Nurse Practice Educator and/or RN		

Facility ID: 923120

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				E SURVEY PLETED
	345143	B. WING			C 10/22/2015	
			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, i</u>	1/22/2015
Y CENTER			S	ILER CITY, NC 27344		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	×		3E	(X5) COMPLETIC DATE
The Smoking Evaluat that independent smor Resident #133. An interview was con AM with Resident #13 smoked in the courty his cigarettes in his b he had his own lighte cigarettes. An observation was m AM of Resident #133 pant pocket and place pocket. An interview was con AM with Resident #13 smoked about four tir has kept his lighter or An observation was m AM of Resident #133 pant pocket and place pocket. An interview was con Staff #1 on 10/22/15 was not aware that R lighter to use for smo the resident 's lighter drawer at the nurses Administrative Staff # to 400 Hall was respon resident 's lighter upp a locked drawer after An interview was con	tion dated 10/17/15 indicated oking was allowed for ducted on 10/20/15 at 11:01 33. He stated that he has ard. He stated that he kept edside table. He stated that r and he lit his own nade on 10/20/15 at 11:01 removing a lighter from his ing the lighter back into the ducted on 10/22/15 at 10:17 33. He stated that he has mes a day. He stated that he n his bedside table at night. nade on 10/22/15 at 10:17 removing a lighter from his ing the lighter back into the ducted with Administrative at 10:38AM. She stated she esident #133 kept his own king. She stated she thought was kept in a locked ' station when not in use. f1 stated the nurse assigned onsible for retrieving the on request and securing it in use. ducted with Nurse #1 on	F 3	323	 heads, licensed nurses (including weekend and prn licensed nurses), certified nursing assistants (including weekend and prn nursing assistants), dietary staff (including weekend and prn housekeeping and Laundry staff (including weekend and prn) and thera staff on the centers Smoking Policy. Social Workers or RN Supervisors will complete random interviews with residents that smoke to ensure they do not have lighting material in their possession. The interviews will be documented in the progress notes on alternating shifts 6 x weekly including weekends for 1 month then 3 x□s weekends for 2 months and quarterly thereafter. 4. Administrator and/or Social Work w report the findings of random spot che of smoking to the Performance 	rn), apy o ekly /ill cks	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER TY CENTER Continued From page The Smoking Evalua that independent smo Resident #133. An interview was con AM with Resident #13 smoked in the courty his cigarettes in his b he had his own lighter cigarettes. An observation was r AM of Resident #133 pant pocket and plact pocket. An interview was con AM with Resident #133 pant pocket and plact pocket. An interview was con AM with Resident #133 pant pocket and plact pocket. An interview was con AM of Resident #133 pant pocket and plact pocket. An observation was r AM of Resident #133 pant pocket and plact pocket. An interview was cons Staff #1 on 10/22/15 was not aware that R lighter to use for smo the resident 's lighter up a locked drawer after An interview was cons Staff #1 on 10/22/15 was not aware that R lighter to use for smo the resident 's lighter up a locked drawer after An interview was cons	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143 ROVIDER OR SUPPLIER Y CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 The Smoking Evaluation dated 10/17/15 indicated that independent smoking was allowed for Resident #133. An interview was conducted on 10/20/15 at 11:01 AM with Resident #133. He stated that he has smoked in the courtyard. He stated that he kept his cigarettes in his bedside table. He stated that he had his own lighter and he lit his own cigarettes. An observation was made on 10/20/15 at 11:01 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted on 10/22/15 at 10:17 AM with Resident #133. He stated that he has smoked about four times a day. He stated that he has kept his lighter on his bedside table at night. An observation was made on 10/22/15 at 10:17 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the has kept his lighter on his bedside table at night.	COPECTION (X1) PROVIDER/SUPPLIER/CLA (X2) MULT A. BUILDI 345143 B. WING ROVIDER OR SUPPLIER 345143 B. WING Y CENTER IDENTIFICATION NUMBER: ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 9 F1 F2 The Smoking Evaluation dated 10/17/15 indicated that independent smoking was allowed for Resident #133. F3 An interview was conducted on 10/20/15 at 11:01 AM AM with Resident #133. He stated that he kept his cigarettes in his bedside table. He stated that he had his own lighter and he lit his own cigarettes. An observation was made on 10/20/15 at 11:01 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted on 10/22/15 at 10:17 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted with Administrative Staff #1 on 10/22/15 at 10:37 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted with Administrative Staff #1 on 10/22/15 at 10:38AM. She stated she was not aware that Resident #133 kept his own lighter to use for smoking. She stated she thought the resident 's lighter was kept in a locked drawer at the nurses 's station when not in use. Administra	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345143 B. WING	S FOR MEDICARE & MEDICAID SERVICES 9° DEPICIENCIES (x1) PROVIDERNUPPLIERCULA IDENTIFICATION NUMMER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345143 B. WING STREET ADDRESS, GIVY, STATE, ZIP CODE 900 WOLPHIN STREET SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 The Smoking Evaluation dated 10/17/15 indicated that independent smoking was allowed for Resident #133. Reservation Was reacted that he has smoked in the courtyer. It is estated that he has monked in the courtyer. It is estated that he has procket. A nobservation was made on 10/20/15 at 11:01 AM of Resident #133. He stated that he has procket. An observation was made on 10/20/15 at 11:01 AM of Resident #133. He stated that he pocket. A nobservation was made on 10/22/15 at 10:17 AM of Resident #133. He stated that he has kept his lighter on his bedside table at night. An observation was made on 10/22/15 at 10:17 AM of Resident #133. He stated that he has kept his lighter on his bedside table at night. An observation was conducted with Administrative staff on 10/22/15 at 10:17 AM of Resident #133. He stated that he has kept his lighter on his bedside table at night. An interview was conducted with Administrative staff on 10/22/15 at 10:17 AM of Resident #133. He stated that he has was phis lighter on his bedsi	S FOR MEDICARE & MEDICAID SERVICES ONE N DF DEFINITION (X) PROVIDENSUPPLERCIA USENTIFICIATION NAMER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) MULTIPLE CONSTRUCTIO

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		D. 0938-039 SURVEY
ND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	. ,		Сом	PLETED
						С
		345143	B. WING		10	/22/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		E	
	TY CENTER			900 W DOLPHIN STREET		
SILER OI	IT GENTER			SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	<u>a</u> 10	F 32	3		
. 020		where Resident #133	1 52			
		ited she was aware that the				
		er. She stated she was not				
		nt kept his lighter in his				
	possession. She state	ed that Resident #133 had				
		eve his lighter from the				
F 00 4	nurses ' station.		F 00			44/40/45
F 334		A AND PNEUMOCOCCAL	F 334	4		11/18/15
SS=E	IMMUNIZATIONS					
	The facility must deve	elop policies and procedures				
	that ensure that					
		influenza immunization,				
	each resident, or the					
		es education regarding the				
	benefits and potential immunization;	I side effects of the				
	(ii) Each resident is o	ffered an influenza				
	immunization Octobe					
		mmunization is medically				
	contraindicated or the	e resident has already been				
	immunized during this	1 7				
	(iii) The resident or the	e resident's legal e opportunity to refuse				
	immunization; and	e opportunity to refuse				
	(iv) The resident's me	edical record includes				
		idicates, at a minimum, the				
	following:					
	(A) That the residen					
		rovided education regarding ntial side effects of influenza				
	immunization; and	Initial side effects of infidenza				
	(B) That the residen	t either received the				
		on or did not receive the				
	influenza immunizatio					
	contraindications or r	efusal.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345143	B. WING			C 22/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	Y CENTER			900 W DOLPHIN STREET		
	T OEITIEK			SILER CITY, NC 27344		
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 334	legal representative n the benefits and pote immunization; (ii) Each resident is o immunization, unless medically contraindica already been immuniz (iii) The resident or the representative has the immunization; and (iv) The resident's me documentation that in following: (A) That the residen representative was put the benefits and pote pneumococcal immunit (B) That the residen pneumococcal immunit (v) As an alternative, and practitioner recor pneumococcal immunity years following the fir immunization, unless	e pneumococcal esident, or the resident's eceives education regarding ntial side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; he resident's legal e opportunity to refuse edical record includes ndicated, at a minimum, the t or resident's legal rovided education regarding ntial side effects of nization; and t either received the nization or did not receive imunization due to medical fusal. based on an assessment mmendation, a second nization may be given after 5 est pneumococcal medically contraindicated or sident's legal representative	F 33	34		
	by: Based on staff interv	is not met as evidenced iew and record review the informed consent when		1. Residents #4, #41 and #98 response parties were contacted regarding the		

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		MEDICAID SERVICES				NO. 0938-03	
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	CONTRACTION		A. BUILDING			с	
		0.151.00					
		345143	B. WING		I	10/22/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE		
SILER CIT	ILER CITY CENTER			900 W DOLPHIN STREE			
				SILER CITY, NC 273	44		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		ER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	,	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC DATE	
F 334	Continued From page	e 12	F 3	34			
		vaccine for the 2014 - 2015			e and education on		
	•	ason for 3 of 5 Residents			se Practice Educator.		
		nd #41). Findings included:			nd Director of Nursing		
	-	admitted 6/1/11. The			rse #4 on Influenza Policy		
	Quarterly Minimum Data Set (MDS) Assessment			and Procedures			
	-	dated 9/22/15 revealed Resident #98 was					
	cognitively impaired.			2. Nurse Practic	e Educator (NPE)		
		za Immunization Informed			of resident consent for		
	Consent form reveale	ed it was signed by a family		Influenza Vaccir	ne on 11/06/2015.		
	member of Resident	#98 on 9/5/13. The section		Residents and/o	or responsible parties that		
	that read " hereby gi	ve the center permission to		had refused the	vaccine in the past were		
	administer an influen	za vaccination annually, in		notified and flu	vaccine information was		
	the fall " was checke				Residents and/or		
		ed Consent form for the			ties that consented to the		
		a immunization season could			ovided the Vaccine		
	not be located within				et (VIS). 110 residents		
		za Vaccine Administration			ble parties consented to		
		Record revealed Resident #98 was administered the vaccine on 10/3/14 for the 2014 - 2015		the vaccine and	11 refused the vaccine.		
				2 Nurse Dreetie	a Educator and/or DN		
	influenza vaccination	PM interview with Nurse #4			e Educator and/or RN re-educate licensed		
	revealed that she had				weekend and prn		
		nator role. She stated that			, on the centers Influenza		
		re that once a consent for			edures, obtaining consent		
		d been obtained in a given			ducation as well as		
	year that it still neede	•			re and after vaccine.		
		ven thou the facility form		-	2015, any newly admitted		
		annual consent. She added			asked if they wish to		
		ould speak for themselves			a vaccine or decline the		
		eir informed consent at the		vaccine. Vaccin	e Information Sheet will		
		n but acknowledged that			hat time. Current		
		dents could not. In addition,			esponsible parties received		
		had been looking through			fluenza Information		
		cate documentation of			. A copy of the VIS was		
		d had not been able to find			sponsible parties on		
	-	tion other than the above.			e Practice Educator to		
		ged that there was no			s weekly x 4 weeks then		
		bw that prior to Resident #98			months and quarterly		
	receiving the influenz	a vaccine in 2014 that the	1	thereafter.		1	

Facility ID: 923120

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE SUF	938-03	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLET	
					с	
		345143	B. WING		10/22/2	2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD)E	
SILER CITY CENTER				900 W DOLPHIN STREET		
				SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CA	(X5) OMPLETIC DATE
F 334	Continued From page	e 13	F 33	34		
		arty was asked to consent				
	for that year, or that t	he family/Responsible Party,		4. Nurse Practice Educator	-	
		ceived the appropriate		findings of audits of how man		
		Statement to make an		received the vaccine and how	-	
	 informed choice. 2. Resident #4 was admitted 2/23/10. The annual Minimum Data Set (MDS) Assessment dated 9/8/15 revealed Resident #4 was cognitively 			declined to the Performance		
				meeting monthly times 3 mor quarterly.	iths then	
				quarterly.		
	impaired. Review of the Influenza Immunization					
	Informed Consent form revealed it was signed by					
	a family member of Resident #4 on 9/16/13. The					
	section that read " he					
	•	ster an influenza vaccination				
	-	was checked. An Influenza				
		ed Consent form for the a immunization season could				
	not be located within					
		za Vaccine Administration				
		ident #4 was administered				
	the vaccine on 10/3/14 for the 2014 - 2015					
	influenza vaccination	season.				
		PM interview with Nurse #4				
	revealed that she had	-				
		nator role. She stated that				
		re that once a consent for d been obtained in a given				
	year that it still neede	u				
	•	en thou the facility form				
		annual consent. She added				
		ould speak for themselves				
	could be asked for th	eir informed consent at the				
		but acknowledged that				
		dents could not. In addition,				
		had been looking through				
		cate documentation of I had not been able to find				
		tion other than the above.				
	Nurse #4 acknowledg	ged that there was no				

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CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULT	PLE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED
					С	
		345143	B. WING		1	0/22/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
				900 W DOLPHIN STREET		
SILER CITY CENTER				SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 334	Continued From page	e 14	F 3:	34		
1 001			F J.	54		
		arty was asked to consent				
		the family/Responsible Party,				
		or other residents, received the appropriate				
	Vaccine Information Statement to make an					
	informed choice.					
	3. Resident #41 was readmitted 12/27/14. The					
	Quarterly Minimum Data Set (MDS) revealed					
		Resident #41 was moderately cognitively				
	impaired.					
	Review of the Influenza Immunization Informed					
	Consent form revealed it was signed by a family					
	member of Resident #41 on 8/27/13. The section that read " hereby give the center permission to					
		za vaccination annually, in				
	the fall " was checke					
		ed Consent form for the				
	2014 - 2015 influenza	2014 - 2015 influenza immunization season could				
	not be located within	not be located within the medical record.				
	Review of the Influenza Vaccine Administration					
		sident #41 was administered				
	the vaccine on 10/21	/14 for the 2014 - 2015				
	influenza vaccination					
		5 PM interview with Nurse #4				
	revealed that she had	-				
		nator role. She stated that re that once a consent for				
		d been obtained in a given				
	year that it still neede					
	-	ven thou the facility form				
	-	annual consent. She added				
		ould speak for themselves				
		eir informed consent at the				
		n but acknowledged that				
		dents could not. In addition,				
		had been looking through				
		cate documentation of				
	Intermed consent and	d had not been able to find	1			
		ation other than the above.				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C	ONSTRUCTION		NO. 0938-039
			A. BUILDING			COMPLETED
	345143		B. WING		C 10/22/2015	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DDE	
SILER CITY CENTER				W DOLPHIN STREET ER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 334 F 520 SS=D	receiving the influenz family/Responsible p for that year, or that F family/Responsible P received the appropri Statement to make a	ged that there was no ow that prior to Resident #41 a vaccine in 2014 that the arty was asked to consent Resident #41, the arty, or other residents, fate Vaccine Information in informed choice. ERS/MEET	F 334 F 520			11/18/15
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the				
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify o which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.				
		ords of such committee th disclosure is related to the ommittee with the				
		by the committee to identify ficiencies will not be used as				
	This REQUIREMENT	is not met as evidenced				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: FORM A OMB NO. (PPROVE
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345143				C 10/22/2015	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SILER CITY CENTER				900 W DOLPHIN STREET SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From page by: Based on record rev		F 52		the	
	interviews, and staff i Quality Assessment a Committee failed to in revise as needed the the 10/30/14 recertific achieve and sustain of accuracy of assessm (F323) . These defic the current recertifica findings included: This tag is cross refe F278 - Accuracy of a review and staff inter accurately code the M assessment for press and for hydration (Re sampled residents re During the recertifica facility was cited F27 code the MDS to refu Screening and Resid F323 - Accidents: Ba resident interview, sta observations, the fac on smoking for 1 of 3 reviewed for smoking During the recertifica facility was cited F32 potentially hazardous portals. On 10/22/15 at 12:35 Administrator was co she is the head of the	ssessment: Based on record view, the facility failed to Minimum Data Set (MDS) sure ulcer (Resident #25) sident #42) for 2 of 23 viewed. tion survey of 10/30/14 the 8 for failing to accurately ect Level II Preadmission ent Review determination. sed on record review, aff interviews, and ility failed to follow the policy residents (Resident #133) g. tion survey of 10/30/14 the 3 for failing to identify s conditions of pipe access iPM an interview with the nducted. She stated that e facility 's QAA Committee. AA Committee consisted of		 Modifications were made to Minimum Data Set for Residen Resident #25 on 10/21/2015. modification for Resident #42 is changing the dehydration statu to no and the modification for 1 #25 was changed from present admission to in-house acquire #133 acknowledged to Admini would like to go to another cer would allow him to keep not or cigarettes but his lighter too. Of found alternate placement for Director of Nursing, Assistan of Nursing and Clinical Reimbor Coordinator completed audit of 11/10/2015 of Minimum Data S residents who were coded for and pressure ulcers. Administrator, Director of Nurs Social Work interviewed current to ensure that they did not hav for lighting cigarettes in their p No resident had lighting mater possession on 10/26/2015. Di Nursing and/or Licensed Nurs reassessed and updated each Smoking Assessment on 11/06/2015 residents who currently smoke Administrator discussed and re centers Smoking Policy with e lighting materials and where the advisor and where the section of the secti	ht #42 and The included us from yes Resident at on d. Resident strator he her that hly his Center has resident. In Director ursement on Set for those dehydration Sing and nt smokers we material ossession. ial in their irector of e resident 5/2015. Workers with b eviewed the mphasis on hey are to	
	During the recertification survey of 10/30/14 the facility was cited F323 for failing to identify potentially hazardous conditions of pipe access			reassessed and updated each Smoking Assessment on 11/08 Administrator and both Social held a meeting on 11/06/2015 residents who currently smoke Administrator discussed and re centers Smoking Policy with e	resident 5/2015. Workers with e. eviewed the mphasis on hey are to ived a copy hed a	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MI II TID	LE CONSTRUCTION		D. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
					С	
		345143	B. WING		10	/22/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SILER CITY CENTER				900 W DOLPHIN STREET		
OILER OIL	SILER OFF CENTER			SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 520	Continued From page	e 17	F 52	0		
	committee had met n		-	Social Work and Clinical Reiml	oursement	
		terly with all participants.		Coordinator completed an aud		
		licated that she was aware		residents requiring a Level II P	ASARR on	
		essments was a repeat		11/09/2015 to ensure their indi		
		revious recertification		Minimum Data Sets are coded		
		hat the action plan that was		All residents were found to be		
		e previous recertification		correctly. Maintenance Directo		
		d by herself, the Director of		completed an audit of pipe acc		
	stated that Administra	Administrative Staff #3. She		on each hall on 11/12/2015 to		
		oding the MDS. She stated		all access portals are at the sa the surrounding flooring and do		
	-	uracy errors that resulted		a hazard for residents, as well		
		caused by human error of		employees and visitors.	45	
	•	#3. The Administrator stated				
	that to her knowledge			3. Administrator will provide re-	education	
	Administrative Staff #			to the Quality Improvement Me		
		-		including Medical Director, Dire		
	The Administrator als	o indicated that she was		Nursing, Assistant Director of N	lursing,	
		was a repeat deficiency		Clinical Reimbursement Coord	inator,	
	-	certification survey. She		Recreation Director, Social Wo		
		plan that was put into place		Register Dietitian, Food Servic		
		certification survey was		Housekeeping Supervisor and		
		and by housekeeping staff.		Records on 11/13/2015. Regio		
		sidents ' lighters were to be		Reimbursement Coordinator w		
		rse ' s station when not in hat she did not know that		re-education to Clinical Reimbu	ursement	
	Resident #133 kept h			Coordinator on MDS accuracy 11/16/2015. The Interdisciplina	ary Team	
		is own lighter.		including Director of Nursing, C	-	
				Reimbursement Coordinator, F		
				Director, Social Worker and Re		
				Dietitian review the entire Minir	-	
				Set for accuracy prior to transm	nission	
				each week on 100% of residen		
				weeks then 50% of residents x		
				then 25% of residents x 4 weel		
				of residents quarterly thereafte		
				Practice Educator and/or RN S		
				will re-educate department hea licensed nurses (including wee		
	1					

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		ND HUMAN SERVICES				FOR	D: 11/19/2015 M APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345143	B. WING				C / 22/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1	
				90	00 W DOLPHIN STREET		
SILER CI	SILER CITY CENTER			SI	ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 18	F	520	prn licensed nurses), certified nursing assistants (including weekend and pr nursing assistants), dietary staff (inclu- weekend and prn), Housekeeping an Laundry staff (including weekend and and therapy staff on the centers Smo Policy by 11/18/2015. Social Workers and/or RN Supervisors will complete random interviews with residents that smoke to ensure they do not have lig material in their possession. The interviews will be documented in the progress notes on alternating shifts 6 weekly including weekends for 1 mor then 3 x□ s weekly for 2 months and quarterly thereafter. Maintenance Director, Maintenance Assistant and/ Housekeeping Supervisor will audit p access portals weekly x 2 months the monthly x 3 months and quarterly thereafter. RN Supervisor will make Environmental Rounds to identify any and/or environmental hazards daily x weeks, 2 times weekly x 4 weeks, we x 2 months, then quarterly. Any haza identified will be addressed immediat and reviewed at stand-up 5 days/weet All incidents/accidents are reviewed at clinical stand-up 5 days/weet. 4. Clinical Reimbursement Coordinat Director of Nursing and Maintenance Director will report the findings of aud the Performance Improvement meetin monthly times 6 months then quarterly thereafter.	n uding d prn) king s nting x th or pe n fall 4 ekly rds ely k. it or, its to ng	

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