STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/05/23 through 6/12/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1NEO11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted onsite from 6/05/23 through 6/08/23. Onsite validation was conducted on 6/12/23. Therefore, the exit date was 6/12/23. Event ID# 1NEO11. The following intake was investigated NC00201784 which resulted in immediate jeopardy. 1 of the 1 complaint allegation resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F561 at a scope and severity (J) CFR 483.12 at tag F600 at a scope and severity (J) The tags F561 and F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/22/23 and was removed on 6/10/23. An extended survey was conducted.	F 000		
F 561 SS=J	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		6/13/23

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

Electronically Signed | 06/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, staff, and family interviews, the facility failed to honor a resident's (Resident #49) right to choose their preferred method of bathing and the resident's right to refuse a shower. On 4-22-23, Resident #49 had refused her shower three times and on the third refusal Nurse #1 was informed of Resident #49's refusal to take a shower. Nurse #1 informed Nursing Assistant (NA) #1 and NA #2 that the resident had to take a shower regardless of Resident #49's refusal. Nurse #1 and 5 NAs	F 561	Tag F561: 1. Resident #49's careplan was reviewed on 06/09/2023. The Intervention/Task for Bathing will remain the same, which states: "If the resident refuses, allow a few minutes to pass and then reattempt to get the resident to agree to shower or bathe." 2. All interviewable residents were interviewed on 06/09/2023 to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 (NA #1, NA #2, NA #3, NA #4, and NA #5) proceeded to "force" Resident #49, who was combative and stating she did not want to get out of bed and have a shower, out of the bed, into a shower chair and into the shower. Resident #49 sustained a bruise to her left hand and had the likelihood of suffering serious physical and psychosocial harm. A reasonable person would have experienced feelings such as intimidation, fear, humiliation, embarrassment, and/or dehumanization (deprivation of human qualities such as compassion). This deficient practice was for 1 of 4 residents reviewed for choices. Immediate Jeopardy began on 4-22-23 when six staff members "forced" Resident #49 out of her bed to receive a shower. Immediate Jeopardy was removed as of 6-10-23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Findings included: Resident #49 was admitted on 7-17-18 with multiple diagnoses that included vascular dementia without behavioral disturbances and atrial fibrillation. The annual Minimum Data Set (MDS) dated 7-22-22 revealed Resident #49 was moderately cognitively impaired, and documentation showed that choosing her preference for bathing was very important to Resident #49.	F 561	their bathing wishes are being followed. The interviews were conducted by the Administrator, Director of Nursing (DON), or trained designee. There were no complaints or concerns voiced to date of their bathing schedule. To ensure that there are no complaints or concerns, the facility (Director of Nursing or Administrator or trained designee) notified the responsible parties of non-interviewable residents via phone messaging system to contact the Administrator or Director of Nursing if they have any concerns about their loved ones' shower or bathing schedules. This also included a survey to choose method of bathing. This was completed at 9:24 AM on 6/9/2023. 3. The Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee trained 100% of all staff regarding Tag F561. This was completed by 12:00 PM on 06/09/2023, and any staff who did not complete was removed from the schedule and not allowed to work until they have been educated. This includes contract and agency staff members. This includes staff in every department as Residents' Rights are relevant for every department. The education will include: a. Residents' rights policy and procedure. b. Allowing the resident to choose bathing options, including bed baths, showers, tub, and refusal all together. c. How to offer the resident options on bathing. d. Understanding that the resident has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 Resident #49's activities of daily living care plan initiated on 1-4-2020 and revised on 9-20-22 revealed the resident had an activities of daily living self-care deficit. The goal for Resident #49 was to maintain current level of function with her activities of daily living. The interventions for the goal included Resident #49 required total assistance with bathing and if the resident refuses, allow a few minutes to pass and then re-attempt to get the resident to agree to a shower or bath. Provide the resident with a sponge/bed bath when a full bath or shower cannot be tolerated. There was no documentation regarding Resident #49's preferred bathing choice. The quarterly Minimum Data Set (MDS) dated 4-21-23 revealed Resident #49 was moderately cognitively impaired and exhibited physical behaviors towards others 1-3 days in the 7 days look back period and had refused care 1-3 days during the 7 days look back period. Resident #49 was documented as needing physical help with two people for bathing and extensive help with two people for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDs also documented Resident #49 received an anticoagulant (medication to inhibit the clotting of blood) 7 out of 7 days during the 7 day look back period. Skin assessments conducted from 4/1/23 through 4/21/23 revealed no bruises were present on Resident #49. Review of Resident #49's medical record revealed a nursing note dated 4-23-23 at 10:37pm written by Nurse #2. The nurse documented she had been called to the resident's	F 561	the right to decline all bathing. e. Understanding that forcing care is abuse and can lead to harm to the patient. f. Staff understanding the methods of offering bathing alternatives (examples include: shower, bed baths, sink baths, bath tubs, and refusing bathing) to meet the residents' needs. g. Reporting refusal of care to the charge nurse so the nurse can take extra measures to have alternative means (examples: psychiatric care referrals, notifying families for involvement, notifying physician for input on care). 4. Beginning June 13th, 2023, the Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee will conduct audits to ensure that the resident's choices of bathing are being honored by the facility staff. The audits will include interviews for residents with a Brief Interview for Mental Status (BIMs) of 8 and above. For residents with a BIMs below 8, the audits will include reviewing their shower and skin sheets. The audits will also include staff questionnaires regarding abuse. The audits will be conducted at the following frequency: a. 5 resident interviews (of alert and oriented residents who have a BIMs of 8 or above) each working week, weekly for 12 weeks. b. 5 resident shower sheet reviews (of non-alert and oriented residents with a BIMs below 8), weekly for 12 weeks. c. 5 staff interviews each working week, weekly for 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 4	F 561		

room by a family member (daughter) who was questioning what had happened to Resident #49's hand which had a bruise on her left hand. Nurse #2 documented that Resident #49 had told her it happened in the shower a couple of days ago.

The facility's final investigation report dated 4-28-23 revealed Resident #49's daughter called the Administrator on 4-25-23 and reported the resident had been abused in the shower on Saturday (4-22-23). The documentation showed the daughter told the Administrator she visited Resident #49 on 4-23-23 and noticed a bruise on the resident's hand. The daughter informed the Administrator that Resident #49 told her staff were pinching her hand during her shower. The daughter also informed the Administrator she had spoken to the charge nurse on 4-23-23 who assessed Resident #49's hand for damage. The investigation report documented Resident #49 had a bruise on the top of her left hand. The investigation report included written statements from staff who had contact with Resident #49 on 4-22-23.

Resident #49 was interviewed on 6-5-23 at 10:39am. Resident #49 confirmed she remembered when she sustained a bruise to her hand on 4-22-23. The resident commented, "It stayed bruised for a long time." Resident #49 said "the girl was trying to force me into the shower chair and was squeezing my hand. I told her to stop because she was hurting me, but she did not." She also stated she was fighting with the staff because she did not want to get a shower. Resident #49 discussed that she preferred to get bed baths. The resident would not discuss how she felt during the incident on 4-22-23 but instead

5. Beginning June 13th, 2023, the facility Quality Assurance and Process Improvement (QAPI) team will meet monthly to discuss follow-up from Tag F561. The team includes: the Administrator, the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Wound Care, Social Services, Medical Records, Minimum Data Set (MDS) nurses, and other relevant members of management.

6. Date of Compliance: 06/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 5	F 561		

kept stating "I don't want to get anyone fired." Resident #49 discussed telling a family member (her daughter) on 4-23-23 what happened and stated she did not tell any other staff because she was concerned about the staff's jobs. She stated she had not received any other bruises since 4-22-23.

Upon observation of the resident, she was observed not to have any bruising to her hands. Resident #49 was observed on 6-5-23 at 10:39am. The resident was observed to be lying in bed. Her clothes were noted to be clean, there were no odors observed, her hair was observed to flow down to the middle of her back and was clean but uncombed.

A telephone interview occurred with Resident #49's daughter on 6-6-23 at 11:35am. The daughter discussed visiting the resident on 4-23-23 and noticed a bruise on the resident's hand that was black and blue in color. She stated when she asked Resident #49 what happened the resident told her staff had given her (resident) a shower yesterday (4-22-23). The daughter further discussed Resident #49 telling her she (the resident) was combative because she did not want a shower, so the resident told the daughter that staff held her hand down and "pinched" her hand. The daughter said she informed Nurse #2 of the bruise to Resident #49's hand and stated the nurse took a picture of the bruise and told her the staff would monitor the area. The daughter stated she never told staff to "force" the resident to have a shower. She explained she told staff to encourage the resident to take a shower but if the resident refused it was ok. She explained she knew the resident did not like getting a shower and preferred to have bed baths. The daughter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 6	F 561		

stated on 4-23-23 during the visit that the resident told her she did not think staff liked her.

NA #1's written statement dated 4-26-23 related to the incident on 4-22-23 indicated that she assisted with transferring Resident #49 from the bed to the wheelchair so she could be brought to the shower room. The statement further indicated that she did not aid with giving Resident #49 the shower.

NA #1 was interviewed on 6-6-23 at 12:46pm. NA #1's written statement related to the 4-22-23 incident with Resident #49 was reviewed. NA #1 was asked to clarify her statement and explain Resident #49's behaviors as well as staff's course of action. NA #1 stated Resident #49 was "real bad to refuse showers". She discussed that she did not know if the resident's preference in bathing was written anywhere but stated she usually asked Resident #49 if she wanted a shower or bed bath. She further discussed the resident being allowed to refuse a shower but not all the time. NA #1 explained Resident #49 was allowed to refuse one shower a week but the second scheduled shower, the resident was not allowed to refuse. NA #1 explained on 4-22-23 Resident #49 refused her shower 2-3 times and after the last refusal, she informed Nurse #1 that the resident was refusing her shower. The NA stated Nurse #1 told her to get the resident up and take her to the shower anyway. She stated there were six staff in the room (Nurse #1, NA #1, NA #2, NA #3, NA #4, and NA #5) and that it took four staff (the NA could not remember which staff) to sit Resident #49 on the edge of the bed. NA #1 explained during this time, the resident was throwing her hands around, pushing away from staff and putting her arms up "guarding" herself.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 7	F 561		

The NA stated once Resident #49 was "talked into" receiving a shower, the resident was no longer combative. NA #1 explained Resident #49 would stick her right hand through the side rails and bang her hand over the bed table when she wanted something. The NA stated she worked with Resident #49 on 4-20-23 and the resident did not have a bruise on her hand and said she did not see if Resident #49 had a bruise on her left hand during the transfer on 4-22-23.

Nurse #1's written statement that was undated following the incident on 4-22-23 read; "I was called down to the resident's room to help them get her up for a shower. She was refusing as she always does. I told her [her son] wanted her to get a shower. She told us [her son] was not the boss of her. We (the CNAs and myself) assisted [Resident #49] to sitting on her bed, then put her on the shower chair. She was not happy getting up, but smiling and apologizing when her shower was done."

During an interview with Nurse #1 on 6-6-23 at 1:17pm, Nurse #1's written statement related to the 4-22-23 incident with Resident #49 was reviewed. The nurse was asked to discuss Resident #49's behavior and explain what happened when the resident refused her showers. The nurse confirmed she was the charge nurse on 4-22-23 but stated she did not remember the incident. Nurse #1 stated if it was a shower day for Resident #49 then the resident would have been combative by flailing her hands and arms but said usually once the resident was assisted by staff into a seated position on the edge of the bed the resident would stop being combative. After reading her written statement for the 4-22-23 incident that she provided to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 8	F 561		

facility during their investigation, she stated she remembered being told Resident #49 was refusing her shower and she went to the resident's room to speak with her along with five NAs (NA #1, NA #2, NA #3, NA #4, and NA #5). Nurse #1 was unable to explain why six staff members went to Resident #49's room. The nurse stated once Resident #49 was placed in the shower chair, the resident stopped being combative. Nurse #1 explained typically if a resident refused a shower three times, the resident would be provided a bed bath but stated with Resident #49, she would sometimes be "forced" to get a shower because the resident's hair was long and became matted if she did not receive a shower. She explained the facility had washing caps that could be used to wash the resident's hair but stated they did not work well. She further stated the family had told staff they wanted the resident to have at least one shower a week.

Review of NA #5's written statement dated 4-26-23 following the incident on 4-22-23 read; Resident #49 "did not want to take her shower but me and [Nurse #1] got her to go take it. The bruise on her hand is where she puts her hand through the rail on the bed all the time. She keeps a bruise on that hand a lot from the bed rails."

A telephone interview occurred with NA #5 on 6-6-23 at 3:01pm. NA #5's written statement related to the 4-22-23 incident with Resident #49 was reviewed. NA #5 was asked to discuss Resident #49's behavior, what happens when the resident refused a shower, and the bruise Resident #49 sustained to her left hand. The NA confirmed she assisted with getting Resident #49 out of bed for a shower on 4-22-23. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 9	F 561		

she remembered the resident was combative because the resident did not want to get out of bed and take a shower. NA #5 stated, while trying to get Resident #49 into the shower chair, the resident attempted to hit one of the NAs. She stated she could not remember which one, but it was one of the NAs standing behind the resident. The NA stated there were six staff members (Nurse #1, NA #1, NA #2, NA #3, NA #4, and NA #5) in the room and she could not remember who was standing behind the resident. NA #5 explained Resident #49 was allowed to refuse one shower a week but then the resident "will be forced the next shower day." She explained if Resident #49 refused the shower, staff tried to talk her into receiving a shower. She further explained that if she was not able to be talked in to receiving her shower, the resident was "forced" to get up out of the bed to take a shower. The NA discussed typically residents were allowed to refuse a shower four to five times on their shower day but then the nurse on duty had to be informed of the refusal and it was up to the nurse on duty to decide if the resident needed to be "forced" to get up and receive a shower. She stated she could not remember if Resident had a bruise on her left hand on 4-22-23.

NA #2's written statement dated 4-25-23 following the incident on 4-22-23 read; "Per [NA #2] I did not help to give [Resident #49] her shower on Saturday. I did assist with getting her back into bed after the shower. She was fine with me and was not being combative. When asked about the bruise on resident's hand, [NA #2] told interviewer that [Resident #49] had that bruise before Saturday."

During a telephone interview with NA #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 10	F 561		

6-6-23 at 3:34pm, NA #2's provided statement related to the 4-22-23 incident with Resident #49 was reviewed. NA #2 was asked if she assisted with Resident #49's transfer prior to the shower, resident's behavior, and what happened if Resident #49 refused a shower, as well as the bruise on Resident #49's hand. NA #2 stated she assisted in transferring Resident #49 from the bed to the shower chair on 4-22-23. NA #2 discussed Resident #49 telling the staff she did not want a shower and had been combative until she was placed in the shower chair. The NA stated she could not remember how many staff were in the room but said there were "a lot of us." She was unable to explain why there were so many staff in the room. She also discussed Resident #49 never wanting to get out of bed and usually when she refused her shower a bed bath was provided. NA #2 explained she did not think the resident's preference for bathing was written anywhere but said she usually asked the resident if she wanted a bed bath or shower. The NA stated she did not know why she was being made to get a shower on 4-22-23. NA #2 stated she did not see a bruise on Resident #49's hand when transferring the resident into the shower chair. She stated she said in her written statement Resident #49 had the bruise before Saturday (4-22-23) because the resident "always keeps a bruise on her hand."

Review of NA #3's written statement dated 4-26-23 to the facility following the incident on 4-22-23 read; [NA #5, NA #4, NA #2, Nurse #1] and myself all assisted in getting her from the bed to the shower chair in her room. She didn't want to go at first but did fine with all of us helping her in the chair. [NA #4] and I pushed her in the shower room and began her shower and she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 11	F 561		

thanking us for bathing her and she even apologized for "being an old fart" (her words) and not wanting to take a shower. We dressed her and took her back to the room and she wanted to go back to bed so we assisted her in that. We hooked up her oxygen and she was good."

NA #3 was interviewed by telephone on 6-6-23 at 7:12pm. NA #3's statement related to the 4-22-23 incident with Resident #49 was reviewed. She was asked to clarify Resident #49's behavior. NA #3 explained Resident #49 was scheduled for a shower on 4-22-23 but the resident had been refusing. She said it took five people (Nurse #1, NA #1, NA #2, NA #4, and NA #5) plus herself to get Resident #49 out of the bed because the resident was pushing them away and not wanting to get up. NA #3 explained Resident #49's preference for bathing was not documented anywhere and said she usually just asked the resident if she wanted a bath or shower.

Na #4's written statement dated 4-27-23 following the incident on 4-22-23 read; "On Saturday we asked [Resident #49] if she was ready for a shower and she didn't want to get out of bed but then finally said she was ready but still gave us a hard time to get out of bed so I went to ask the other CNAs [NA #5, NA #1, NA #3] if they could help because she was screaming at me, at that time [NA #5] went and got the charge nurse [Nurse #1] to help. They got [Resident #49] up put of the bed and into the shower chair and we wheeled her down to the shower room and me and [NA # 3] gave her a shower. She was fine in the shower and kept saying how sorry she was for giving us a hard time getting out of bed. She was calm and gentle while in the shower. We washed and dressed her and got her back in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 12	F 561		

room and she got her toenails cut by [NA #2] and [NA #2] had helped me get her in the bed and she was fine and helped us and said thank you."

An interview with NA #4 occurred on 6-7-23 at 9:01am. NA #4's written statement related to the 4-22-23 incident with Resident #49 was reviewed. She was asked to clarify Resident #49's behavior prior to the shower. NA #4 stated on 4-22-23 she asked Resident #49 if she wanted a shower and said the resident was agreeable to receiving a shower. She stated she left the resident's room to ask for more help because she was not familiar with the resident and could not transfer the resident on her own. NA #4 was unable explain why her written statement was different. She stated during the transfer Resident #49 was pushing against them and fighting. NA #4 explained she never heard the resident say she did not want a shower.

The previous Social Worker (SW) was interviewed by telephone on 6-6-23 at 4:44pm. The previous SW stated she had conducted the investigation for the abuse allegation towards Resident #49 on 4-25-23 after the Administrator received a call from Resident #49's daughter, saying the resident had been "roughed up" by staff in the shower on 4-22-23. She stated she first questioned staff and then questioned Resident #49 about the incident on 4-22-23. She stated the staff were consistent in their statements that Resident #49 was combative getting into the shower chair because the resident did not want a shower. The previous SW stated she had not questioned staff on their response when the resident was refusing her shower or when the resident had been combative. She explained once Resident #49 was refusing her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 13	F 561		

shower and had become combative, the staff should have walked away instead of "forcing her into the shower."

Resident #49's son who was the resident's Power of Attorney (POA), was interviewed by telephone on 6-7-23 at 9:30am. The son discussed Resident #49 being difficult at times and being strong willed but stated he never told staff to "force" the resident to get a shower. The son explained he knew the resident did not like showers and preferred to stay in the bed to receive bed baths. He stated he had spoken with staff to encourage Resident #49 to take a shower but said he told the staff if the resident refused to let her refuse.

During an interview with NA #7 on 6-7-23 at 2:06pm, she stated resident preferences for bathing were not documented anywhere. NA #7 discussed when she was hired at the facility a few months ago, she was informed by staff (unable to recall who) residents could not just receive bed baths. NA #7 explained she asked the residents if they would like a shower or bed bath. She stated if a resident refused their shower three times, she informed the nurse and the nurse spoke with the resident. The NA stated she never felt like she was forcing a resident to take a shower.

The Administrator was interviewed on 6-7-23 at 3:01pm. He stated, "forcing a resident was abusive" and if he had known he would "have stopped it from happening."

The Administrator was notified of the Immediate Jeopardy on 6-7-23 at 3:01pm.

The facility provided the following Credible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 14 Allegation of Immediate Jeopardy (IJ) removal: " Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. o This deficient practice at tag F561 impacts Resident #49. o This deficient practice at tag F561 could potentially impact all residents. o During the admissions process, the admitting nurse asks about bathing preferences which is acknowledged and incorporated in their plan of care. o All interviewable residents will be interviewed by 11:59 PM on 06/09/2023 to ensure that their bathing wishes are being followed. The interviews will be conducted by the Administrator, Director of Nursing (DON), or trained designee. There have been no complaints or concerns voiced to date of their bathing schedule. To ensure that there are no complaints or concerns, the facility (Director of Nursing or Administrator or trained designee) notified the responsible parties of non-interviewable residents via phone messaging system to contact the Administrator or Director of Nursing if they have any concerns about their loved ones' shower or bathing schedules. This also included a survey to choose method of bathing. This was completed at 9:24 AM on 6/9/2023. " Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. o The Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee will educate 100% of all staff regarding Tag F561 by 12:00 PM on 06/09/2023,	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 15	F 561		

or the staff will be removed from the schedule and not allowed to work until they have been educated. This includes contract and agency staff members. The educate will include:
o Residents' rights policy and procedure.
o Allowing the resident to choose bathing options, including bed baths, showers, tub, and refusal all together.
o How to offer the resident options on bathing.
o Understanding that the resident has the right to decline all bathing.
o Understanding that forcing care is abuse and can lead to harm to the patient.
o Staff understanding the methods of offering bathing alternatives (examples include shower, bed baths, sink baths, bathtubs, and refusing bathing) to meet the residents' needs.
o Reporting refusal of care to the charge nurse so the nurse can take extra measures to have alternative means (examples: psychiatric care referrals, notifying families for involvement, notifying physician for input on care).
o 100% of staff will be educated by 12:00 PM on Friday, June 9th, 2023, or they will be removed from the schedule.

Alleged date of IJ removal: June 10, 2023

On 6-12-23, the facility's plan for Immediate Jeopardy removal effective 6-10-23 was validated by the following: documentation and interviews with residents and staff. Review of the in-service sign-in sheets revealed all staff and all departments received education which included residents' right to refuse care and how to manage residents who refused care. Residents interviewed revealed all residents reported they had not been forced to do anything they did not wish to do or have care provided against their will.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 16 The staff interviewed all stated residents had the right to choose and/or refuse care and should not be forced against their will. The facility's Immediate Jeopardy removal date of 6-10-23 was confirmed.	F 561		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, family and resident interviews, the facility failed to protect Resident #49's right to be free from physical and emotional abuse for one of two sampled residents reviewed for abuse. On 4-22-23 Resident #49 had refused a shower three times and on the third refusal, six staff members (Nurse #1, Nursing Assistant (NA) #1, NA #2, NA #3, NA #4, and NA #5) proceeded to force Resident #49, who was combative and pushing staff away, out of bed and into a shower chair and into the shower. Resident #49 sustained a bruise to her left hand and had the high likelihood of suffering	F 600	Tag F600: 1. Resident #49□s careplan was reviewed by the Interdisciplinary Care Team (IDT) on 06/09/2023. The Intervention/Task for Bathing will remain the same, which states: If the resident refuses, allow a few minutes to pass and then reattempt to get the resident to agree to shower or bathe. Resident #49 has shown no signs or symptoms of psychosocial harm as of 6/8/2023. No signs or symptoms of psychosocial harm	6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17 other serious physical and psychosocial harm. A reasonable person would have experienced feelings such as intimidation, fear, humiliation, embarrassment, and/or dehumanization (deprivation of human qualities such as compassion). Immediate Jeopardy began on Saturday 4-22-23 when six staff members forced Resident #49 out of her bed to receive a shower with the resident sustaining a bruise to her hand and feeling that staff did not like her. Immediate Jeopardy was removed as of 6-10-23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Findings included: Resident #49 was admitted on 7-17-18 with multiple diagnoses that included vascular dementia without behavioral disturbances, atrial fibrillation and chronic respiratory failure. Physician order dated 11-24-20 revealed Resident #49 was to receive Eliquis (medication to prevent blood clots) 5 milligrams (mg) twice a day. Resident #49's activities of daily living care plan initiated on 1-4-2020 and revised on 9-20-22 revealed the resident had an activities of daily living self-care deficit. The goal for Resident #49 was to maintain current level of function with her activities of daily living. The interventions for the	F 600	were documented from the below assessments: a. Resident #49 was visited by the Administrator on 4/25/2023. b. Resident #49 was visited by Licensed Clinical Social Worker (LCSW) on 4/25/2023. c. Resident #49 was assessed by Registered Nurse (RN) on 5/11/23. d. Resident #49 was visited by LCSW on 5/12/2023. e. Resident #49 was visited by Psychiatric NP on 5/12/2023. f. Resident #49 was assessed by Licensed Practical Nurse (LPN) on 5/13/23. g. Resident #49 was visited by Palliative Care Nurse NP on 5/24/23. h. Resident #49 was visited by LCSW on 5/26/2023. i. Resident #49 was visited by Nurse Practitioner (NP) 5/31/2023. 2. The facility completed the following to attempt to identify any residents who could have been impacted by the deficient practice: a. All residents with a Brief Interview for Mental Status (BIMs) below 8 (who had a shower on the allegation date) had skin assessments completed with no relevant findings during the initial investigation. This was completed by RN Charge Nurse on 4/26/2023. b. All residents with a BIMs 8 or above (who had a shower on the allegation date) were interviewed and there were no relevant findings during the initial investigation. The Social Services Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18 goal included Resident #49 required total assistance with bathing and if the resident refuses, allow a few minutes to pass and then re-attempt to get the resident to agree to a shower or bath. Provide the resident with a sponge/bed bath when a full bath or shower cannot be tolerated. There was no documentation regarding Resident #49's preferred bathing choice. The quarterly Minimum Data Set (MDS) dated 4-21-23 revealed Resident #49 was moderately cognitively impaired and exhibited physical behaviors towards others 1-3 days in the 7 days look back period and had refused care 1-3 days during the 7 days look back period. Resident #49 was documented as needing physical help with two people for bathing and extensive help with two people for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS also documented Resident #49 received an anticoagulant (medication to inhibit the clotting of blood) 7 out of 7 days during the 7 day look back period. Skin assessments conducted from 4/1/23 through 4/21/23 revealed no bruises were present on Resident #49. Review of Resident #49's medical record revealed a nursing note dated 4-23-23 at 10:37pm written by Nurse #2. The nurse documented she had been called to the resident's room by a family member (daughter) who was questioning what had happened to Resident #49's hand which had a bruise on her left hand. Nurse #2 documented that Resident #49 had told her it happened in the shower a couple of days ago.	F 600	interviewed the residents on 4/26/2023. c. Completed on 6/9/2023, the facility conducted interviews regarding abuse. The interviews include all residents with a BIMs of 8 or above. The interviews were conducted by the Administrator or Director of Nursing (DON) or trained designee. There were no areas of concern during the interviews. d. Completed on 6/9/2023, the facility conducted skin assessments on all residents with a BIMs below 8. The DON or other licensed nurses as designated by the DON were responsible for the skin assessments. There were no relevant issues. 3. The Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee educated 100% of staff regarding Tag F600 by 12:00 PM on 06/09/2023. Any staff who did not complete was removed from the schedule and not allowed to work until they have been educated. This includes contract and agency staff members. This includes staff in every department as abuse prevention is relevant to every department. This includes new hires. The education will include: a. Understanding and identifying the types of abuse. b. The reasonable person concept in regard to abuse. c. How to manage and address residents who refuse care. d. How to address and handle residents with combative behaviors e. Understanding that forcing care is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19 The initial investigative report completed by the facility's previous Social Worker (SW) dated 4-25-23 revealed the facility had received a phone call from Resident #49's daughter who told the facility the resident had been abused in the shower on Saturday (4-22-23). According to the report the daughter informed the facility that Resident #49 had told her staff were pinching her hand during her shower. The previous SW documented per the nursing assessment Resident #49 was not in any acute pain from the bruising and the resident did not report any mental anguish from the incident. The facility's final investigation report dated 4-28-23 revealed Resident #49's daughter had called the Administrator on 4-25-23 and reported the resident had been abused in the shower on Saturday (4-22-23). The documentation showed the daughter told the Administrator she had visited Resident #49 on 4-23-23 and noticed a bruise on the resident's hand. The daughter informed the Administrator that Resident #49 had told her staff were pinching her hand during her shower. The daughter also informed the Administrator she had spoken to the charge nurse on 4-23-23 who assessed Resident #49's hand for damage. The investigation report documented Resident #49 had a bruise on the top of her left hand. The investigation report included written statements from staff who had contact with Resident #49 on 4-22-23. Resident #49 was interviewed on 6-5-23 at 10:39am. Resident #49 confirmed she remembered when she sustained a bruise to her hand on 4-22-23. The resident commented, "It	F 600	abuse and can result in serious injury. f. Understanding that the resident has a right to be free from abuse. 4. Beginning 06/13/2023, the Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee will conduct audits to ensure that the residents are free of abuse and neglect. The audits will include interviews for residents with a Brief Interview for Mental Status (BIMs) of 8 and above. For residents with a BIMs below 8, the audits will include reviewing their shower and skin sheets. The audits will also include staff questionnaires regarding abuse. The audits will be conducted at the following frequency: a. 5 resident interviews (of alert and oriented residents who have a BIMs of 8 or above) each working week, weekly for 12 weeks. b. 5 resident shower sheet reviews (of non-alert and oriented residents with a BIMs below 8), weekly for 12 weeks. c. 5 staff interviews each working week, weekly for 12 weeks. 5. Beginning 06/13/2023, the facility Quality Assurance and Process Improvement (QAPI) team will meet monthly to discuss follow-up from Tag F600. The team includes: the Administrator, the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Wound Care, Social Services, Medical Records, Minimum Data Set (MDS) nurses, and other relevant members of management.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

stayed bruised for a long time." Resident #49 said "the girl was trying to force me into the shower chair and was squeezing my hand. I told her to stop because she was hurting me, but she did not." She also stated she was fighting with the staff because she did not want to get a shower. Resident #49 discussed that she preferred to get bed baths. The resident would not discuss how she felt during the incident on 4-22-23 but instead kept stating "I don't want to get anyone fired." Resident #49 discussed telling a family member (her daughter) on 4-23-23 what had happened and stated she did not tell any other staff because she was concerned about the staff's jobs. She stated she had not received any other bruises since 4-22-23.

Upon observation of the resident, she was observed not to have any bruising to her hands. Resident #49 was observed on 6-5-23 at 10:39am. The resident was observed to be lying in bed. Her clothes were noted to be clean, there were no odors observed, her hair was observed to flow down to the middle of her back and was clean but uncombed.

A telephone interview occurred with Resident #49's daughter on 6-6-23 at 11:35am. The daughter discussed visiting the resident on 4-23-23 and noticed a bruise on the resident's hand that was black and blue in color. She stated when she asked Resident #49 what had happened the resident told her staff had given her (resident) a shower yesterday (4-22-23). The daughter further discussed Resident #49 telling her she (the resident) was combative because she did not want a shower, so the resident told the daughter that staff had held her hand down and "pinched" her hand. The daughter said she

6. Date of Compliance: 06/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

informed Nurse #2 of the bruise to Resident #49's hand and stated the nurse took a picture of the bruise and told her the staff would monitor the area. The daughter stated she had never told staff to "force" the resident to have a shower. She explained she told staff to encourage the resident to take a shower but if the resident refused it was ok. She explained she knew the resident did not like getting a shower and preferred to have bed baths. The daughter stated on 4-23-23 during the visit that the resident told her she did not think staff liked her.

NA #1's written statement dated 4-26-23 related to the incident on 4-22-23 indicated that she assisted with transferring Resident #49 from the bed to the wheelchair so she could be brought to the shower room. The statement further indicated that she did not aid with giving Resident #49 the shower.

NA #1 was interviewed on 6-6-23 at 12:46pm. NA #1's written statement related to the 4-22-23 incident with Resident #49 was reviewed. NA #1 was asked to clarify her statement and explain Resident #49's behaviors as well as staff's course of action. NA #1 stated Resident #49 was "real bad to refuse showers". She discussed she did not know if the resident's preference in bathing was written anywhere but stated she would usually ask Resident #49 if she wanted a shower or bed bath. She further discussed the resident being allowed to refuse a shower but not all the time. NA #1 explained Resident #49 was allowed to refuse one shower a week but the second scheduled shower, the resident was not allowed to refuse. NA #1 explained on 4-22-23 Resident #49 had refused her shower 2-3 times and after the last refusal, she had informed Nurse #1 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

the resident was refusing her shower. The NA stated Nurse #1 told her to get the resident up and take her to the shower anyway. She stated there were six staff in the room (Nurse #1, NA #1, NA #2, NA #3, NA #4, and NA #5) and that it took four staff (the NA could not remember which staff) to sit Resident #49 on the edge of the bed. NA #1 explained during this time, the resident was throwing her hands around, pushing away from staff and putting her arms up "guarding" herself. The NA stated once Resident #49 was "talked into" receiving a shower, the resident was no longer combative. NA #1 explained Resident #49 would stick her right hand through the side rails and bang her hand over the bed table when she wanted something. NA #1 stated when the resident was combative, she would try to speak with the resident to calm her or she would inform the nurse on duty. The NA stated she did not see if Resident #49 had a bruise on her left hand during the transfer on 4-22-23.

Nurse #1's written statement that was undated following the incident on 4-22-23 read; "I was called down to the resident's room to help them get her up for a shower. She was refusing as she always does. I told her [her son] wanted her to get a shower. She told us [her son] was not the boss of her. We (the CNAs and myself) assisted [Resident #49] to sitting on her bed, then put her on the shower chair. She was not happy getting up, but smiling and apologizing when her shower was done."

During an interview with Nurse #1 on 6-6-23 at 1:17pm, Nurse #1's written statement related to the 4-22-23 incident with Resident #49 was reviewed. The nurse was asked to discuss Resident #49's behavior and explain what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

happened when the resident refused her showers. The nurse confirmed she was the charge nurse on 4-22-23 but stated she did not remember the incident. Nurse #1 stated if it was a shower day for Resident #49 then the resident would have been combative by flailing her hands and arms but said usually once the resident was assisted by staff into a seated position on the edge of the bed the resident would stop being combative. After reading her written statement for the 4-22-23 incident that she provided to the facility during their investigation, she stated she remembered being told Resident #49 was refusing her shower and she went to the resident's room to speak with her along with five NAs (NA #1, NA #2, NA #3, NA #4, and NA #5). Nurse #1 was unable to explain why six staff members went to Resident #49's room. The nurse stated once Resident #49 was placed in the shower chair, the resident stopped being combative. Nurse #1 explained typically if a resident refused a shower three times, the resident would be provided a bed bath but stated with Resident #49, she would sometimes be "forced" to get a shower because the resident's hair was long and became matted if she did not receive a shower. She explained the facility had washing caps that could be used to wash the resident's hair but stated they did not work well. She further stated the family had told staff they wanted the resident to have at least one shower a week.

Review of NA #5's written statement dated 4-26-23 following the incident on 4-22-23 read; Resident #49 "did not want to take her shower but me and [Nurse #1] got her to go take it. The bruise on her hand is where she puts her hand through the rail on the bed all the time. She keeps

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24	F 600		

a bruise on that hand a lot from the bed rails."

A telephone interview occurred with NA #5 on 6-6-23 at 3:01pm. NA #5's written statement related to the 4-22-23 incident with Resident #49 was reviewed. NA #5 was asked to discuss Resident #49's behavior, what happens when the resident refused a shower, and the bruise Resident #49 sustained to her left hand. The NA confirmed she assisted with getting Resident #49 out of bed for a shower on 4-22-23. She stated she remembered the resident was combative because the resident did not want to get out of bed and take a shower. NA #5 stated, while trying to get Resident #49 into the shower chair, the resident attempted to hit one of the NAs. She stated she could not remember which one, but it was one of the NAs standing behind the resident. The NA stated there were six staff members (Nurse #1, NA #1, NA #2, NA #3, NA #4, and NA #5) in the room and she could not remember who was standing behind the resident. NA #5 explained Resident #49 was allowed to refuse one shower a week but then the resident "will be forced the next shower day." She explained if Resident #49 refused the shower, staff tried to talk her into receiving a shower. She further explained that if she was not able to be talked in to receiving her shower, the resident was "forced" to get up out of the bed to take a shower. The NA discussed typically residents were allowed to refuse a shower four to five times on their shower day but then the nurse on duty had to be informed of the refusal and it was up to the nurse on duty to decide if the resident needed to be "forced" to get up and receive a shower. She stated she could not remember if Resident had a bruise on her left hand on 4-22-23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

NA #2's written statement dated 4-25-23 following the incident on 4-22-23 read; "Per [NA #2] I did not help to give [Resident #49] her shower on Saturday. I did assist with getting her back into bed after the shower. She was fine with me and was not being combative. When asked about the bruise on resident's hand, [NA #2] told interviewer that [Resident #49] had that bruise before Saturday."

During a telephone interview with NA #2 on 6-6-23 at 3:34pm, NA #2's provided statement related to the 4-22-23 incident with Resident #49 was reviewed. NA #2 was asked if she assisted with Resident #49's transfer prior to the shower, resident's behavior, and what happened if Resident #49 refused a shower, as well as the bruise on Resident #49's hand. NA #2 stated she assisted in transferring Resident #49 from the bed to the shower chair on 4-22-23. NA #2 discussed Resident #49 telling the staff she did not want a shower and had been combative until she was placed in the shower chair. The NA stated she could not remember how many staff were in the room but said there were "a lot of us." She was unable to explain why there were so many staff in the room. She also discussed Resident #49 never wanting to get out of bed and usually when she refused her shower a bed bath was provided. NA #2 explained she did not think the resident's preference for bathing was written anywhere but said she usually asked the resident if she wanted a bed bath or shower. The NA stated she did not know why she was being made to get a shower on 4-22-23. NA #2 stated she did not see a bruise on Resident #49's hand when transferring the resident into the shower chair. She stated she said in her written statement Resident #49 had the bruise before Saturday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26	F 600		

(4-22-23) because the resident "always keeps a bruise on her hand."

Review of NA #3's written statement dated 4-26-23 to the facility following the incident on 4-22-23 read; [NA #5, NA #4, NA #2, Nurse #1] and myself all assisted in getting her from the bed to the shower chair in her room. She didn't want to go at first but did fine with all of us helping her in the chair. [NA #4] and I pushed her in the shower room and began her shower and she was thanking us for bathing her and she even apologized for "being an old fart" (her words) and not wanting to take a shower. We dressed her and took her back to the room and she wanted to go back to bed so we assisted her in that. We hooked up her oxygen and she was good."

NA #3 was interviewed by telephone on 6-6-23 at 7:12pm. NA #3's statement related to the 4-22-23 incident with Resident #49 was reviewed. She was asked to clarify Resident #49's behavior. NA #3 explained Resident #49 was scheduled for a shower on 4-22-23 but the resident had been refusing. She said it took five people (Nurse #1, NA #1, NA #2, NA #4, and NA #5) plus herself to get Resident #49 out of the bed because the resident was pushing them away and not wanting to get up.
Na #4's written statement dated 4-27-23 following the incident on 4-22-23 read; "On Saturday we asked [Resident #49] if she was ready for a shower and she didn't want to get out of bed but then finally said she was ready but still gave us a hard time to get out of bed so I went to ask the other CNAs [NA #5, NA #1, NA #3] if they could help because she was screaming at me, at that time [NA #5] went and got the charge nurse [Nurse #1] to help. They got [Resident #49] up put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27	F 600		

of the bed and into the shower chair and we wheeled her down to the shower room and me and [NA # 3] gave her a shower. She was fine in the shower and kept saying how sorry she was for giving us a hard time getting out of bed. She was calm and gentle while in the shower. We washed and dressed her and got her back in the room and she got her toenails cut by [NA #2] and [NA #2] had helped me get her in the bed and she was fine and helped us and said thank you."

An interview with NA #4 occurred on 6-7-23 at 9:01am. Na #4's written statement related to the 4-22-23 incident with Resident #49 was reviewed. She was asked to clarify Resident #49's behavior prior to the shower. NA #4 stated on 4-22-23 she had asked Resident #49 if she wanted a shower and said the resident was agreeable to receiving a shower. She stated she left the resident's room to ask for more help because she was not familiar with the resident and could not transfer the resident on her own. NA #4 was unable explain why her written statement was different. She stated during the transfer Resident #49 was pushing against them and fighting. NA #4 explained she never heard the resident say she did not want a shower.

Nurse #2 was interviewed by telephone on 6-6-23 at 2:17pm. The nurse explained on 4-23-23, Resident #49's family member had asked her how the resident received a bruise to her left hand. Nurse #2 stated she assessed the area and saw the resident had a bruise to her left hand and thought Resident #49 might have had blood work completed. The nurse stated once she saw there was no documentation of blood work being completed, she informed the family member staff would monitor the site and stated she took a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28	F 600		

picture of the bruise. Nurse #2 discussed being told by the family member, that Resident #49 had told her the bruise had occurred with staff while she was in the shower.

The previous Social Worker (SW) was interviewed by telephone on 6-6-23 at 4:44pm. The previous SW stated she had conducted the investigation for the abuse allegation towards Resident #49 on 4-25-23 after the Administrator had received a call from Resident #49's daughter, saying the resident had been "roughed up" by staff in the shower on 4-22-23. She stated she first questioned staff and then questioned Resident #49 about the incident on 4-22-23. She stated the staff were consistent in their statements that Resident #49 was combative getting into the shower chair because the resident did not want a shower. The previous SW stated she had not questioned staff on their response when the resident was refusing her shower or when the resident had been combative. She explained once Resident #49 was refusing her shower and had become combative, the staff should have walked away instead of "forcing her into the shower."

The Administrator was interviewed on 6-7-23 at 3:01pm. He stated, "forcing a resident was abusive" and if he had known he would "have stopped it from happening."

The Administrator was notified of Immediate Jeopardy on 6-7-23 at 3:01pm.

The facility provided the following Credible Allegation of immediate Jeopardy removal:

" Identify those recipients who have suffered,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29	F 600		

or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
o This deficient practice cited at tag F600 had a high likelihood of resulting in serious physical and psychosocial harm for Resident #49.
o Initial Report was filed at 3:43 PM on 04/25/2023.
o Adult Protective Services (APS) notified on 4/26/2023.
o Date of final investigation submission was 4/28/2023 at 2:24 PM.
o Police Notified 5/4/2023.
o This deficient practice at tag F600 could potentially impact all residents.
o Resident #49 has shown no signs or symptoms of psychosocial harm as of 6/8/2023. No signs or symptoms of psychosocial harm were documented from the below assessments:
o Resident #49 was visited by Administrator on 4/25/2023.
o Resident #49 was visited by Licensed Clinical Social Worker (LCSW) on 4/25/2023.
o Resident #49 was assessed by Registered Nurse (RN) on 5/11/23.
o Resident #49 was visited by LCSW on 5/12/2023.
o Resident #49 was visited by Psychiatric NP on 5/12/2023.
o Resident #49 was assessed by Licensed Practical Nurse (LPN) on 5/13/23.
o Resident #49 was visited by Palliative Care Nurse NP on 5/24/23.
o Resident #49 was visited by LCSW on 5/26/2023.
o Resident #49 was visited by Nurse Practitioner (NP) 5/31/2023.
o All residents with a Brief Interview for Mental Status (BIMs) below 8 (who had a shower on the allegation date) had skin assessments completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 30	F 600		

with no relevant findings during the initial investigation. This was completed by RN Charge Nurse on 4/26/2023.
o All residents with a BIMs 8 or above (who had a shower on the allegation date) were interviewed and there were no relevant findings during the initial investigation. The Social Services Director interviewed the residents on 4/26/2023.
o The facility will interview all residents with a BIMs of 8 or above regarding Abuse by 11:59 PM on 06/09/2023. The interviews will be conducted by the Administrator or Director of Nursing (DON) or trained designee.
o The facility will conduct skin assessments on all residents with a BIMs below 8 by 11:59 PM on 06/09/2023. The Director of Nursing or other licensed nurses as designated by the DON will be responsible for the skin assessments.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
o The Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee will educate 100% of staff regarding Tag F600 by 12:00 PM on 06/09/2023, or the staff will be removed from the schedule and not allowed to work until they have been educated. This includes contract and agency staff members. The educate will include:
o Understanding and identifying the types of abuse.
o The "reasonable person concept" in regard to abuse.
o How to manage and address residents who refuse care.
o How to address and handle residents with combative behaviors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 31 o Understanding that forcing care is abuse and can result in serious injury. o Understanding that the resident has a right to be free from abuse. o 100% of staff will be educated by 12:00 PM on Friday, June 9th, 2023, or they will be removed from the schedule. Alleged date of IJ removal: June 10, 2023 On 6-12-23, the facility's plan for Immediate Jeopardy removal effective 6-10-23 was validated by the following: documentation and interviews with the residents and staff. Review of the in-service sign in sheets revealed all staff and all departments received education which included understanding and identifying the various types of abuse, residents' right to be free from abuse, and how/who/when to report concerns of abuse. Review of the facility documentation revealed skin audits were completed 06/09/23 on all cognitively impaired residents with no concerns or new skin abnormalities identified and staff interviews completed 06/09/23 with all alert and oriented residents revealed no concerns of abuse. Residents interviewed revealed no concerns of abuse. Residents all reported they felt safe residing in the facility. Staff interviewed from various departments and shifts all confirmed they received in-service education and were able to verbalize the types of abuse, what constituted abuse, and when and who to report any concerns. The facility's Immediate Jeopardy removal date of 6-10-23 was confirmed.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies	F 607		6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 32 CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and family interviews the facility failed to follow their abuse policy in the areas of identification, immediately reporting an allegation of abuse to the Administrator, and reporting an allegation of abuse to the state agency within two hours. This	F 607	Tag F607: 1. Nurse #2 was educated by the Director of Nursing (DON) and Administrator on the facility's abuse and reporting policy and procedures on 06/09/2023. The policies include: the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 33 occurred for 1 of 2 residents (Resident #49) reviewed for reporting. Findings included: The facility's "Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating" policy and procedure revised on 9-2022 revealed in part; If resident abuse is suspected, the suspicion must be reported immediately to the Administrator. The Administrator immediately reports the suspicion to the agency within two hours of an allegation involving abuse. A telephone interview occurred with Resident #49's daughter on 6-6-23 at 11:35am. The daughter explained she had visited the resident "around supper time" on 4-23-23 and saw the bruise on her hand. She stated when she asked Resident #49 what had happened, the resident told her staff had held her hand down and "pinched" her hand on 4-22-23 because she did not want to get a shower and she was being combative. The daughter discussed informing Nurse #2 "before supper" on 4-23-23 that Resident #49 had a bruise on her hand and that the resident had told her staff had done it to her while she was in the shower. She stated Nurse #2 looked at the area, took a picture and told her staff would monitor the bruise. A review of a nursing note written by Nurse #2 on 4-23-23 at 10:37pm documented she was called to Resident #49's room by a family member (Resident #49's daughter) who was questioning what happened to the resident's hand which had a bruise to the left hand. The note documented the resident told Nurse #2 that the bruise happened in the shower a couple of days ago.	F 607	abuse policy; identifying and knowing the types of abuse; who the abuse coordinator is; how to report and reach the abuse coordinator; the timeliness and guidelines on reporting abuse; the necessity of protecting all residents from abuse. 2. The facility completed the following to attempt to identify any residents who could have been impacted by the deficient practice: a. All residents with a Brief Interview for Mental Status (BIMs) below 8 (who had a shower on the allegation date) had skin assessments completed with no relevant findings during the initial investigation. This was completed by RN Charge Nurse on 4/26/2023. b. All residents with a BIMs 8 or above (who had a shower on the allegation date) were interviewed and there were no relevant findings during the initial investigation. The Social Services Director interviewed the residents on 4/26/2023. c. Completed on 6/9/2023, the facility conducted interviews regarding abuse. The interviews include all residents with a BIMs of 8 or above. The interviews were conducted by the Administrator or Director of Nursing (DON) or trained designee. There were no areas of concern during the interviews. d. Completed on 6/9/2023, the facility conducted skin assessments on all residents with a BIMs below 8. The DON or other licensed nurses as designated by the DON were responsible for the skin assessments. There were no relevant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 34 Nurse #2 was interviewed by telephone on 6-6-23 at 2:17pm. Nurse #2 confirmed she was the charge nurse on 4-23-23. She explained she had been called to Resident #49's room around 5:00pm by the resident's daughter who wanted to know what happened to the resident's hand. The nurse said she assessed the area and found a bruise on Resident #49's left hand. Nurse #2 stated the daughter had told her Resident #49 had said the bruise occurred while she was in the shower with staff. The nurse discussed the protocol if an allegation of abuse was made. She stated she would have done an incident report and notified the Administrator immediately. Nurse #1 stated she did not follow protocol because she did not think it was abuse. The facility's initial report conducted by the facility's previous Social Worker dated 4-25-23 revealed the incident occurred on 4-22-23 but the facility was not made aware of the incident until 4-25-23 when Resident #49's daughter called the facility and reported the resident had been abused in the shower on 4-22-23. The initial investigation also revealed Resident #49's daughter informed the Administrator on 4-25-23 that she had visited the resident on 4-23-23 and had spoken to the charge nurse on duty (Nurse #2) who had assessed Resident #49's hand for damage. The facility's investigation report was completed on 4-28-23. The previous Social Worker (SW) was interviewed by telephone on 6-6-23 at 4:44pm. The SW confirmed she was the person responsible for conducting the investigation and that the investigation began on 4-25-23 when the Administrator had received a call from Resident	F 607	findings. 3. Completed by 12:00 PM on 06/09/2023, the Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee educated 100% of staff regarding Tag 607. Any staff who did not complete was removed from the schedule and not allowed to work until they have been educated. This includes contract and agency staff members. This includes staff in every department as abuse prevention is relevant to every department. This includes new hires. The education will include: a. The abuse policy. b. Knowing and identifying the types of abuse. c. Who the abuse coordinator is. d. How to report and reach the abuse coordinator. e. The timeliness and guidelines on reporting abuse. f. The necessity of protecting all facility residents from abuse. 4. Beginning 6/13/2023, the Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee will conduct audits to ensure that there were no instances of abuse allegations that were unreported. The audits will include interviews for residents with a Brief Interview for Mental Status (BIMs) of 8 and above; the audit will also include interviews with responsible parties of residents with a BIM below 8. The audits will also include staff questionnaires regarding identifying	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 35 #49's daughter alleging the resident had been "roughed up" in the shower. She stated it was at that time she learned the initial allegation of abuse had been made to Nurse #2 on 4-23-23. She also stated she was aware the allegation should have been reported immediately to the Administrator by Nurse #2 on 4-23-23 and a report turned into the agency within two hours. During an interview with the Administrator, Director of Nursing (DON), and the facility's owner on 6-7-23 at 3:40pm, the DON stated Nurse #2 had used her "professional judgement" on 4-23-23 regarding if the bruise on Resident #49's hand was abuse and did not need to report the incident.	F 607	abuse. The audits will be conducted at the following frequency: a. 5 resident interviews (of alert and oriented residents who have a BIMs of 8 or above) each working week, weekly for 12 weeks. b. 5 resident shower sheet reviews (of non-alert and oriented residents with a BIMs below 8), weekly for 12 weeks. c. 5 staff interviews each working week, weekly for 12 weeks. 5. Beginning 06/13/2023, the facility Quality Assurance and Process Improvement (QAPI) team will meet monthly to discuss follow-up from Tag F607. The team includes: the Administrator, the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Wound Care, Social Services, Medical Records, Minimum Data Set (MDS) nurses, and other relevant members of management. 6. Date of Compliance: 06/13/2023	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 36 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide protection for residents during the investigation of an allegation of abuse for 1 of 2 residents (Resident #18) reviewed for abuse. Findings included: A review of the facility policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" last revised September 2022 revealed in part: "Investigating Allegations: 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete." Resident #18 was admitted to the facility on 6/13/22 with a diagnosis of osteoarthritis (the wearing down of protective tissue at the end of bones). A review of Resident #18's annual Minimum Data Set (MDS) assessment dated 4/14/23 revealed she was cognitively intact. She required the extensive assistance of 2 people for bathing and dressing. A nursing progress note dated 6/2/23 at 4:53 PM	F 610	F610: 1. NA #9 and NA#1 were suspended pending investigation by the Administrator on 06/06/2023 after he became aware of the involvement of the staff members. The management team was educated on the Abuse Policy and Procedure on 6/09/2023. This includes suspension of alleged perpetrators during an abuse investigation. The allegation was unsubstantiated by the abuse committee on 06/07/2023. 2. The facility completed the following to attempt to identify any residents who could have been impacted by the deficient practice: a. Completed on 6/9/2023, the facility conducted interviews regarding abuse. The interviews include all residents with a BIMs of 8 or above. The interviews were conducted by the Administrator or Director of Nursing (DON) or trained designee. There were no areas of concern during the interviews. b. Completed on 6/9/2023, the facility conducted skin assessments on all residents with a BIMs below 8. The DON	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 37 written by Nurse #3 revealed she was called to Resident #18's room to look at a bruise on Resident #18's right forearm. It further revealed Resident #18 had thin skin and the bruise looked superficial. The area was assessed and the Director of Nursing (DON), the Administrator and Resident #18's Physician Assistant (PA) were notified of the bruise. Resident #18 reported to Nurse #3 that she got the bruise yesterday during her bed bath when "She grabbed my arm to pull me forward". A progress note dated 6/2/23 at 5:39 PM written by the Administrator revealed in part that a Nurse Aide (NA) made management aware of a complaint from Resident #18 regarding a bruise. The police and Adult Protective Services (APS) were notified. An initial allegation report was faxed to the "State". On 6/5/23 at 2:42 PM Resident #18 was observed to have a flat oval shaped reddish-purple area to her right forearm. An interview with Resident #18 at that time indicated it had been caused by an NA when she grabbed her arm and jerked it to try to raise her up to put her gown on after her bath the other day. She stated there were 2 NAs that helped with her bath, and they were rushing. She went on to say the tall one pulled her brief too tight. She stated when she told that NA it was too tight, she looked mad and left the room. Resident #18 went on to say she felt the remaining NA jerked her arm deliberately causing the bruise. She further indicated she did not know the names of the NAs, but she would remember their faces if she saw them again. Resident #18 stated she had reported this, and the Director of Nursing had come to look at the area on her arm. She went on	F 610	or other licensed nurses as designated by the DON will be responsible for the skin assessments. There were no areas of concern related to abuse during the skin assessments. 3. Completed by 12:00 PM on 06/09/2023, the Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee educated 100% of staff regarding Tag 610. Any staff who did not complete were removed from the schedule and are not allowed to work until they have been educated. This includes contract and agency staff members. This includes all departments and any new hires. The education will include: a. The abuse policy. b. Knowing and identifying the types of abuse. c. Who the abuse coordinator is. d. How to report and reach the abuse coordinator. e. The timeliness and guidelines on reporting abuse. f. The necessity of protecting all facility residents from abuse. 4. Beginning 06/13/2023, the Chief Executive Operator (CEO), Administrator, Director of Nursing (DON) or trained designee will conduct audits to ensure that there are no unreported abuse allegations. The audits will also include staff questionnaires regarding identifying abuse or any confirmed cases of abuse. The audits will be conducted at the following frequency:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 38 to say she really couldn't say how this made her feel. On 6/8/23 at 8:54 AM in a follow-up interview Resident #18 stated she felt safe in the facility. She went on to say while she couldn't always remember names, she could remember faces. She stated she had not seen the NAs involved with her bath the day she was bruised again. On 6/6/23 at 12:31 PM an interview with Nurse #3 indicated Resident #18 reported to her on 6/2/23 that she got a bruise on her right forearm the previous day during her bed bath on the 7AM to 3PM shift when an NA pulled her forward to pull her shirt down. Nurse #3 stated Resident #18 did not indicate to her whether this occurred accidentally or not. She went on to say she did not ask Resident #18 whether she felt it was an accident because she did not want to ask any leading questions. She further indicated Resident #18 had not expressed any concerns to her regarding the way staff treated her. Nurse #3 stated NA #1 and NA #9 assisted Resident #18 with her bed bath on the 7AM-3PM shift on 6/1/23. On 6/6/23 at 12:56 PM an interview with NA #1 indicated she and NA #9 assisted Resident #18 with a bed bath on 6/1/23 on the 7AM to 3PM shift. She stated she had been on Resident #18's left throughout the bath and NA #9 had been on Resident #18's right. She went on to say neither had pulled Resident #18's arms to raise her up to put her gown on. She further indicated they had slipped the gown over Resident #18's head and rolled her from side to side to pull it down. NA #1 stated they used the pad to pull Resident #18 up in bed. She went on to say she left Resident #18's room to take out the dirty sheets. She further indicated Resident #18 had not expressed	F 610	a. 5 staff interviews each working week, weekly for 12 weeks. 5. Beginning 06/13/2023, the facility Quality Assurance and Process Improvement (QAPI) team will meet monthly to discuss follow-up from Tag F610. The team includes: the Administrator, the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Wound Care, Social Services, Medical Records, Minimum Data Set (MDS) nurses, and other relevant members of management. 6. Date of Compliance: 06/13/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 39	F 610		

any concerns about the care she or NA #9 provided that day.

On 6/6/23 at 1:43 PM an interview with NA #9 indicated she and NA #1 assisted Resident #18 with a bed bath on 6/1/23 on the 7AM-3PM shift. She stated she had been on Resident #18's right side during the bath. She went on to say Resident #18 already had her gown on, but she had to lean her forward to pull her up. NA #1 stated she scooped her arm under Resident #18's arm to do this. She further indicated Resident #18 had not expressed any pain or concerns to her when she did this.

On 6/6/23 at 1:53 PM an interview with the DON indicated Resident #18 reported to NA #10 on 6/2/23 on the 3PM to 11PM shift that she had a bruise on her right arm from the way staff treated her during her bath. She went on to say NA #10 immediately reported this to her. She further indicated when she spoke with Resident #18 on 6/2/23, Resident #18 had initially been confused about when the incident occurred, but the more she spoke with her, Resident #18 had been able to pinpoint the incident as occurring on 6/1/23 when she received her bath before 3PM. The DON stated Resident #18 reported that one of the NAs present during her bath had been mad and walked out. She further indicated Resident #18 reported to her that the NA that remained had also been mad. The DON stated Resident #18 told her she felt the remaining NA bruised her on purpose. The DON described the bruise as oval, light pink in color and appearing superficial. She stated there had been no finger marks. She went on to say Resident #18 had not complained of pain. She further indicated while she thought she narrowed the staff involved down to NA #1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 40	F 610		

NA #9; she had not been sure. She further indicated she had looked to see if NA #1 and NA #9 were still working on the hall on 6/2/23 when she became aware of the allegation so she could speak to them, but they had not been. The DON stated she immediately reported this to the Administrator on 6/2/23 as an allegation of abuse.

On 6/6/23 at 2:11 PM an interview with the Administrator indicated Resident #18 reported to NA #10 on 6/2/23 that the two girls who gave her bath the previous day hurt her. He went on to say he spoke with Resident #18 on 6/2/23 and observed the bruise himself. He stated the bruise on her right forearm appeared superficial and there were no hand or finger marks. He went on to say Resident #18 told him during this bath one of the NAs left the room and the NA that remained asked if she was leaving her. He stated Resident #18 told him the remaining NA raised her up to pull her shirt down and as she was letting her back down the NA's hand caused the bruise. He further indicated Resident #18 had been sure the bruise had been caused deliberately. The Administrator stated Resident #18 told him she was sure that NA knew what she was doing. He went on to say Resident #18 had not been able to provide him with the names of the staff involved. He further indicated normally when there was an allegation of abuse, he would suspend the staff involved immediately pending the investigation, but he had not done that this time. He stated he had not suspended anyone because he did not know for certain which staff were involved as Resident #18 had not been able to provide any names. He went on to say he had not spoken with NA #1 or NA #9 until today. He stated the investigation was still ongoing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 41 On 6/6/23 a review of the timecard information for NA #1 and NA #9 provided by the facility revealed NA #1 was present in the facility working on 6/1/23 from 7:54 AM through 2:58 PM, was not present working in the facility on 6/2/23 through 6/4/23 and was present in the facility working on 6/5/23 from 7:15 AM through 2:49 PM and 6/6/23 from 7:09 AM through 2:42 PM. It further revealed NA #9 was present in the facility working on 6/1/23 from 8:19 AM through 2:55 PM, was not present working in the facility on 6/2/23 through 6/4/23 and was present in the facility working on 6/5/23 from 7:09 AM through 3:17 PM and 6/6/23 from 7:15 AM through 2:43 PM. On 6/6/23 at 3:13 PM an interview with NA #10 indicated on 6/2/23 Resident #18 showed him a bruise and told him that 2 ladies the previous evening were getting her ready for bed when one got flustered and lifted her up when they were trying to get her gown pulled down in the back and that caused the bruise. He stated he took this as an allegation of abuse and immediately informed the DON. On 6/7/23 at 9:31 AM a telephone interview with NA #11 indicated on 6/2/23 she observed a bruise on Resident #18's right arm. She stated Resident #18 told her that she had gotten this the previous day when 2 NAs were bathing her. She further indicated Resident #18 had not been able to provide any names. NA #11 went on to say Resident #18 told her the tall NA had gotten upset and left the room and while that NA was gone the other NA tried to lift her up causing the bruise. NA #11 stated NA #10 had immediately gone to report this to the DON.	F 610		
F 732 SS=C	Posted Nurse Staffing Information	F 732		6/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 42 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post complete and accurate daily nurse staffing information for 2 of the 5 days reviewed (6/06/23 and 6/07/23). Findings included: The daily nurse staffing information posted was observed on 6/06/23 at 9:30 AM. The posting revealed no total staff hours for nursing assistants or nurses for any shift. The daily nurse staffing information posted was observed on 6/07/23 at 10:45 AM. The posting revealed no total staff hours for nursing assistants or nurses for any shift. An observation and interview on 6/07/23 at 10:54 AM with the Director of Nursing revealed that she posted the daily nurse staffing information at the nurses' station. She stated she was aware of the requirement to post the total staffing hours by position and shift. She was unaware that the current information posted did not include the total hours. She stated it must have happened when the facility switched staffing software systems and she had not noticed it did not include the required information. An interview on 6/07/23 at 11:10 AM with the Administrator revealed he was unaware of that the posted nursing staff information did not include the required total number of hours for nursing assistants and nurses.	F 732	1. The correct staffing form was immediately put into place by the Administrator and Director of Nursing (DON) on 06/12/2023. 2. The wrong census information sheet was posted incorrectly prior to 06/12/2023. This has minimal impact to the residents and their care. 3. The updated census sheet that was put into place on 6/12/2023 includes: i. Facility name ii. Date iii. Resident Census iv. Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered Nurses (RNs) 2. Licensed Practical Nurses (LPNs) 3. Certified Nursing Aides (CNAs) v. The data is clear and readable and will be posted on the Bulletin Board next to the nurse’s station. b. Each day, the first shift Charge Nurse is responsible for posting the staffing form. By 11:59 PM on 06/20/2023, all licensed nurses who perform as the Charge Nurse will be educated on the staff posting sheet. Those who have not completed after this time will be removed from the schedule and not allowed to work until completing education. The education will be performed by the Director of Nursing (DON) or trained designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 44	F 732	4. Beginning on 06/20/2022, the Administrator will audit the staffing sheet at the following frequency: a. 5 days per week for 12 weeks. 5. Beginning after 6/10/2023, the facility Quality Assurance and Process Improvement (QAPI) team will meet monthly to discuss follow-up from Tag F732. The team includes: the Administrator, the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Wound Care, Social Services, Medical Records, Minimum Data Set (MDS) nurses, and other relevant members of management. 6. Date of Compliance: 06/21/2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		6/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to (1) perform hand hygiene and change gloves after removing a dirty dressing, after cleansing a wound, and before applying a clean dressing to a wound and (2) provide a clean field for wound care materials for 1 of 1 staff member observed for wound care (Nurse #4). Findings included: Review of a facility policy titled "Wound Care" revised in October 2010 read in part in steps #3 through #5 "Put on exam glove. Loosen tape and remove dressing. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hand thoroughly. Put on gloves." Step #12 read in part "Be certain all clean items are on clean field." An interview on 6/07/23 at 2:28 PM with Nurse #4 revealed he was the Infection Control Preventionist and Wound Treatment Nurse. An observation on 6/07/23 at 2:28 PM with Nurse #4 for wound care on Resident #82's right shin skin tear. Nurse #4 was observed to place wound care supplies on the overbed table without	F 880	1. Nurse #4 was educated on the facility's policy entitled "Wound Care" on 06/16/2023. 2. Nurse #4's wound care list was audited to ensure that there were no wounds that were impacted by the deficient infection control practices. The audit included visualization of the wounds and determination of any signs and symptoms of infection. There were no suspicions of infections. 3. By 11:59 PM on 06/20/2023, all licensed nurses will be educated on the facilities policy and procedure entitled "Wound Care." Those who have not completed after this time will be removed from the schedule and not allowed to work until completing education. 4. Beginning after 06/20/2023, the Director of Nursing (DON) or trained designee will audit to ensure compliance with infection control and wound care at the following frequency: a. Wound care being performed 3 times per work week for 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 sanitizing it or placing a protective barrier. Nurse #4 brought wound care supplies (wound cleanser bottle, camera, foam border gauze package, gauze package, permanent marker, calcium alginate dressing package, scissors) in the resident's room and placed them on the overbed table, sanitized his hands and applied clean gloves. He then removed the old skin tear dressing which had a moderate amount of serous drainage, sprayed wound cleanser on the wound, and wiped the wound with gauze. He then took a picture of the skin tear with the camera, used scissors to cut the calcium alginate to wound size, placed it on the wound, and applied the foam border dressing on top of the calcium alginate, used the permanent marker to write the date on the foam border dressing. Nurse #4 pulled the resident's sock up and her pants leg down. He was observed to wear the same pair of gloves during the entire wound care process. During an interview with Nurse #4 on 6/07/23 at 2:40 PM he stated he was unaware of the need to have an infection control barrier on the resident's overbed table surface where he placed the wound care supplies, the need to perform hand hygiene or change gloves during the wound care process. An interview with the Director of Nursing on 6/07/23 at 3:03 PM revealed she believed that Nurse #4 had just made an error during the wound care observation. She stated he must have just blanked on the correct infection control process for wound care. An interview with the Administrator on 6/08/23 at 8:30 AM revealed he thought that Nurse #4 was nervous to observed during wound care but	F 880	5. Beginning after 6/10/2023, the facility Quality Assurance and Process Improvement (QAPI) team will meet monthly to discuss follow-up from Tag F880. The team includes: the Administrator, the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Wound Care, Social Services, Medical Records, Minimum Data Set (MDS) nurses, and other relevant members of management. 6. Date of Compliance: 06/21/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 stated he should have followed infection control policy.	F 880		