PRINTED: 10/19/2016 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345143	B. WING			1	C 19/2016
NAME OF PE	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	19/2010
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SILER CIT	Y CENTER						
				SILE	ER CITY, NC 27344		
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F 000	INITIAL COMMENTS	;	F 0	000			
F 253 SS=E	483.15(h)(2) HOUSE MAINTENANCE SEF		F 2	253			9/16/16
		s necessary to maintain a					
	by: Based on observation facility failed to provide necessary to maintain interior on five of five and 500) and failed to environment on one of findings included: On 8/18/16 at 2:55 Phallways was conducted observed in the hallway rooms. 100 hall: In the hallway, wallpat baseboard was taped room 110-111	of five halls (200 hall). The M, a tour of the rooms and sted. The following was ays and in the resident aper just above the divith clear tape between		r s v [k r [4 a a [2 r	1. Rooms 105, 106, 112 and 210 will repaired by 09/16/16 including replacir sheetrock, patching walls and painting walls by the Maintenance Director/Assistant. Room 105 southroom door and door handle will be repaired by 09/16/16 by the Maintena Director/Assistant. Rooms 108,316 and 12 bifold closet doors were inspected and put back on track by Maintenance Director/Assistant on 08/19/16. Room 205 sommode seat was removed a replaced on 08/19/16 by the Maintena Director.	ng the ance d nd	
	baseboard on wall by hole the size of the ro handle cover on the i Room 106scuffed with sheetrock missing ne Room 108bifold clorup Room 112scuffed with above baseboard near lower part of door to be hold to be seen as the size of	board by the closet; missing r closet; bathroom door had bom door handle; door nside of the door was loose. valls; baseboard and some ar the closet set doors off track ralls approximately 12 inches ar the closet; paint peeled on		F C C C C C C C C C C C C C C C C C C C	2. Center Executive Director (CED) an Admission Director completed commo seat audit on 08/26/16 to identify any commode seats that needed to be replaced. 16 commode seats were dentified and replaced by Environment Services Director on 09/07/16. Environmental Services Director completed sink audit on 08/16/16 to ensure the cleanliness of the sinks. 3 sinks were identified and cleaned	de	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

09/08/2016

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.

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		345143	B. WING			08/	19/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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OILLIN OIT	TOLITICA			S	ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	baseboard in the hall Wallpaper loose and baseboard in the hall Black and peeling was sheetrock above basebetween rooms 205-2 Room 205-commode paint coming off seat Room 210paint chi 210 door frame; black door and wall approxifloor. 300 hall: Loose wallpaper and hallway between room Peeling wallpaper just hallway between room Dark area and loose into the courtyard bet Loose baseboards in located between 300 Room 316bifold close 400 hall: Loose wallpaper in had 410-411 Loose wallpaper and between rooms 402 are Room 412closet do 500 hall: Loose baseboard applength on left side of loor. On 8/18/16 at 3:10PN conducted with the Matated he had been a	n sheetrock just above way between rooms 201-202 broken sheetrock in way between rooms 203-204 Ilpaper and broken eboard in the hallway 206 seat was very loose and pped and peeling on room c scuffs along the closet imately 12 inches above loose baseboard in the ms 305-306 t above baseboard in the ms 313-314 baseboard in hallway going ween 300 and 400 hall bathing room which was and 400 hall set doors off track allway between rooms baseboard in hallway and 403 or off track. broximately 12 inches in mallway near the courtyard	F	2253	08/16/16. CED completed door audit of 08/22/16 to identify any doors that may have holes in them or any door knobs were loose or in need of repair. Areas were identified were repaired and/or replaced. Wall Door Bumpers will be placed on each resident bathroom door prevent any future damage by the Maintenance Director/Assistant by 09/16/16. Center Executive Director completed closet door audit on 09/08/16 to identify any bifold closet doors that were off the track or in need of repair. Four closet doors were identified will be repaired or replaced by 09/16/16. Regional Property Manager, Maintena Director and Maintenance Assistant audited all five halls of the center on 08/31/16 for walls/sheetrock/wallpaper/baseboard to was in need of repair. Areas were identified on all five halls including area between 110-111, 201-202, 203-204, 205-206, 305-306, 313-314, 300-400, 410-411 and 402-403. All areas identified in the Regional Property Manager, Maintenance Director and Maintenance Assistant. 3. Nurse Practice Educator (NPE) will reeducate licensed nurses, certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), dietary, housekeeping and department heads by 09/16/16, concerning completing maintenance worder forms when needs or concerns and order forms when needs or concerns and forms the needs or concerns and forms and forms when needs or concerns and forms and	y that that that or to 16 e nce hat as fied 6 by e	

Facility ID: 923120

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		345143	B. WING				19/2016
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				9(00 W DOLPHIN STREET		
SILER CIT	Y CENTER			s	SILER CITY, NC 27344		
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F 253	Continued From page indicated he performe building every mornin Friday. The Maintenawere blank work ordestation for 100,200,30 hall. Anyone could fil Maintenance Directonursing staff who fille He stated the maintedoors, door frames a hall to the next. He sahall done, they were 300 hall was being pamaintenance staff ha baseboard on 100 ha and replaced the bas was completed. A walk through of the the Maintenance Director sink in room 205 was brown liquid. He state work orders for repair room 105 or the close and 412. He stated the walls doors on 200 he maintenance Director that some of the wall disrepair. He indicactoset doors being of On 8/18/16 at 3:30 PM conducted with the He stated any staff or	e 2 ed "walk throughs" of the ang from Monday through ance Director stated there er forms at the main nursing 00, 400 halls and one on 500 II out the form. The r stated it was usually d out the work order forms. nance staff were painting the nd walls and went from one aid by the time they got 500 back on 100 hall. Currently, ainted. He also said the d removed some of the ail, repaired the sheetrock eboard-not sure of time that building was conducted with ector at 3:05PM. All above and shown to the r. Also, it was noted that the er stopped up " with light ed he had not received any r to the bathroom door in et doors in rooms 108, 316 hey had just painted the rall 2 weeks ago. The ralso stated he was aware paper and sheetrock was in ted he was not aware of the f-track.		253	DEFICIENCY)	nce n e tor, ts, s	
		corder and put it in the box.					
		d the box every morning and					
		es, in the evening. Also, he staff told him if there was					

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		345143	B. WING				19/2016
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OII ED 017	TV OFNITED			90	00 W DOLPHIN STREET		
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F 253	tell the Maintenance On 8/18/16 at 4:15P conducted with the A expectation was for complete a work ord that was in disrepair they had identified they had instituted a month the painting and wall on each floor each in had an in-service in orders and facility stresponsibilities of correturning the work of A review of the Works/19/15 was reviewed staff (nursing, social housekeeping, dieta on the location of the responsibility to compaw something in the On 8/19/16 at 8:45A conducted with house worked on the floor of had worked on 200 in noted that the sinks stopped up "but did because the assistal already completed a would complete a would complete a would complete a worked on 100 hall a facility for two years.	d repair and he would verbally Director. M, an interview was administrator. She stated her any staff member to er if they noticed anything. The Administrator stated nat there was a need for a ing schedule and they had thly schedule to ensure that I repairs would be completed north. She stated the facility May, 2015 regarding work aff were educated on their impleting a work order and order forms to maintenance. A Orders in-service dated and noted that all facility work, administrative, ry, laundry) were educated as work order forms and their implete the forms when they be building that needed repair. M, an interview was sekeeper #1. She stated she on occasion and stated she in 205 and 206 had "I a not fill out a work order int maintenance director had slip. Jackie stated that she ork order form if she saw	F	253			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	· /	DATE SURVEY COMPLETED
		345143	B. WING _			C 08/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	Continued From pag		F 2	53		
	needed repair and hathroom door in rofew days and had consider the also stated she work order for the close of the close o	ad not noticed anything that had not noticed the hole in the som 105-she had been off a some back to work yesterday. had not noticed or filled out a oset doors in room 108. M, an observation of the 205 and room 206 was hak in each of the bathrooms ck/ brown material. The som 206 had brown water at the front of the sink, hes in width. There was an oms. Nursing staff interviewed hats in room 206 and the 5 did not use the bathroom.				
	bathrooms was come She stated the sinks up" and they had us drains. The Adminis maintenance to notif	AM, an observation of both ducted with the Administrator. It is must have been "stopped ed something to unstop the strator stated she expected for housekeeping that the is needed to be cleaned after the drains.				
	bathroom sinks in robathroom floor in 20 Housekeeping Super He stated housekee until 7:00pm 8/18/16 housekeeping had bathrooms. He statestaff to notify housele	M, an observation of the soms 205 and 206 and the 6 was conducted with the ervisor and the Administrator. Uping staff were in the facility 6. He was not aware if seen notified to clean the ed he expected maintenance keeping that the bathroom on the floor in the bathroom cleaned.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SU COMPLE	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD B HE APPROPRIA	_	(X5) COMPLETION DATE
F 253	housekeeper #3. He 7:00PM yesterday an the bathrooms in room be cleaned.	M, an interview was held with e stated he worked until and he was not informed that ms 205 and 206 needed to		253			
F 272 SS=D	a comprehensive, accreproducible assessing functional capacity. A facility must make a assessment of a resident assessment by the State. The assesst the following: Identification and den Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be Physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of suit the additional assess	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at nographic information; atterns; ing; and structural problems; and health conditions; I status; and procedures; mmary information regarding ment performed on the care to completion of the Minimum	F:	272		9.	/16/16

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345143	B. WING		08/19/2016
	ROVIDER OR SUPPLIER Y CENTER	-		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	, 537.15.25.15
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F 272	Continued From page Documentation of page 1	ge 6 articipation in assessment.	F 27.	2	
	by: Based on medical rinterview, the facility residents on the corthe area of pain for 28 and #44) review medications. The fill 1. Resident #28 was 1/17/14 with multiple failure, depression, The annual Minimur assessment dated 7 had significant cogn assessed as able to and able to understate Health Conditions of completed. Question assessment intervier Resident #28. The resident pain assess J0300 through J060 staff assessment for indicated it was not dated 7/1/16 for Res Nurse #1 completed.	andings included: a admitted to the facility on a diagnoses including heart and chronic pain. In Data Set (MDS) In Data		1. Pain assessments were updated Resident #28 and Resident #44 on 09/07/16 by the Licensed Nurse. 2. Clinical Reimbursement Coordina (CRC) completed audit on 08/31/16 Pain Assessment (Section J) for the 90 days (05/01/16-08/31/16) and ide ten pain assessments that were not completed. Pain Assessments were completed by 09/07/16 by the Licen Nurse. 3. Nurse Practice Educator (NPE) were-educated licensed nurses, including weekend and prn licensed nurses by 09/16/16, concerning pain assessments being completed accurately and time Center Nurse Executive, Clinical Reimbursement Coordinator or Nurse Supervisor will review the Nursing Assessment/User Defined Assessment (UDA) (which includes the Pain Assessment) that are scheduled each week five times/weekly in Clinical Stand-up times one month then weet times two months. Clinical Reimbursement Coordinator(s) will reliable to the pain and the pain assessment.	ators of the last entified essed fill ing y ents ely. sing ent ch

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 900 W DOLPHIN STREET SILER CITY, NC 27344	т	00/13/2010
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F 272	annual MDS for Resi MDS Nurse #1. She completed Section J Resident #28. She re to her that this section Nurse #1 stated that responsible for conduthe Electronic Medica pain assessment interassessment reference MDS Nurse #1 indicated documented answers completed the reside interview questions on She explained that so not completed the resinterview prior to the unable to complete the interview questions of this is what must have annual MDS for Resinterview questions of this is what must have annual MDS for Resinterview for the Direct Stated this had not have had happened "occar reported the facility with system to double che assessment interview staff prior to the ARD this new system begathree weeks ago. MI had seen an improve completion of the resinterview prior to the An interview was con Nursing on 8/18/16 a expected the MDS to	dent #28 was reviewed with indicated she had of the 7/1/16 annual MDS for evealed it was not a surprise in was incomplete. MDS nursing staff was ucting and documenting in al Record (EMR) the resident erview prior to the e date (ARD) of the MDS. It was not a sure that the resident erview prior to the e date (ARD) of the MDS. It was seen that the strong that the same in Section J of the MDS. It was mere sident pain assessment and the man assessment and the man assessment in the MDS. She revealed the happened for the 7/1/16 dent #28. She indicated the reported to the nursing ector of Nursing (DON). She appened "frequently", but it was working on a monitoring that the resident pain was completed by nursing of the MDS. She stated an its implementation about DS Nurse #1 indicated she ment with nursing staff's ident pain assessment	F2	accuracy prior to on 100% of residents x 4 wresidents x 4 wee quarterly thereafted. Center Nurse Efindings of audits	Executive will report th to the Performance eting monthly times 3	0% nts

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	being completed and improving this issue. 2. Resident #44 was 6/10/16 with multiple failure, depression, at the admission Minimassessment dated 6 #44 had significant of was assessed as us understood and usua others. Section J, the was not fully completed indicated a pain assecompleted with Resiquestions in the resigniterview, questions not assessed. The question J0700, indicated admission MDS #44 indicated MDS MJ. An interview was con AM with MDS Nurse admission MDS for F	admitted to the facility on admitted to the facility on admitted to the facility on a diagnoses including heart and chronic pain. The diagnoses including heart and chronic pain and the diagnost and the di	F2			
	completed Section J MDS for Resident #4 surprise to her that the MDS Nurse #1 state responsible for cond the Electronic Medic pain assessment into	ce date (ARD) of the MDS. ated she took the				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMI	E SURVEY PLETED
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(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272	She explained that so not completed the reinterview prior to the unable to complete the interview questions of this is what must have annual MDS for Resilvant when this occurred so supervisor or the Direct stated this had not have had happened "occareported the facility was system to double che assessment interview staff prior to the ARD this new system begithree weeks ago. MI had seen an improve	nt pain assessment in Section J of the MDS. In Section ARD and therefore, she was the resident pain assessment in the MDS. She revealed the happened for the 6/17/16 dent #44. She indicated the reported to the nursing ector of Nursing (DON). She appened "frequently", but it is issionally". MDS Nurse #1 was working on a monitoring eck that the resident pain was completed by nursing of the MDS. She stated an its implementation about DS Nurse #1 indicated she ment with nursing staff's ident pain assessment	F2	72		
F 278 SS=D	Nursing on 8/18/16 a expected the MDS to residents. She reveated with the resident pair being completed and improving this issue. 483.20(g) - (j) ASSES ACCURACY/COORD The assessment must resident's status.	DINATION/CERTIFIED st accurately reflect the ust conduct or coordinate	F 2	78		9/16/16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
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F 278	Each individual who assessment must sithat portion of the assument Medicare and willfully and knowing false statement in a subject to a civil more \$1,000 for each asswillfully and knowing to certify a material aresident assessment.	h professionals. nust sign and certify that the pleted. completes a portion of the gn and certify the accuracy of	F 2	278		
	This REQUIREMENtby: Based on observation and staff interviews, accurately code the three of seventeens the areas of medicar	T is not met as evidenced on, medical record review the facility failed to Minimum Data Set (MDS) for eampled residents reviewed in tions (Resident #11) and		1. Modifications were made t Minimum Data Set for Reside Resident #28 and Resident #3 08/18/2016. The modification Resident #42 and Resident #3	nt #11, 59 on 1 for 59 included	
	included: 1. Resident #110 w. originally 12/15/14 a Cumulative diagnos without behavioral d	as admitted to the facility nd last readmitted 7/29/16. es included: Dementia isturbance, Diabetes, Major Psychosis, Anxiety, Mood		changing Section LO200B state to yes. For Resident #11 the Awere reviewed and Sections NO410 ABC were modified to correct number of insulin inject 2. Clinical Reimbursement Co (CRC) completed audit on 09.	ARD dates NO300 & reflect the ctions.	

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F 278	noted the following: Ativan (medication umilligrams every 8 h Lexapro (antidepresonce a day Humulin 70/30 insulisubcutaneously two Seroquel (antipsychiby mouth at bedtime) Physician orders for and noted the follow Resident #110's retulexapro 20 milligram Humulin 70/30 5 unidaily Ativan 0.5 milligrams anxiety Remeron (antidepremouth at bedtime Risperdal (antipsychimilligrams by mouth An Annual Minimum indicated Resident # in cognition. Medicaseven day look-back 7 days of injections, of antidepressant medicated resident me	July 2016 were reviewed and assed for anxiety) 0.5 ours as needed for anxiety sant) 20 milligrams by mouth in inject 5 units times a day for diabetes otic medication) 50 milligrams of the facility on 7/297/31/16 were reviewed ing medications ordered on arm to the facility on 7/29/16: as by mouth daily the subcutaneously two times are every 8 hours as needed for seant) 7.5 milligrams by notic medication) 0.5 at bedtime for psychosis. Data Set (MDS) dated 8/2/16 at 10 was moderately impaired at tions administered during the coperiod was documented as 7 days of insulin and 7 days edications. The use of atton and anti-anxiety	F 27	Minimum Data Set for last 90 (05/01/16-08/31/16) for those who were coded for medicati dental. No other residents we with incorrect coding of insuli residents were identified with coding of dental and were mo 09/02/16 by Clinical Reimbur Coordinator. 3. Regional Clinical Reimburs Coordinator will provide re-ect Clinical Reimbursement Coordinator Worker and Register Dietitian Minimum Data Set for accurate transmission each week on 1 residents x 4 weeks then 50% x 4 weeks then 25% of reside weeks and 10% of residents thereafter. 4. The centers Clinical Reimburs Coordinator will present the raudit for accuracy for the enti Data Set that was completed submission monthly to the Pelimprovement meeting for 3 maguarterly.	e residents ons and ere identified in. 6 incorrect odified on sement ducation to rdinators on The ing Director rement ctor, Social in will review icy prior to 00% of of residents ents x 4 quarterly oursement esults of the ire Minimum prior to erformance	
	A review of the Medi Records (MARs) for	ication Administration the 7 day look back period: licated Resident #110 was not				

Facility ID: 923120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION IG	(>	(X3) DATE SURVEY COMPLETED	
		345143	B. WING _			C 08/19/2016	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP 0 900 W DOLPHIN STREET SILER CITY, NC 27344	CODE		
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F 278	were as follows: Humulin 70/30 insulin 7/30/16, 7/31/16. 8/1 Lexapro 20 milligram milligrams were adm 7/30/16, 7/31/16, 8/1 Risperdal 0.5 milligra administered 7/27/16 8/1/16 and 8/2/16 (6 Ativan 0.5 milligrams 9PM (1 day) On 08/18/2016 t 9:34 conducted with MDS usually made a copy look-back period and from the MAR to com of the MDS. She revethe insulin should hall having been administed said she may have stand 7/29 and did not that Resident #110 we further stated she shifted use of the antipsymedications as noted. On 08/18/2016 at 10 conducted with MDS went back and review Resident's ARD date was changed to 8/2/16 date had been change. On 08/18/2016 at 11.	the 7 day look-back period In was administered 7/27/16, In and 8/2/16 (5 days) Is and Remeron 7.5 Inistered 7/27/16, 7/29/16, In and 8/2/16 (6 days). In at bedtime was In 7/29/16, 7/30/16, 7/31/16, In at bedtime was In 7/29/16, 7/30/16, 7/31/16, In at bedtime was	F 2	278			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345143	B. WING			C 8/19/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344		1 00/10/2010	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 278	2. Resident #59 was 4/10/09 with multiple Vascular Dementia. Set (MDS) assessment that Resident #59 has impairment and was The dental consult for 7/30/15 was reviewed indicated that the resident and no dental applia. On 8/17/16 at 2:05 Fobserved. Resident edentulous. On 8/17/16 at 2:14 Fobserved. Resident edentulous. On 8/18/16 at 10:05 interviewed. MDS Not information from the carried over to the Monot indicate that Resident #28 was 1/17/14 with multiple failure and depression. The annual Minimum assessment dated 7 had significant cognitions.	admitted to the facility on diagnoses including The annual Minimum Data ent dated 9/16/15 indicated ad moderate cognitive not edentulous. The dental consult sident was edentulous and nces. PM, Resident #59 was #59 was observed to be PM, NA #2 was interviewed. The had known Resident #59 sident was edentulous. AM, MDS Nurse #1 was lurse #1 stated that the nursing assessment were IDS and the assessment did sident #59 was edentulous. The resident #59 was edentulous are stated that she had the sident was eannual assessment was annual assessment was annual assessment was admitted to the facility on a diagnoses including heart on.	F 2	78			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345143	B. WING_		0.5	C 3/19/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 900 W DOLPHIN STREET SILER CITY, NC 27344		3/19/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE	
F 278	dental conditions. An interview was cor PM with a family mer family member indicanatural teeth. An observation of Resident and with MDS Nurse completed the Oral/DMDS. She stated shoursing assessments section of the MDS. she also conducted a verify the information assessments. The OMS Resident #28's 7/1/1 with MDS Nurse #1. information and resident #28 was #1. MDS Nurse #1. why the 7/1/16 annut #28 had no dental conceded to review her A follow up interview 9:20 AM with MDS Norrectly for Oral/D section should have no natural teeth. She conducted an observerify the information	anducted on 8/16/16 at 3:12 Imber of Resident #28. The lated Resident #28 had no resident #28 on 8/16/16 at lee had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 6/18/16 at 9:20 If the late had no natural teeth. Inducted on 6/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the late had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20 If the had no natural teeth. Inducted on 8/18/16 at 9:20	F2	278			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 278	Continued From pag	e 15	F 2	78		
	AM with the Director	nducted on 8/18/16 at 11:00 of Nursing. She indicated for the MDS to be coded				
F 279 SS=D	483.20(d), 483.20(k) COMPREHENSIVE	• •	F 21	79	9/16/16	
	to develop, review ar comprehensive plan					
	plan for each resider objectives and timeta medical, nursing, and	elop a comprehensive care at that includes measurable ables to meet a resident's d mental and psychosocial fied in the comprehensive				
	to be furnished to att highest practicable p psychosocial well-be §483.25; and any se be required under §4 due to the resident's	ing as required under rvices that would otherwise .83.25 but are not provided exercise of rights under e right to refuse treatment				
	by: Based on record rev facility failed to devel measurable goals to treatment related to l	T is not met as evidenced riew and staff interview, the lop a care plan with address the care and hospice for 1 (Resident # 79) at reviewed for hospice.		Hospice care plan for Resident was added on 08/18/16 to reflect hand treatment related to Hospice. Social Services completed an a all Hospice residents on 08/22/16	ner care	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY	
		345143	B. WING _			l	C 1 19/2016
	ROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE 0 W DOLPHIN STREET LER CITY, NC 27344	<u> </u>	13/2010
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F 280 SS=D	7/15/16 with multiple Congestive Heart Fai Minimum Data Set (N 7/22/16 indicated that hospice care while a The care plan dated in were reviewed. Ther goal and interventions treatment related to h On 8/18/16 at 9:25 Al interviewed. MDS Nu plan for Resident #79 care plan for hospice missed. 483.20(d)(3), 483.10(PARTICIPATE PLANI The resident has the incompetent or other incapacitated under to participate in planning changes in care and in A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a registere for the resident, and of disciplines as determ and, to the extent pra the resident, the resident,	mitted to the facility on diagnoses including lure. The admission IDS) assessment dated to Resident #79 had received resident at the facility. 7/22/16 for Resident #79 e was no care plan problem, as to address care and lospice. M, MDS Nurse #1 was lurse #1 reviewed the care of and acknowledged that the for Resident #79 was k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to go care and treatment or treatment. e plan must be developed	F 2		ensure appropriate Hospice care plans were in place. Care plans were in place for all current hospice residents. 3. Center Executive Director provided re-education to the Director of Social Services and Social Worker on developing a care plan with measurable goals to address care and treatment related to our hospice residents on 08/31/16. Interdisciplinary Team will review hospice residents for appropriat care plan each week in clinical stand-up indefinitely. 4. Director of Social Services will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	e e e p	9/16/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER	040140		S	TREET ADDRESS, CITY, STATE, ZIP CODE	08/	19/2016
				9(00 W DOLPHIN STREET		
SILER CIT	Y CENTER			s	ILER CITY, NC 27344		
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F 280	Continued From page	e 17	F:	280			
		n of qualified persons after	' '	_00			
	each assessment.	n or qualified persons after					
	This DECLUDEMENT	C is not mot as suideneed					
	by:	Γ is not met as evidenced					
	Based on record rev			1. Wandering care plan for Resident #	44		
	facility failed impleme			was added on 08/19/16 to reflect her c			
	prevent a resident to			and treatment related to wandering.			
		pattern of physical behaviors,			Behavioral care plans for Resident #44		
	verbal behaviors, and	d wandering behaviors			were revised on 09/07/16 by the Cente	r	
	(Resident #44). The	findings included:			Nurse Executive to reflect appropriate		
					interventions when displaying		
		Imitted to the facility on			aggressive/combative behaviors.		
	-	diagnoses that included			2. Casial Comitana commistad on audit	-4	
		epression, dementia, and (disorder of the brain).			 Social Services completed an audit of all wandering residents on 08/22/16 to 	זו	
	toxic encephalopathy	(disorder of the braili).			ensure appropriate wandering care pla	ne	
	A nhysician's order d	ated 6/10/16 indicated			were in place. Care plans were in place		
		edication) 0.25 milligrams			for all current wandering residents.	Ü	
		as needed (PRN) for			Interdisciplinary Team completed a rev	iew	
	anxiety.	, ,			on 09/06/16 & 09/08/16 of those reside		
					who have displayed physical behaviora	al	
	The admission Minim	num Data Set (MDS)			symptoms, verbal behavioral symptom	s,	
		17/16 indicated Resident			inappropriate behaviors (pacing,		
	_	ognitive impairment and had			rummaging, disrobing, etc&), delusiona		
		level II Preadmission			behaviors and wandering behaviors in	tne	
	_	lent Review (PASRR) for dent #44 was assessed as			last 90 days (05/01/16-08/31/16). Revisions were made to care plans that	.+	
		and hallucinations. She			did not have effective interventions to	.t	
		e had no behaviors or			address the behaviors.		
		e 6/17/16 MDS look back			addition the boliaviols.		
		4 received antipsychotic			3. Center Executive Director provided		
	•	s, antidepressant medication			re-education to the Clinical		
		nxiety medication on 2 days			Reimbursement Coordinators, Director	of	
	during the 7 day MDS				Social Services and Social Worker on		
	_				revising care plans appropriately on		

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	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	, 03.70.20.0
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F 280	and verbally aggressi The plan of care for F focus area was initiat to care, combative be cursing. The goals in have no more than 2 behavior per week for demonstrate less that the next review perior interventions, initiated read: If resident/patien resistive, postpone ca her to regain con Approach the res unhurried manner; re Explain all care/p time) as resident will Redirect resident Nursing documentation Resident #44 was ver staff. Nursing documentation Resident #44 had phy toward staff. The June 2016 Medic (MAR) indicated Resi PRN Xanax eight time 6/24, 6/27, 6/28, and Nursing documentation	on dated 6/26/16 and sident #44 was physically ve toward staff. Resident #44 indicated a ed on 6/27/16 for resistance shavior and occasional dicated Resident #44 was to episodes of combative r 90 days and she was to n 2 episodes of cursing by d (target date 10/6/16). The d and revised on 6/27/16, t becomes combative or are/activity and allow time for an assure as needed procedures (one step at a allow before initiating t as needed on dated 6/28/16 indicated rebally aggressive toward on dated 6/29/16 indicated existed behaviors directed cation Administration Record dent #44 was administered es (6/11, 6/16, 6/22, 6/23,	F 280	08/31/16. Nurse Practice Educator (will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses ar nursing assistant), concerning wandresidents and those residents that ar displaying aggressive/combative beron the importance or documenting a reporting to ensure that care plans a updated and revised with the most effective interventions by 09/16/16. 24 Hour Report will be reviewed by Interdisciplinary Team for any occurr of wandering and/or aggressive residive days/weekly at Clinical Stand-up Documentation of interdisciplinary nowhich includes documented wanderi and behaviors is populated and is calcover to the 24 hour report from Point Care (PCC). Any occurrences that a identified, the care plans will be revied for effective interventions and revised needed. 4. Center Nurse Executive will report findings of audits to the Performance Improvement meeting monthly times months then quarterly.	ering enavior nd re ences dents o otes ng arried c Click are ewed d as

(X3) DATE SURVEY COMPLETED	
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CTION (X5) DULD BE COMPLETION ROPRIATE DATE	

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F 280	Continued From page	ge 20	F 2	280			
		ion dated 7/12/16 indicated andering around the unit by heelchair.					
	•	ion dated 7/14/16 indicated erbally aggressive toward					
	Resident #44 was coaggressive toward s	ion dated 7/17/16 indicated ombative with staff, verbally taff, and was wandering and into other residents'					
	Resident #44 had in	e dated 7/22/16 indicated creased wandering over the ent #44 was to be moved to					
	Resident #44 was so	ion dated 7/22/16 indicated elf-propelling her wheelchair rooms and was taking their					
	Resident #44 was co	ion dated 7/30/16 indicated ombative with staff and was ther residents' rooms.					
	administered PRN X	indicated Resident #44 was fanax sixteen times (7/1, 7/2, 10, 7/13, 7/14, 7/15, 7/17, , and 7/31).					
	indicated she had si impairment. She ha toward others, verba others, other behavi	ay review MDS dated 8/5/16 gnificant cognitive d physical behaviors directed al behaviors directed toward oral symptoms not directed vandering behaviors on 7 of 7					

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	ROVIDER OR SUPPLIER Y CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	<u>'</u>	33/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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) COMPLETION DATE
F 280	Resident #44 receiv on 7 days, antidepre and antianxiety med day MDS look back Nursing documentate revealed a late entry incident that occurre 8/6/16 after dinner. to have been sitting doorway. Resident at the other resident attempted to redirect location. Resident #4 third staff attempt. Resident #44 contin other residents' roor Nursing documentate revealed a late entry incident that occurre 8/6/16. "At 6:35 PM another resident root	and the state of t	F 2	· ·		
	hands on the other rewere separated and noted at this time." Nursing documentatindicated Resident # residents' rooms thru #44 was noted to go dresser drawers and Resident #44 was a resisted returning the	v [Resident #44] with her resident neck area, residents assessed with no injuries and the through other into other oughout the shift. Resident at through other residents and remove items. It closets and remove items. It closets and remove items. Resident #44 was updated				

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F 280	on 8/8/16 and indicated involved in an altercaresident on 8/7 - put ly woman's neck." The was to inflict no harm days (target date 10/4 initiated on 8/8/16, re - Monitor her interfor clues that they may separate as need - Staff to monitor redirect her out of other the was no plan of for Resident #44. Nursing documentating Resident #44 was located and hitting staff, and residents' rooms. The August 2016 MA was administered PR and 8/18). An interview was cons/18/16 at 11:50 AM, was noted to have be Resident #44 wanderstated sometimes Reherself in her wheeld ambulated. She indicated a lot of the wandered throughout staff just tried to mon as much as possible.	tion with another female her hands around that goal indicated Resident #44 on other residents for 90 6/16). The interventions, ad: actions with other residents ay not be getting along and ded resident's whereabouts and hers' rooms To care to address wandering and discrete to address wandering was going to into other R indicated Resident #44 and X Xanax 3 times (8/7, 8/17, 8/17), and with the without the unit. She sident #44 self-propelled hair and other times she cated Resident #44 went in lents' rooms. Nurse #1 residents on the locked unit at the halls. She stated the itor residents' whereabouts	F2	280			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 280	was familiar with R Resident #44 had a unit a few weeks d She stated Resider residents' rooms an SW #1 revealed Re for wandering. She to care plan for wa to watch Resident Resident #44 was was not an elopem wandering behavior admission. SW #* the physical alterca between Resident reported the incide the morning staff m #44's plan of care of focus area of the p resident. She indicher wandering beh there were no new to prevent wanderi stated Resident #4 consultation on 8/1 medication adjustn the management of An interview was c 8/18/16 at 4:10 PN on the locked unit of per week. She sta Resident #44 with behaviors directed wandering behavior never observed Residents behaviors directed	a at 3:30 PM. She stated she esident #44. She reported a room change to the locked ue to her wandering behaviors. In the stated up their belongings esident #44 had no care plan estated that there wasn't much indering other than staff trying #44 more often. She indicated not exit seeking and therefore ent risk. She stated the rs had been ongoing since her indicated she was aware of ation that occurred on 8/6/16 #44 and another resident. She int was discussed on 8/9/16 in the eting. She stated Resident was updated to include the hysical altercation with another exated Resident #44 continued aviors. SW #1 reported that interventions in the care planing for Resident #44. She 4 was seen for a psychiatric 7/16 and she was hoping a ment was going to be helpful for	F2	280		

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F 280	Resident #44 had a another resident. S continued to wande down the halls, and rooms. She indicat there were no new in Resident #44's physical behaviors, or wanded an interview was consumed at the locker was familiar with Resident was familiar with Resident was familiar with Residents and wandering other residents' root tried to redirect Residents and heard about the 8/6/16 in which Residents altercation with another had not heard at the incident. She resident was familiar with Residents aware of any new in place for Resident #	ed on 8/6/16 in which physical altercation with he stated Resident #44 r throughout the unit, up and in and out of other residents' ted that to her knowledge nterventions put into place for sical behaviors, verbal	F 2	80		
	Nursing (DON) on 8 indicated she was a occurred on 8/6/16 physical altercation stated that a lot of the wandered around the revealed she was neplan of care wander unable to say if any	onducted with the Director of 1/19/16 at 8:55 AM. She ware of the incident that in which Resident #44 had a with another resident. She he residents on the locked unit broughout the day. She ot aware Resident #44 had no ring. She stated she was new interventions were put ncident with Resident #44 on				

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		345143	B. WING _		C 08/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	1 00/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 280 F 323 SS=D	she was aware of the 8/6/16 in which Resaltercation with anothe facility had failed interventions to present 483.25(h) FREE OF HAZARDS/SUPER' The facility must enenvironment remain as is possible; and of the sum of the	onducted with the 19/16 at 10:00 AM. She stated the incident that occurred on sident #44 had a physical ther resident. She indicated to develop effective went to the incident. ACCIDENT	F 2		9/16/16
	by: Based on record refacility failed to man and implement efferesident to resident resident with a patte verbal behaviors, at (Resident #44). The Resident #44 was a 6/10/16 with multiple psychosis, anxiety, toxic encephalopate. A physician's order	eview and staff interview the large inappropriate behaviors of tive interventions to prevent a physical altercation for a tern of physical behaviors, and wandering behaviors included: Indicated to the facility on the diagnoses that included depression, dementia, and the hy (disorder of the brain). Indicated 6/10/16 indicated medication) 0.25 milligrams		1. Resident #44 was separated a redirected from the other resident injuries were noted and no other i noted. 2. Social Services completed an a all wandering residents on 08/22/ensure appropriate wandering car were in place. Care plans were ir for all current wandering residents Interdisciplinary Team completed on 09/06/16 & 09/08/16 of those r who have displayed physical beha symptoms, verbal behavioral syminappropriate behaviors (pacing,	audit of 16 to re plans n place s. a review residents avioral

PRINTED: 10/19/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
	345143 B. WING			08	/19/2016			
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 33		
				90	00 W DOLPHIN STREET			
SILER CIT	Y CENTER			SI	ILER CITY, NC 27344			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE	
F 323	Continued From pag	e 26	F3	323				
F 323	(mg) every six hours anxiety. The admission Minir assessment dated 6 #44 had significant obeen evaluated as a Screening and Resident and an analysis of the significant of the signific	num Data Set (MDS) /17/16 indicated Resident ognitive impairment and had level II Preadmission dent Review (PASRR) for dent #44 was assessed as and hallucinations. She had no behaviors or for 6/17/16 MDS look back freceived antipsychotic and antidepressant medication enxiety medication on 2 days S look back period. ion dated 6/26/16 and esident #44 was physically	F3	323	rummaging, disrobing, etc.&), delusion behaviors and wandering behaviors in last 90 days (05/01/16-08/31/16). Revisions were made to care plans the did not have effective interventions to address the behaviors. 3. Center Executive Director provided re-education to the Clinical Reimbursement Coordinators, Directo Social Services and Social Worker on revising care plans appropriately on 08/31/16. Nurse Practice Educator (Nill reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), concerning wander residents and those residents that are displaying aggressive/combative behave on the importance or documenting and reporting to ensure that care plans are updated and revised with the most effective interventions by 09/16/16. Licensed Charge Nurse on each hall we monitor that intervention on care plans utilized by the certified nursing assistant.	the at r of PE) ing vior d viill s are		
	behavior per week for	or 90 days and she was to an 2 episodes of cursing by			as needed. 24 Hour Report will be reviewed by Interdisciplinary Team for			
	the next review period interventions, initiate read: - If resident/patien	od (target date 10/6/16). The d and revised on 6/27/16, and becomes combative or are/activity and allow time for			occurrences of wandering and/or aggressive residents five days/weekly Clinical Stand-up. Any occurrences the are identified, the care plans will be reviewed for effective interventions.	at		
	- Approach the re unhurried manner; re - Explain all care/	sident/patient in a calm, eassure as needed procedures (one step at a allow before initiating			4. Center Nurse Executive will report t findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.			

Facility ID: 923120

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345143	B. WING			l	C 19/2016
	ROVIDER OR SUPPLIER		1	9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 W DOLPHIN STREET SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Resident #44 was verstaff. Nursing documentating Resident #44 had photoward staff. The June 2016 Media (MAR) indicated Resident #45 and Nursing documentation indicated Resident #45 toward staff. A psychiatric consult Resident #44 recommendation recommendation of the commendation of the commendation of the commendation of the nursing assessing Resident #44 had delast 7 days. The behalist 7 days. The behalist 7 days. The behalist 7 days region of illness, significant #44's care, significant #44's care, significant #44's care, significant properties of the commendation of the com	on dated 6/28/16 indicated erbally aggressive toward on dated 6/29/16 indicated ysical behaviors directed cation Administration Record ident #44 was administered les (6/11, 6/16, 6/22, 6/23, 6/29). on dated 7/1/16 and 7/4/16 44 was verbally aggressive ation dated 7/6/16 for mended no medication 444 was noted to have hort tempered, and had enent, dated 7/8/16, indicated elusions and behaviors in the laviors were indicated to put ifficant risk for physical injury y interfered with Resident atty interfered with Resident	F	323			
	environment. The be to have put others at injury and had not in others activities. Resident #44's quart	activities or social rupted the care or living ehaviors were indicated not significant risk of physical truded on the privacy of erly MDS dated 7/8/16 gnificant cognitive impairment					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLETED	
		345143	B. WING		C 08/19/2016
	ROVIDER OR SUPPLIER	'		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	00/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 323	and delusions. She directed toward oth day look back period Resident #44 received on 7 days, antidepriand antianxiety med day MDS look back. Nursing documentar Resident #44 was wastaff and had physical staff. Nursing documentar Resident #44 was was rooms and was ver Nursing documentar Resident #44 was was rooms and was ver Nursing documentar Resident #44 was wastaff. Nursing documentar Resident #44 was wastaff. Nursing documentar Resident #44 was wastaff. A social service not Resident #44 had in past 2 days. Resident #44 had in past 2 days. Resident #44 was service not Resident #44 was service not Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 was service not Resident #44 had in past 2 days. Resident #44 was service not Resident #44 was	e had verbal behaviors eers on 1 to 3 days during the 7 od of the 7/8/16 MDS. eved antipsychotic medication ressant medication on 7 days, dication on 4 days during the 7 of period. ation dated 7/10/16 indicated everbally aggressive toward cal behaviors directed toward ation dated 7/11/16 indicated wandering into other residents' bally aggressive toward staff.	F 32	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345143	B. WING			C 08/19/2016
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	 	00/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Resident #44 was taking items out of The July 2016 MAR administered PRN 7/3, 7/5, 7/8, 7/9, 7 7/20 (x2), 7/29, 7/3 Resident #44's 60 indicated she had simpairment. She h toward others, vertothers, other behav toward others, and days during the 8/5 Resident #44 recei on 7 days, antideprand antianxiety me day MDS look back. Nursing documentarevealed a late entincident that occurr 8/6/16 after dinner. to have been sitting doorway. Resident at the other resider attempted to redire location. Resident third staff attempt.	ation dated 7/30/16 indicated combative with staff and was other residents' rooms. R indicated Resident #44 was Xanax sixteen times (7/1, 7/2, /10, 7/13, 7/14, 7/15, 7/17, 0, and 7/31). day review MDS dated 8/5/16 significant cognitive ad physical behaviors directed oal behaviors directed vioral symptoms not directed wandering behaviors on 7 of 7 is/16 MDS look back period. Ved antipsychotic medication ressant medication on 7 days, dication on 2 days during the 7	F 32	23		
	revealed a late enti	oms. Pation dated 8/7/16 at 10:55 AM ry was documented for an area with Resident #44 on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	' '	COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	I	00/13/2010
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	another resident roo outside the door, [Nuimmediately and saw hands on the other rivere separated and noted at this time." Nursing documentatindicated Resident #residents' rooms through the resident #residents' rooms through the resident #44 was noted to go dresser drawers and Resident #44 was an resisted returning the The plan of care for on 8/8/16 and indicatinvolved in an altercate resident on 8/7 - put woman's neck." The was to inflict no harm days (target date 10 initiated on 8/8/16, resident woman's neck." The was to inflict no harm days (target date 10 initiated on 8/8/16, resident they make a separate as needs. Staff to monitor redirect her out of other was no plan of the resident #44. Nursing documentating Resident #44 was loand hitting staff, and residents' rooms.	[Resident #44] went into m, cussing was heard from ursing Assistant] went in a [Resident #44] with her esident neck area, residents assessed with no injuries I an dated 8/7/16 at 3:22 PM 44 was wandering into other oughout the shift. Resident through other residents' closets and remove items. It gumentative with staff and the other residents' items. Resident #44 was updated the focus area, "Resident ation with another female her hands around that a goal indicated Resident #44 in on other residents for 90 (6/16). The interventions, ead: ractions with other residents any not be getting along and ided resident's whereabouts and	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345143	B. WING _			C 08/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	•	00/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	and 8/18). An interview was co 8/18/16 at 11:50 AM was noted to have be Resident #44 wands stated sometimes Resident #6. She indicated a lot of the wandered throughous taff just tried to mo as much as possible. An interview was co (SW) #1 on 8/18/16 was familiar with Resident #44 had a unit a few weeks du She stated Resident residents' rooms and SW #1 revealed Refor wandering. She	RN Xanax 3 times (8/7, 8/17, anducted with Nurse #1 on a l. She indicated Resident #44 sehaviors. She stated ared throughout the unit. She esident #44 self-propelled chair and other times she icated Resident #44 went in dents' rooms. Nurse #1 aresidents on the locked unit at the halls. She stated the nitor residents' whereabouts	F3	, , , , , , , , , , , , , , , , , , ,		
	Resident #44 was n was not an elopeme wandering behavior admission. SW #1 the physical altercat between Resident # reported the inciden the morning staff me #44's plan of care w focus area of the phresident. She indicate	44 more often. She indicated of exit seeking and therefore ent risk. She stated the shad been ongoing since her indicated she was aware of ion that occurred on 8/6/16 44 and another resident. She t was discussed on 8/9/16 in seting. She stated Resident as updated to include the ysical altercation with another ated Resident #44 continued viors. SW #1 reported that				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	l \ /	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	1	10/19/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	to prevent wandering stated Resident #44 consultation on 8/17 medication adjustment the management of An interview was co 8/18/16 at 4:10 PM. on the locked unit we per week. She states Resident #44 with per behaviors directed to wandering behaviors directed to she revealed she has incident that occurred Resident #44 had a another resident. Sincontinued to wander down the halls, and rooms. She indicate there were no new in Resident #44's physis behaviors, or wander An interview was co 8/18/16 at 4:30 PM. worked on the locked was familiar with Rehad observed Resident wandering other residents' room tried to redirect Resident wandering other resident wandering wandering wandering wa	nterventions in the care plan g for Resident #44. She was seen for a psychiatric /16 and she was hoping a ent was going to be helpful for her behaviors. Inducted with Nurse #3 on She indicated she worked ith Resident #44 about once ed she had observed hysical behaviors and verbal loward staff as well as s. She reported she had ident #44 with physical oward any other resident. Ad not heard about the ed on 8/6/16 in which physical altercation with the estated Resident #44 throughout the unit, up and in and out of other residents' ed that to her knowledge interventions put into place for ical behaviors, verbal	F 32	23		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		345143	B. WING			l	C
NAME OF PI	ROVIDER OR SUPPLIER	010110	STREET ADDRESS, CITY, STATE, ZIP CODE		ET ADDRESS, CITY, STATE, ZIP CODE	00/	/19/2016
SILER CIT	Y CENTER				DOLPHIN STREET R CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	she had not heard ab the incident. She rev aware of any new interplace for Resident #4 verbal behaviors, or verbal	out all of the details about ealed that she was not erventions that were put into 4's physical behaviors, wandering behaviors. ducted with the Director of 9/16 at 8:55 AM. She are of the incident that which Resident #44 had a ith another resident. She residents on the locked unit oughout the day. She aware Resident #44 had no g. She stated she was ew interventions were put cident with Resident #44 on	F	323			
F 329 SS=D	she was aware of the 8/6/16 in which Resid altercation with anoth the facility had failed 483.25(I) DRUG REGUNNECESSARY DRUGNECESSARY DRUGNECE	incident that occurred on ent #44 had a physical er resident. She indicated to prevent to the incident. EIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate to or in the presence of es which indicate the dose discontinued; or any	F	329			9/16/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	1 00/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 329	resident, the facility r who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventic contraindicated, in an drugs.	ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical s who use antipsychotic al dose reductions, and ons, unless clinically n effort to discontinue these	F 3	329	
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the effectiveness of antianxiety medications for 1 of 5 residents (Resident #44) reviewed for unnecessary medications. The findings included: Resident #44 was admitted to the facility on 6/10/16 with multiple diagnoses that included anxiety disorder. A physician's order dated 6/10/16 indicated Xanax (antianxiety medication) 0.25 milligrams (mg) every six hours as needed (PRN) for anxiety. The admission Minimum Data Set (MDS) assessment dated 6/17/16 indicated Resident #44 had significant cognitive impairment and had received antianxiety medications on 2 out of 7 days during the MDS review period.			1. Resident #44 has not receive doses of Xanax since 08/18/16. 2. Center Nurse Executive and R Resource Nurse completed an at residents ☐ medication administrated record on 09/08/16. Audit concluted 12 of 39 residents receiving as net (prn) antianxiety medication did redocumentation of effectiveness in 3. Nurse Practice Educator (NPE re-educate licensed nurses, inclusive weekend and prn licensed nurses 09/16/16, concerning prn medical sheets and the centers policy and procedure of documenting and medication that is administered will be documented.	egional udit of ation ided that eeded not have oted.) will ding is by tion ding conitoring ons ures

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ´	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 W DOLPHIN STREET SILER CITY, NC 27344		13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 329	(MAR) indicated Res PRN Xanax eight tim administered PRN Xaincreased agitation a effective. There was MAR for 7 out of 8 ac for Resident #44 that administration or its 66/22, 6/23, 6/24, 6/27. The plan of care for 8 focus area of psychoantidepressants, antimedications. The goindicated Resident #4 and most effective do The July 2016 MAR administered PRN Xaincreased was effective. There the MAR for 15 out of Xanax for Resident #6 for the administration 7/2, 7/3, 7/5, 7/8, 7/9 (x2), 7/29, 7/30, and The August 2016 MAR was administered PR was no documentation #44 that indicated the #44 that indicated the #45 for the administrations #44 that indicated the formal for the formal for the formal formal for the formal formal formal formal formal formal for the formal for	cation Administration Record ident #44 was administered les. Resident #44 was anax on 6/29/16 for and the medication was a no documentation on the diministrations of PRN Xanax at indicated the reason for the effectiveness (6/11, 6/16, 7, and 6/28). Resident #44 included the attropic medications: psychotics, and antianxiety hal, initiated on 7/1/16, 44 was to have the smallest one without side effects. Indicated Resident #44 was anax sixteen times. Iministered PRN Xanax on a danxiety and the medication is was no documentation on a few 16 administrations of PRN 444 that indicated the reason in or its effectiveness (7/1, 7/10, 7/14, 7/15, 7/17, 7/20 7/31). AR indicated Resident #44 RN Xanax 3 times. There on on the MAR for 3 out of a few 17 and 18	F 32	effectiveness. Nurse Mana including Center Nurse Exect Assistant Director of Nursing Supervisors will audit the prosheets daily times one week times a week for three week times two month. 4. Center Nurse Executive we findings of audits to the Performant Improvement meeting month months then quarterly.	cutive, g, RN n medication then three s then weekly vill report the ormance	
	An interview was cor AM with Nurse #1. S	nducted on 8/18/16 at 11:50 She stated that PRN				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 329	were to include the as well as its effective. An interview was concentrated as well as its effective there is well as its effective is a nurse got off track then forget to go bat the effectiveness. An interview was concentrated in administration as we revealed that a lack reason for use and the medications had be earlier today. She in the process of being on this issue. An interview was concentrated in the process of being on this issue.	cocumented in the MAR and reason for the administration veness. Inducted on 8/18/16 at 11:52 She stated that PRN ocumented in the MAR and reason for the administration veness. She revealed that in instances in the past when with another task and would ock to the MAR to document Inducted with the Nurse 16 at 4:20 PM. She stated has were documented in the clude the reason for the reason for the left as its effectiveness. She of documentation for the he effectiveness of PRN ren brought to her attention indicated an inservice was in a planned to re-educate staff reducted with the Director of reat 8:55 AM. She stated that	F 3.	29		
F 353 SS=E	reason for the admin effectiveness. 483.30(a) SUFFICIE PER CARE PLANS The facility must have	inistration as well as its ENT 24-HR NURSING STAFF We sufficient nursing staff to related services to attain or	F 3	53		9/16/16
		practicable physical, mental,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143			PLE CONSTRUCTION IG	COMF	(X3) DATE SURVEY COMPLETED		
		345143	B. WING _		C		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344		08/19/2016		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE	
F 353			F3	1. Resident #99 has been discharge from the center, Resident #98 was interviewed on 09/08/16 by Center Executive Director regarding call liggeresponsiveness and if she has had incontinent care provided. Residen	ght timely t #98		
	physical altercation sampled residents remedications. Findin			stated during interview that the restime had improved with call lights a as incontinent care. She also state second shift was not taking as long before. Much better she said. Resi #33 was interviewed on 09/08/16 b	s well ed that as dent y		
	review, observation the facility failed to p for 1 (Resident # 40	ag F312 - Based on record and family and staff interview, provide incontinent care timely of 4 sampled residents as of daily Living (ADL).		Center Executive Director regardin light responsiveness and if she has timely incontinent care provided. R #33 stated that it was some better, that she had to wait this morning to	had esident but		

1 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		l\ /	(X3) DATE SURVEY COMPLETED	
		345143	B. WING			С	
NAME OF B	DOLUBER OF CLIEBULE	345145	D. WING _	OTDEET ADDRESS SITY STATE 712 6	•	/19/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
SILER CIT	TY CENTER			900 W DOLPHIN STREET			
0				SILER CITY, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 353	Continued From pa	age 38	F3	353			
F 353	Cross reference to review and staff int manage inappropri effective intervention resident physical a pattern of physical and wandering behavior of the standard wandering to standard wandering wet. In April 2016, wet and a sheet was sheet so the aide was heet. Most of the on the hall and a standard wandering was brought to on the hall and moperson assist for the on the hall and moperson assist for the daministration and trying to get more hall was brought to administration and trying to get more hall stafew years as nur the last few years as nur the last few years a split needed 2 person a	tag F323 - Based on record erview the facility failed to ate behaviors and implement ons to prevent a resident with a behaviors, verbal behaviors, naviors (Resident #44). PM, a family interview was dent #40. The family member acility was always short of staff amily member indicated that the found the resident soaking she found the resident's bed as placed over the wet bed would not change the bed. In the the resident soaking wet sheets, his gown and draw time only one nurse aide (NA) politter (a nurse aide assigned halls). There were 30 residents set of the residents needed 2 ansfer and personal hygiene. The the only answer was they were	F3	on the bedpan. Education to certified nursing assistant her hall on 09/08/16 by Ce Executive. Resident #123 on 09/08/16 by Center Exeregarding being assisted to Resident #123 stated that when she wanted to go to stated that the girls put her she is ready. Resident #12 may have to wait for just a but they always put her to was ready and they were gresident #40 was provide care timely and appropriate Resident #44 was separate redirected from the other reinjuries were noted and no have occurred. 2. Interviews will be conducted and oriented residents regardered residents regardered from the other reinjuries were noted and no have occurred. 2. Interviews will be conducted and oriented residents regardered from the other residents regardered from the other residents from the other residents occurred. 2. Interviews will be conducted and oriented residents regardered from the other residents regardered from the other residents occurred. 3. Interviews will be conducted and oriented residents regardered from the other residents	ants assigned to other Nurse was interviewed ocutive Director of bed timely. She went to bed bed. She to bed when 23 said that she few minutes, bed when she good to her. It do incontinent ely on 07/18/16. The dother incidents and timely services by other of non meach hall will ervices by insiveness to timent care. Seted incontinent tent on other concluded and to be ents that were		
	available. NA #2 fu were short staff, the	urther stated that when they e residents were not getting ave to wait to be put back to		Social Services completed wandering residents on 08 ensure appropriate wander	/22/16 to		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345143	345143 B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	343143	B: Willo		TREET ADDRESS CITY STATE ZID CODE	08/	19/2016	
NAIVIE OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SILER CIT	Y CENTER				00 W DOLPHIN STREET			
				S	ILER CITY, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From page	e 39	F3	353				
	bed or get out of bed				were in place. Care plans were in place	:e		
	bed of get out of bed	•			for all current wandering residents.			
	On 8/17/16 at 3:45 P			Interdisciplinary Team completed a rev	iew			
	On 8/17/16 at 3:45 PM, NA #3 was interviewed. NA#3 stated that she was employed at the facility				on 09/06/16 & 09/08/16 of those reside			
		se aide (NA). She stated			who have displayed physical behaviora			
	that the normal staffir			symptoms, verbal behavioral symptom				
		As for 3-11 shift and 1 NA for			inappropriate behaviors (pacing,			
	11-7 shift. NA #3 add			rummaging, disrobing, etc&), delusiona	al			
	was really bad. One i			behaviors and wandering behaviors in	the			
	assigned on each ha	II. Most of the residents			last 90 days (05/01/16-08/31/16).			
		ist and so the residents have			Revisions were made to care plans that	ıt		
	-	er was available. She stated			did not have effective interventions to			
		get the job done but she			address the behaviors.			
		e could. NA #3 further						
		and residents soaking wet			3. Nurse Practice Educator (NPE) will	_1		
	due to short of staff.				reeducate licensed nurses and certified	ג		
	The resident souncil	minutes were reviewed for			nursing assistants (including weekend and prn licensed nurses and nursing			
		ne July 20, 2016 meeting			assistant), concerning providing timely			
		it several residents reported			incontinent care and timely call light			
		rned about the nurse aides			responsiveness by 09/16/16. Nurse			
	when they have to wo				Management including Center Nurse			
					Executive, Assistant Director of Nursin	a.		
	On 8/18/16 at 11:00 A	AM, the Director of Nursing			RN Supervisors (first, second and third	•		
	(DON) was interviewed	ed. The DON indicated that			shifts) and Nurse Practice Educator wi	il		
	the normal staffing fo	r each hall was 3 NAs on			complete rounds of two resident on ea	ch		
	7-3 shift, 2 NAs on 3-	11 shift and 1 NA for 11-7			hall, each shift three times weekly time	:S		
	shift. There were 27 r	esidents on 100 hall, 30			one month then two residents per hall	•		
	residents on 200, 400				shift weekly times two months to ensur	e		
		. The DON further indicated			the incontinent care is being provided			
		hat the normal staffing was			timely.			
	not always met but th				Center Executive Director provided			
	required number of s	ιαπ.			re-education to the Clinical	of		
	The quarterly MDS a	seesement for Desident #00			Reimbursement Coordinators, Director Social Services and Social Worker on	OI		
		ssessment for Resident #99 ed that his cognition was						
		riew for Mental Status			revising care plans appropriately on 08/31/16. Nurse Practice Educator (N	DE)		
		no behavior and totally			will reeducate licensed nurses and	-)		
		ng. On 8/18/16 at 11:50 AM,			certified nursing assistants (including			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NI IMPED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345143	B. WING			08/19/2016	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				9	00 W DOLPHIN STREET		
SILER CIT	Y CENTER			S	SILER CITY, NC 27344		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 353	Continued From pag	ge 40	F3	353			
	Resident #99, the pr	resident of the resident			weekend and prn licensed nurses and		
		wed. Resident #99 stated			nursing assistant), concerning wander		
	that the concerns ab	oout short staff was brought to			residents and those residents that are	Ū	
	the resident council	meeting on several			displaying aggressive/combative beha	vior	
	occasions. The response from Social Worker				on the importance or documenting and	l	
	was " we were working on it." Resident #99				reporting to ensure that care plans are		
	indicated that last Tuesday, he was scheduled to				updated and revised with the most		
	have a shower in the morning. He asked his aide				effective interventions by 09/16/16.		
	for a shower that morning and his aide told him it				Social Services will conduct interviews	of	
		they were short of staff. He			alert and oriented residents. Two		
		can have the shower before			residents on each hall, each shift three		
		tend the activities at 2 PM.			times weekly times one month then tw		
	Resident #99 stated that he received the shower at 1:30 PM and was late for the activities.				residents per hall per shift weekly time		
					two months regarding timely response	to	
		ndicated that 1 aide and a			call lights.		
		he hall was an issue. Most of			24 Hour Report will be reviewed by		
		d 2 person assist with transfer			Interdisciplinary Team for any occurrer		
		it until the splitter was			of wandering and/or aggressive reside five days/weekly at Clinical Stand-up.		
	avaliable belole the	y were put back to bed.			occurrences that are identified, the car		
	Pacident # 08's ann	ual MDS assessment dated			plans will be reviewed for effective	C	
		t her cognition was intact with			interventions. Nurse Management		
		no behavior and needed			including Center Nurse Executive,		
	· ·	n personal hygiene. On			Assistant Director of Nursing and RN		
		I, the resident was inter			Supervisors (first, second and third shi	fts)	
		nt stated that she attended			will complete rounds of two resident or		
		meeting every month and she			each hall, each shift three times weekl		
		ssue of short staff on all shift.			times one month then two residents pe	-	
		ed that she had to wait more			hall per shift weekly times two months	to	
	than 30 minutes for	the call light to be answered			ensure the incontinent care is being		
	and she had to lay o	on a wet diaper.			provided timely. Certified Nursing		
					Assistants assignments will be assess	ed	
					and adjustments will be made based o	n	
	Resident #33's quar	terly MDS assessment dated			resident acuity to provide nursing care	to	
		at her cognition was intact			all residents in accordance with reside		
		f 14, no behavior and needed			care plans. The number of staff workin	•	
		toilet use. The assessment			each hall is looked at on a daily basis a	and	
		ne resident was occasionally			the staff to resident ratio is adjusted		
	incontinent of bowel and bladder. On 8/18/16 at				according to census numbers. Center		

Facility ID: 923120

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345143 B. WING			C 08/19/2016		
	ROVIDER OR SUPPLIER			STREET ADDRESS, O 900 W DOLPHIN ST SILER CITY, NC		1 00/	13/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRO (EACH I CROSS-R	3E	(X5) COMPLETION DATE	
	12:20 PM, Resident # resident stated that the staff on all shift. She bowel and bladder are she called for the staff before the staff answestaff informed her than On 8/18/16 at 4:00 Pl was interviewed. She responsible for the restated that the issue abrought up in the resistated that she didn't because there was not SW #1 stated that she they were trying to him Resident #123's quard dated 7/26/16 indicated intact with a BIMS so needed extensive as 8/19/16 at 9:25 AM, Finterviewed. The resident back to bed at 10:30 On 8/19/16 at 10:05 Am the DON were inform	# 33 was interviewed. The file facility was very short of was mostly continent of id needed a bedpan when if. She had to wait an hour ered the call light and the it they were short of staff. M, Social Worker (SW) #1 stated that she was sident council meeting. She about short staff was dent council meeting. She write a grievance form of care issues mentioned. It informed the residents that the more aides. Iterly MDS assessment the did that her cognition was one of 13, no behavior and sist with transfer. On Resident #123 was dent stated that last and the staff to be put back to staff told her to wait a stated that she was put PM. AM, the administrator and ed of the staffing concerns. understood the concerns remation provided. ERS/MEET	F 3	has been and certified nurs following: addinewspapers Sanford), addindeed, Heal Career Board Facebook. C Analysis, offer blasts within supplemental employees. 4. Center Nut Social Service audits and in Improvement months then	d is continuing to recruit for sing assistants by doing the local (Siler City, Asheboro & Vertising on Career Builder Ith Jobs Nationwide, Nursed ZipRecruiter, Craigslist, Center has completed a Wering Sign-on Bonuses, er 50 mile radius and followial staffing bonus to current curse Executive and Directors will report the findings interviews to the Performant meeting monthly times 3 quarterly.	er, e and age mail ing or of of	9/16/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345143	B. WING _			C 08/19/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344		10/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.		F 5	520			
	by: Based on record reinterviews, the facil Assurance (QAA) (implemented proceinterventions that the following the 10/22 was for two recited assessment accurate (F323). These defit the current recertific continued failure of	eview, observations, and staff ity's Quality Assessment and Committee failed to maintain dures and monitor these ne committee put into place /15 recertification survey. This deficiencies in the areas of acy (F278) and accidents ciencies were cited again on cation survey of 08/19/16. The ithe facility during two federal how a pattern of the facility's an effective Quality		1. Modifications were made to the Minimum Data Set for Resident #Resident #28 and Resident #59 08/18/2016. The modification for Resident #42 and Resident #59 is changing Section LO200B status to yes. For Resident #11 the ARI were reviewed and Sections NO3 NO410 ABC was modified to reflect rounder of insulininjection Resident #44 was separated and redirected from the other resident injuries were noted and no other	#11, on included from no dates 300 & ect the as. I		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345143	B. WING _	B. WING		08/	19/2016
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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SILER CIT	Y CENTER			SII	LER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	findings included: This tag is cross refe 1. F278 - Assessme observation, medical interviews the facility Minimum Data Set (Nampled residents remedications (Resider #28, #59). During the recertifica facility was cited F27 assess residents in the and hydration on the recertification survey to accurately assess medications and den 2. F323 - Accidents: staff interview the facinappropriate behavior interventions to prevent physical altercation for physical altercation for physical behaviors. During the recertification facility was cited F32 facility's policy on sm recertification survey to manage inappropri	urance program. The renced to: Int Accuracy: Based on record review, and staff failed to accurately code the MDS) for three of seventeen viewed in the areas of int #11) and dental (Resident tion survey of 10/22/15 the 8 for failing to accurately ne areas of pressure ulcer MDS. On the current of 8/19/16, the facility failed residents in the areas of tal. Based on record review and cility failed to manage ors and implement effective ent a resident to resident or a resident with a pattern of terbal behaviors, and (Resident #44). Ition survey of 10/22/15 the 3 for failing to follow the oking. On the current of 08/19/16, the facility failed iate behaviors and interventions to prevent a	F 5	520	noted. 2. Clinical Reimbursement Coordinator (CRC) completed audit on 09/02/16 of Minimum Data Set for last 90 days (05/01/16-08/31/16) for those residents who were coded for medications and dental. No other residents were identificing with incorrect coding of insulin. 6 residents were identified with incorrect coding of dental and were modified on 09/02/16 by Clinical Reimbursement Coordinator. Social Services completed an audit of all wandering residents on 08/22/16 to ensure appropriate wander care plans were in place. Care plans were in place for all current wandering residents. Interdisciplinary Team completed a review on 09/06/16 & 09/08/16 of those residents who have displayed physical behavioral symptom verbal behavioral symptoms, inappropriate behaviors (pacing, rummaging, disrobing, etc&), delusional behaviors and wandering behaviors in last 90 days (05/01/16-08/31/16). Revisions were made to care plans that did not have effective interventions to address the behaviors. Social Work interviewed current smokes to ensure that they did not have materia for lighting cigarettes in their possession. No resident had lighting material in their possession on 09/08/16. Director of Nursing and/or Licensed Nurse reviewee each resident Smoking Assessment on 09/08/16 to ensure accuracy. All reside	ed d ing is, al the t ers al in. ir	
	An interview was con Administrator on 8/19	iducted with the 9/16 at 10:00 AM. She			smoking assessments are appropriate. Social Worker and Clinical		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345143	B. WING			08/19/2016	
NAME OF P	ROVIDER OR SUPPLIER	0.01.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	19/2010
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F 520	Continued From page	e 44	F	520			
		ead of the facility's QAA	•		Reimbursement Coordinator completed	d	
		ed the QAA Committee			an audit of those residents requiring a	•	
		ctor of Nursing, Assistant			Level II PASARR on 09/08/16 to ensure	e	
	Director of Nursing, N	<u> </u>			their individual Minimum Data Sets are	_	
	_	ces, Admissions Director,			coded correctly. All residents were fou		
	Business Office Mana				to be coded correctly. Clinical		
	Educator/Staff Development, Director of Therapy,				Reimbursement Coordinators complete	∍d	
	Director of Dining Services, Director of Social				audit on 09/08/16 of Minimum Data Se	t	
	Services, Health Info	rmation Management			for those residents who were coded for	Ī	
	_	Dietician, Pharmacist, and			dehydration and pressure ulcers. All		
	Medical Director. She stated all members of the				residents were found to be coded		
	· ·	erly, as well as monthly			correctly. Center Executive Director an		
	meetings without the	pharmacist.			Maintenance Director completed an au	dit	
					of pipe access portals on each hall on		
		licated she was aware			09/07/16 to ensure that all access por		
	-	y was a repeat deficiency			are at the same level as the surroundir	ig	
	·	ertification survey. She			flooring and do not pose a hazard for residents, as well as employees and		
	-	action plan. She indicated			visitors.		
	the facility presently a				Visitors.		
	transmitted MDS ass				3. Administrator will provide re-education	on	
	Administrator stated t				to the Quality Improvement Members	J11	
		cords (EMR) system that			including Medical Director, Director of		
		ted some areas of the MDS			Nursing, and Assistant Director of		
	assessments from co				Nursing, Clinical Reimbursement		
		ndicated the MDS Nurses			Coordinator, Recreation Director, Socia	al	
	had not double check	red all of the automatically			Worker, Register Dietitian, Food Service	e	
	populated areas which	ch led to some inaccuracies.			Director, Housekeeping Supervisor and		
		ited that MDS Nurse #2 was			Medical Records on 09/08/16. Region	al	
		to assist MDS Nurse #1.			Clinical Reimbursement Coordinator		
		DS Nurse #1 and MDS			provided re-education to Clinical		
		luled to attend the state			Reimbursement Coordinator on MDS		
	MDS training on Octo	ober 25, 2016.			accuracy 09/07/16. The Interdisciplina	ry	
		B (. 1 . 1			Team, including Director of Nursing,		
		licated she was aware			Clinical Reimbursement Coordinator,		
	•	eat deficiency from the			Recreation Director, Social Worker and		
	I -	on survey. She stated the			Register Dietitian will review the entire		
		d an audit tool that was			Minimum Data Set for accuracy prior to)	
	⊟initially completed da	ily and then progressed to	1		transmission each week on 100% of		1

Facility ID: 923120

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	19/2010
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SILER CITY CENTER							
				SI	LER CITY, NC 27344		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 520	520 Continued From page 45		F 5	520			
F 520	weekly. The audit too safety or accident has monitoring for potenti that needed to happe indicated the facility for monitoring plan from	ol was used to assess any zards. She indicated that al accidents was something n daily. The Administrator	F 5	520	residents x 4 weeks then 50% of resider x 4 weeks then 25% of residents x 4 weeks and 10% of residents quarterly thereafter. Center Executive Director provided re-education to the Clinical Reimbursement Coordinators, Director Social Services and Social Worker on revising care plans appropriately on 08/31/16. Nurse Practice Educator (NF will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), concerning wandering residents and those residents that are displaying aggressive/combative behave on the importance or documenting and reporting to ensure that care plans are updated and revised with the most effective interventions by 09/16/16. 24 Hour Report will be reviewed by Interdisciplinary Team for any occurrent of wandering and/or aggressive resider five days/weekly at Clinical Stand-up. A occurrences that are identified, the care plans will be reviewed for effective interventions. Maintenance Director, Maintenance Assistant and/or Housekeeping Supervisor will audit pipe access portal weekly x 2 months then monthly x 3 months and quarterly thereafter. RN Supervisor will make Environmental Rounds to identify any fall and/or environmental hazards daily x 4 weeks times weekly x 4 weeks, weekly x 2 months, then quarterly. Any hazards	of PE) ng vior ces nts Any e	
				identified will be addressed immediately and reviewed at stand-up 5 days/week. All incidents/accidents are reviewed at	.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345143	B. WING _			08/19/2016	
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OILLIN OIT	CENTER			SILER CITY, NC 27344			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	(X5) COMPLETION DATE		
F 520	Continued From page	46	F 5:	clinical stand-up 5 days/week. 4. Clinical Reimbursement Coo Director of Nursing and Mainten Director will report the findings of MDS accuracy and accident/haz the Performance Improvement of two times a month for three mor monthly.	ance of audits of zards to Committee		