

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0395	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/03/2022
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NAME OF PROVIDER OR SUPPLIER SILER CITY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS A licensure complaint investigation was conducted on 6/3/2022. Event ID# #7LB11. The following intakes were investigated NC00189570. The complaint allegation was substantiated resulting in a deficiency.	L 000		
L 414	N.C.G.S. 131E-130 First Available Bed Priority Certain NH Pati § 131E-130. First available bed priority for certain nursing home patients. (a) If a patient is temporarily absent, for no more than 15 days, from a nursing home to obtain medical treatment at a hospital other than a State mental hospital, the nursing home; (i) shall provide the patient with the first bed available at or after the time the nursing home receives written notification of the specific date of discharge from the hospital; and (ii) shall grant the patient priority of admission over applicants for admission to the nursing home. The duration of the temporary absence shall be calculated from the day of the patient's admission to a hospital until the date the nursing home receives written notice of the specific date of discharge. This subsection shall not apply in instances in which the patient's treatment can no longer be provided by the nursing home upon re-admission. (b) If the Department finds that a nursing home has violated the provisions of subsection (a) of this section, the Department may assess a civil penalty of fifty dollars (\$50.00) a day, up to a	L 414		6/16/22

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
06/16/22

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L 414	<p>Continued From page 1</p> <p>maximum of one thousand five hundred dollars (\$1,500), against the nursing home, for each violation.</p> <p>The clear proceeds of penalties provided for in this subsection shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.</p> <p>(c) The provisions of Chapter 150B of the General Statutes that govern contested cases apply to appeals from Department action pursuant to this section. (1987 (Reg. Sess., 1988), c. 1080, s. 1; 1998-215, s. 79.)</p> <p>This Rule is not met as evidenced by: Based on record review and staff, hospital staff and family interview, the facility failed to readmit Resident #99 back to the nursing home after a facility-initiated discharge from the nursing home and admission to the emergency room and then notice from the hospital to the nursing home that Resident #99 was ready to return. This deficient practice affected one of one resident reviewed for readmission (Resident #99).</p> <p>Findings included:</p> <p>Resident #99 was admitted to the facility on 4/7/2022. Her admission Minimum Data Set assessment dated 4/14/2022 indicated she had moderately impaired cognition, trouble concentrating and inattention behaviors that fluctuated. It also indicated the stay was not covered for Medicare or Medicaid.</p> <p>According to an interview with the Administrator on 6/3/2022 at 8:59 AM, Resident #99 had an episode of threatening behavior toward staff on 5/25/2022. Police were called and she was sent</p>	L 414	<p>L414 – First Available Bed Priority Certain NH Patients</p> <p>1) Resident was discharged to the hospital for a psychiatric evaluation after threatening to commit suicide and threatening staff with a taser. Resident stated she would commit suicide if she had to return to Center. Center notified hospital that Resident had refused to return and would not be readmitted to the Center.</p> <p>2) No other residents were at risk of the stated deficiency in the Center.</p> <p>3) Administrator received education from the North Carolina Department of Health and Human Services Assistant Section Chief and a copy of North Carolina General Statute 131E-130 on June 3, 2022. Administrator provided education to the Director of Nursing (DON), Assistant Director of Nursing (ADON),</p>	
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L 414	Continued From page 2 to the emergency room for evaluation. The hospital history and physical notes dated 5/25/2022 indicated Resident #99 was evaluated for aggressive behavior and suicidal ideation. A psychiatric consult was performed on 5/25/2022 resulting in diagnoses of disruptive behavior and dementia with behavioral disturbance. The clinical impression of the emergency department visit resulted in final diagnoses of acute cystitis without hematuria and aggressive behavior. The discharge summary indicated the patient was evaluated and cleared by telepsych. She was at her mental baseline and not at imminent risk of self-harm or harm to others. On 5/25/2022 at 4:59 PM the hospital documented the nursing home refused to take patient back. On 5/26/2022 the hospital social worker noted the nursing home stated they were unable to take Resident #99 back because they felt she was a danger to herself and others. Resident #99 received a bed offer from an assisted living facility and the family was agreeable. An interview was conducted with the Chief Operating Officer (COO) at the hospital on 6/3/2022 at 9:14 AM and information was provided. He said the hospital had assessed the resident on 5/25/2022 and had no mental health findings were found. Hospital staff informed the nursing home later 5/25/2022 that the resident was ready for discharge. The hospital staff said the Administrator had said the resident was violent, self-pay, did not hold the bed and the nursing home did not have to take the resident back. The COO added the resident remained calm and cooperative. She had an unnecessarily long stay at the hospital and was discharged on 5/31/2022 to an assisted living facility.	L 414	Admissions/Marketing Director, and the Social Workers on 6/15/22 regarding the North Carolina Statute. Administrator educated the listed staff that the Center could not refuse to accept the return of a Resident who had been temporarily absent for no more than 15 days to obtain medical treatment at a hospital, and that the Center was required to provide the Resident with the first bed available after receiving notification of discharge; and shall grant the patient priority of admission over applications for admission to the Center, unless the Center was unable to provide the appropriate treatment for the Resident upon their readmission to the Center. All staff receiving education was given a copy of North Carolina General Statute 131E-130. 4) Director of Nursing/Director of Marketing/Admissions will audit all discharges to the hospital from the Center on an ongoing basis to ensure that all Residents discharged to the hospital for medical treatment are accepted for return to the Center or given priority over other applicants for admission, after the Center is notified of the pending discharge from the hospital. 5) Compliance date: 6/16/22	

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L 414	<p>Continued From page 3</p> <p>The Family Member was interviewed on 6/3/2022 at 9:40 AM. He said Resident #99 was banned from the nursing home and she went to an assisted living. He said he did not want her to go back to the nursing home.</p> <p>A follow up interview was conducted with the Administrator on 6/3/2022 at 10:03 AM. He said the hospital only did a psychiatric evaluation via telehealth and the nursing home felt she needed an in-person evaluation. Resident #99 also expressed that she did not want to come back to the nursing home.</p>	L 414		