PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345143	B. WING _				C / 12/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2023
				90	00 W DOLPHIN STREET		
SILER CIT	Y CENTER			SI	ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	6/5/23 to 6/6/23. The facility on 6/12/23 to vallegation of immedia Therefore, the exit da Event ID #96W111	ite jeopardy removal. ite was changed to 6/12/23.			Past noncompliance: no plan of correction required.		
	One of one allegation	resulted in a deficiency.					
	Immediate Jeopardy CFR 483.25 at tag F6 (J).	was identified at: 689 at a scope and severity					
	Immediate Jeopardy on 6/10/23.	began on 1/4/23 and ended					
	The tag F689 constitu Care.	uted Substandard Quality of					
F 561 SS=D	A partial extended su Self-Determination CFR(s): 483.10(f)(1)-	•	F 5	561			6/14/23
	promote and facilitate through support of re-	right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f)					
	activities, schedules (waking times), health	sident has a right to choose (including sleeping and care and providers of health ent with his or her interests,					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	ı		TITLE		(X6) DATE

Electronically Signed 06/15/2023

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345143	B. WING				12/2023
	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 W DOLPHIN STREET SILER CITY, NC 27344	1 001	12/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	choices about aspect facility that are signifi §483.10(f)(3) The reswith members of the community activities facility. §483.10(f)(8) The resparticipate in other acreligious, and communiterfere with the right facility. This REQUIREMENT by: Based on record revresident and staff, the resident who had been assessed as supervisat the facility for 1 of reviewed for choices Findings included: Resident #1 was adm 11/5/21. The quarterly Minimulassessment dated 5/Resident #1 had mode and was independent and ambulation. A smoking assessment	an of care and other of this part. Sident has a right to make is of his or her life in the cant to the resident. Sident has a right to interact community and participate in both inside and outside the sident has a right to ctivities, including social, unity activities that do not its of other residents in the is not met as evidenced iew and interview with the eracility failed to allow a en known to smoke and was seed with smoking, to smoke 3 sampled residents (Resident #1). In Data Set (MDS) 12/23 indicated that derate cognitive impairment it with locomotion, transfers,	F	561	F561 – Self Determination 1. Resident # 1 was advised by the Administrator and Assistant Director of Nursing on 6/9/23 that she has the right smoke if she desires. Resident # 1 verbalized understanding that she has right to smoke with supervision if she desires. 2. All residents who desire to smoke he the potential to be effected. Social Services interviewed 100% of Alert and Oriented residents with BIMs scores above an 11 to ensure that their reside rights are being met, including desire to smoke. 3. Education provided by the Regional Nurse to the Administrator, Nursing	at to the ave d nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345143	B. WING				C / 12/2023
NAME OF P	ROVIDER OR SUPPLIER		 	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2023
					W DOLPHIN STREET		
SILER CIT	Y CENTER				LER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	÷ 2	F 5	61			
	smoking". Resident #1 care plar "patient may smoke v assessment". The ap	•			Leadership and Social Services 6/14/2 regarding Resident's Rights including tright to smoke as desired either Independently or with supervision per assessment. All staff to include agency staff were educated by the Nurse Prace Educator related to Resident Bights on Educator related to Resident Bights on	heir y tice	
	monitoring the reside smoking policy and m smoking materials at	naintaining resident's			Educator related to Resident Rights or before 6/14/23. No staff will work prior education being completed. Staff members were educated verbally via		
	at 12:42 AM revealed her room and had car	n by Nurse #2 dated 5/31/23 Resident #1 lit a cigarette in ught a small fire, burning the ing and the curtain in the			phone by the Nurse Practice Educator/designee if they were not in t center at time of education. Any employees returning to work that have been educated, will be educated by the Nurse Practice Educator and the	not	
	A smoking assessme 5/31/23 for Resident indicated that the resismoking practices by	#1. The assessment dent had exhibited unsafe			education completion will be tracked by the Director of Nursing and Assistant Director of Nursing.	y	
		ted to smoke in unsafe decision was "resident was ".			4. Social Services will interview 5 rand residents per week X 4 weeks, then randomly thereafter regarding facility meeting their resident rights. Social	om	
	the Director of Nursin resident regarding he explained to the resid able to smoke because practices. The resident	esident was offered a			Services Staff will review resident right monthly Resident Council. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for on-go compliance. 5. Date of Compliance 6/14/23	the	
	AM. She reported she long time. She report supervised smoker si smoking policy by kee				S. Date of Compilation of 14720		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	, ,	COMPLETED		
		345143	B. WING _			C 06/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	I	00/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 561	room a week ago. S not supposed to smo safe, and she would but she did not know indicated that her ox been low, which mad that after the incident allowed to smoke. S happy about it but the do. A follow up interview. Resident #1 on 6/6/2 her room sitting at the expression on her fawanted to go outside while they were smoto smoke anymore. A telephone interview. Ombudsman on 6/13 reported she was aw with Resident #1 that was notified that Resident #1 that was notified that Resident had the must allow her to smoviolation of her right. The Director of Nurson 6/5/23 at 3:10 PN. Resident #1 was not smoking policy. The past trying to smoke also caught with smopossession. She was smoking policy. The	d that she smoked in her he stated she knew she was oke in her room, it was not break the smoking policy, why she did it. She ygen saturation might have de her out of it. She added to no 5/30/23, she was not he stated that she was not here was nothing she could was conducted with 23 at 12:25 PM. She was in he side of the bed. With sad ce, the resident stated she had talk with her friends king, but she was not allowed was conducted with the 3/23 at 1:05 PM. She ware of the smoking incident thappened on 5/30/23. She sident #1 had not been g policy. She stated that if desire to smoke the facility loke. She added that it was a to stop her from smoking. In (DON) was interviewed the total compliant with the facility's resident was caught in the in the room and she was oking materials in her is reeducated on the facility's DON stated after talking with of all-inclusive care for the	F 5	61			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
						(С
		345143	B. WING _			06/	12/2023
	ROVIDER OR SUPPLIER Y CENTER			90	TREET ADDRESS, CITY, STATE, ZIP CODE OO W DOLPHIN STREET ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	people meet their hear community and the O was provided a Nicoti allowed to smoke.	dicaid program that helps lith care needs in the mbudsman, Resident #1 ne patch and was not		561			6/14/23
F 689 SS=J	CFR(s): 483.25(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	are that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced ew, observation and sident and staff, the facility conitor a resident who had a nce with the smoking policy, smoking materials including pled residents reviewed for). Resident #1, who was on have lighters in her , 5/18/23 and 5/30/23. On rette in the room with the on which resulted in a small mat, privacy curtain and the lent #1 was assessed with dent #4 (Resident #1's ssed with no physical injury d she was "okay but angry". gh likelihood of serious		689	F689 - Free of Accident Hazards/Supervision/Devices 1. Resident (#1) is currently residing in facility, is assessed and care planned to be a supervised smoker. 2. All residents have a potential to be affected. The center Administrator reviewed the non-smoking signage in the center and found that it was in place at time of the incident. A new smoking assessment was completed for all smokers by Nurse Leadership to include Unit Managers and Assistant Director of Nursing (ADON) on 5/31/23 to ensure safe smoking and supervision provided indicated. All current residents that smowere assessed to ensure that their smoking materials were secured per	o he the le of	6/14/23

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345143	B. WING _				C 12/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2023
	101.02.1 01.1 001.1 2.2.1				00 W DOLPHIN STREET		
SILER CIT	Y CENTER						
					ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pag	ue 5	F 6	689			
		nd smoking in the room and			policy by the Social Services		
		ave a monitoring system in			Department/designee on 5/31/23. The		
	place for unsecured	- ·			center determined there were six		
	· ·	was removed on 06/10/23			additional residents that were also four	nd	
		vided an acceptable credible			to have a history of non-compliance wi		
		iate jeopardy removal. The			the center smoking policy by center sta		
	_	of compliance at a lower			noting resident smoking materials		
		evel of "D" (No actual harm			unsecured and the Director of Nursing		
		re than minimal harm that is			and Administrator in conjunction with the	ne	
		rdy) to ensure completion of			Social Services Department revised the		
	• •	oring systems put into place			smoking assessment(s) to make them		
	are effective.				supervised smokers on 6/2/2023 or pri-	or.	
					Upon completion of the updated smoki	ng	
	Findings included:				evaluation, care plans for the identified		
					residents were updated by the Unit		
		g policy with the revision date			managers, Assistant Director of Nursin		
		" smoking will only be			and Social Services Department. Upda	tes	
		d smoking areas, oxygen use			reflected on the care plans were		
		ing areas, smoking supplies			communicated to the direct care staff b	y	
	, -	nited to tobacco, matches,			the Director of Nursing and Assistant		
		beled with the patient's			Director of Nursing at the time of the		
	name, room number				updates on 5/31/23, 6/1/23, 6/2/23 and		
	_	aff and stored in a suitable			ongoing. Room sweeps were conduct	∌d	
		ursing station and patients			by the RN nursing supervisor and	~ 0	
		maintain their own lighter,			Maintenance Director on 5/30/23 (At tir		
	lighter fluid or match	es.			of incident) to ensure there were no oth	iei	
	Posidont #1 was adr	mitted to the facility on			unsecured smoking items to include cigarettes and lighters. Additionally,		
		diagnoses including chronic			smoking residents with oxygen use we	ro	
		ry disease (COPD) and was			reviewed by the Quality Assurance	, C	
	dependent on supple				Performance Improvement (QAPI)		
	aspondont on supple	Sinonal oxygon.			committee to include the Director of		
	Resident #1 had a n	hysician's order dated			Nursing, Assistant Director of Nursing,		
		t 3 Liters (L) per minute via			Medical Director, Social Services		
		iously. On 5/19/23, the			Department, Unit Managers and the		
		ed to 5L/minute continuously.			center Administrator for additional		
	,,,	- · · · · · · · · · · · · · · · · · · ·			recommendations on 5/31/23.		
	Resident #1 had a si	moking assessment dated					
	11/20/22 and the res				3. Education was completed by the Nu	rse	
			1		I ·		

Facility ID: 923120

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3	' '	(X3) DATE SURVEY COMPLETED	
		345143	B. WING			C 06/12/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
SII ED CIT	Y CENTER			900 W DOLPHIN STREET		
SILER OII	CENTER			SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Continued From pag	e 6	F 68	39		
L 009	"independent with sn A nursing note writte at 6:38 PM revealed smoking in the room the hospital on 1/5/2 respiratory distress. on 1/16/23 and was until 1/19/23 due to thappened on 1/4/23. 1/23/23, Resident #1 check. Resident #1 check. Resident #1 smoking policy. Nurse #1 was not av Resident #1 had a sr 1/16/23 and she was smoking" due to non	n by Nurse #1 dated 1/4/23 Resident #1 was observed The resident was sent to 3 and was admitted due to The resident was readmitted placed on 1:1 supervision he smoking incident that From 1/19/23 through was placed on a 15-minute was reeducated on facility's ailable for interview.	F6	Practice Educator/designee on the smoking policy (Genesis Healthon Smoking Policy and Procedure in Operations Policy 137) on or beferit 6/2/23 for all staff (activities staff business office staff, dietary staff housekeeping staff, therapy staff department managers, licensed maintenance staff and nursing as to include agency staff members regarding smokers, supervised a unsupervised. No staff will work education being completed. Staff members were educated verbally phone by the Nurse Practice Educator/designee if they were in center at time of education. Any employees returning to work that been educated, will be educated	care named fore f, f, nurses, ssistants) and prior to ff y via not in the y t have not by the	
	1/16/23 revealed res supervision per smol approaches included matches must be matches must ensure no oxygen us resident's compliance maintain resident's station. The quarterly Minimus assessment dated 5/Resident #1 had mode and she was indepentransfers, and ambul	` ,		Nurse Practice Educator and the education completion will be tract the Director of Nursing and Assis Director of Nursing. Education in assistance with utilization of light cigarettes, supervising smoking accordance with assessed needs ensuring disposal receptacles ar available in smoking areas, mon compliance with policy, maintain resident smoking materials at the station and smoking assessment completed quarterly and with sig changes. Ongoing education to be completed during New Employee Orientation by the Nurse Practice Educator/designee. All current resmokers to be educated on smol policy by the center Administrato 5/31/23. Ongoing education to be	eked by estant ncluded ting in s, e itoring ing e nurses' ts to be nificant be e esident king ir on	

Facility ID: 923120

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345143	B. WING _				C 12/2023
NAME OF P	ROVIDER OR SUPPLIER	_ _		S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2023
					00 W DOLPHIN STREET		
SILER CIT	Y CENTER				ILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From pag	ge 7	F 6	589			
	A progress note write (SW) dated 5/18/23 lighters and a partia found in Resident # confiscated. The refacility's smoking powas completed, and supervised with smooth the SW verified that non-compliant with the The resident was cated (1/4/23) and was obpossession (5/18/23 #1 had been educated policy. She stated the monitoring of smoking rooms. The SW also where the resident windicated twice a ween PACE (Program of A elderly), a Medicared people meet their hecommunity and at the community and at the community and at the community and at the safely, went into the fire. He grabbed the two safely, went into the fire, then closed system sounded, ar residents' doors, and residents'	ten by the Social Worker at 11:45 AM revealed 2 I pack of cigarettes were 1's pocketbook and were sident was reeducated on licy. A smoking assessment the resident remained oking. Ewed on 6/5/23 at 12:28 PM. It Resident #1 was the facility's smoking policy. The SW reported Resident ed on the facility's smoking nere was no scheduled and materials in residents' to stated that she did not know was getting the lighters. She wek, Resident #1 goes to All-Inclusive Care for the //Medicaid program that helps ealth care needs in the mes she goes on leave of		009	completed with new admissions by the Admissions Director/designee on facilit smoking policy. This process was reviewed with the Admissions Director the Administrator on 5/31/23. 4. The Director of Nursing/designee wi complete an audit of all resident smoke supervised and unsupervised, for smoking safety and proper storage of smoking materials Daily x4 weeks, then bi-weekly x2 weeks, then weekly x1 month, randomly thereafter beginning 5/31/23. The Administrator will audit the resident (#1) belongings and resident assessments completed by the Director Nursing, Assistant Director of Nursing, Admissions Director, Nursing Supervis Nurse Practice Educator, Skin Health Team Lead, Infection Preventionist, Minimum Data Set Nurse, Social Work and licensed nurses upon resident, #1' return from LOAs or visits from individu from outside the Center beginning 6/9/2023 daily x4 weeks, then bi-weekl x2 weeks, then weekly x1 month, randomly thereafter beginning 6/9/23. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendation and to ensure the facility remains in compliance. Date of Compliance - 6/14/23	by II ers, t r of ors, ers s, ials	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345143	B. WING _				C 6/12/2023
	ROVIDER OR SUPPLIER			900 V	EET ADDRESS, CITY, STATE, ZIP CODE N DOLPHIN STREET ER CITY, NC 27344		G. 12/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	Continued From pag	ge 8	F	689			
	was reviewed. The r 10:30 PM on 5/30/2: #1 and #4 shouting hallway, he saw smoof Residents #1 and coming out of the roresidents out of the he entered the room between Resident # concentrator. The floxygen concentrator off and got the fire end closed the dalarm, the overhead then told the nurse a everything from the residents' doors and out into the hallway. Supervisor that there Residents #1 and #4 out. The two residents tation and Resident 5L/minute via nasal Resident #1's left shinjuries noted. Resident The note further revinto room of Resident cigarette in the area. Nurse #2 was interv Nurse #2 reported he 5/30/23 and was asset.	by Nurse #2 dated 5/31/23 note revealed it was around 3, Nurse #2 heard Residents at each other. From the oke coming out from the room #4 and both residents were om. He assisted both room away from harm. When he saw a fire on the floor 1's bedside table and oxygen ame was moving towards the re, he turned the concentrator xtinguisher. He put out the loor. Before he could pull the alarm system went off. He aides (NAs) to remove hallway, close all the le ensure no residents came He informed the Nurse was a fire in room of and he was able to put it tots were moved to the nurse's total the was placed on oxygen cannula. When assessed, noe was burnt but she had no lent #1 reported that she was out. When asked what total #1 stated she didn't know. Healed when Nurse #2 went total #1, he found a half-burnt where he saw the flame. I iewed on 6/5/23 at 1:29 PM. He worked from 7P-7A on Signed to Resident #1. He sing note and his written turate.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			С
		345143	B. WING _			06/12/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
SII ED CIT	Y CENTER			900 W DOLPHIN STREET		
SILER CIT	I CENTER			SILER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	-	F 6	89		
	dated 5/30/23 revelence received a phorn Nursing (DON) that fire in a resident's resident and the fire was out, and fire department was the building. He propanel. When he we room, he found a coxygen tubing was and the Nurse Supfor smoking materiasome cigarettes. That a room sweep conducted and 4 reshad smoking materials.	a by the Maintenance Director aled at 10:40 PM on 5/30/23, are call from the Director of at a staff member just put out a room. When he arrived at the red that a resident who was on amoking in her room and the caught fire. He confirmed that ad the resident was safe. The segetting all the smoke out of roceeded to reset the fire alarm and back to Resident #1's igarette on the floor where the and found two lighters and the statement also revealed of residents who smoked was residents including Resident #1 rials in their possession and rials were confiscated.				
	6/5/23 at 11:48 AM verified his written added he was instr to remove the burn from the room to pi that the oxygen tub and ½ foot of the fl the curtain were buresident was move concentrator, tubin to Resident #1. A statement writter dated 5/30/23 reve PM on 5/30/23, the	Director was interviewed on . The Maintenance Director statement was accurate. He nucted by the Fire Department to floor mat, tubing, and curtain revent reignition. He stated bing was burnt and melted, 1 floor mat and about 2 inches of furnt. He added that the dot on another room and a new grand floor mat were provided and by the Nurse Supervisor alled at approximately 10:10 fire alarm sounded. She and called code red (alerts				

OLITICIT	OT OIL WEDIO, ILL G	MEDIO/ ND CEITVICEC				CIVID ITC	7. 0000 000 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			1 50.25				2
		345143	B. WING			l	_ 12/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2023
					000 W DOLPHIN STREET		
SILER CIT	Y CENTER			9	SILER CITY, NC 27344		
(V4) ID	SLIMMADV ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	n 10		600			
1 003				689			
		le fire) to 400 halls. She was					
		sidents in room 406 had le room and the nurse had					
		re. She completed a quick esidents and there were no					
	injuries. Both residen						
	_	cted another skin check on					
		esident #1 was noted to					
		y burnt and she had a black					
		I. The resident did not have					
	redness, blisters, or r						
	Resident #1's oxyger	n saturation was 94% on					
	oxygen. When the Fir	re department personnel					
	arrived, Resident #1's	s room was checked, and					
	they used fans to clea	ar the smoke. The fire					
	department silenced						
		reset the panel. She					
		all clear. Accompanied by					
		ector, she checked Resident					
		g paraphernalia and they					
		ter, half a smoked cigarette,					
		vith one cigarette in it. They					
	_	e lighter in her pocket. An					
		of all smokers to check if als were properly stored.					
	_	• • •					
		by the Nurse Supervisor ed that she interviewed					
		the fire happened. Resident					
		tarted on its own on her					
		lid not remember smoking or					
		he resident stated that she					
		ot physically hurt but needed					
		rves. Another statement					
	_	Supervisor dated 5/30/23					
	_	erviewed Resident #1's					
	roommate. The room	mate stated that she did not					
	know how the fire sta	rted. She looked and there					
	was a fire on her roor	mmate's side of room and					
	her roommate saying	to get out of the room. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,			COMPLETED		
	345143	B. WING			C		
ROVIDER OR SUPPLIER Y CENTER	0.01.40		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	I	06/12/2023		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE		
roommate denied a from the incident. The Nurse Supervi at 2:50 PM and she statements were as tatements were as The Director of Nur on 6/5/2 at 2:55 PM #1 and #2 were as Practitioner on 5/3 noted. Resident #1 was in AM. She reported so Iong time. She was smoking policy to smoking areas and materials including reported that she was smoking material wundesignated smoking materials including residents. She also the room several materials including reported that she was smoking materials including reported that she was smoking areas and materials including reported that she was smoking areas and materials including reported that she was smoking areas and materials including reported that she was smoking areas and materials including reported she was smoking areas and materials including repor	sor was interviewed on 6/5/23 e verified that her written occurate. The sing (DON) was interviewed on 6/5/23 at 10:15 seessed by the Nurse 1/23 and there were no injuries of the facility's sees only in designated of 1/25 and there were no injuries of the facility's sees only in designated of 1/25 and there were no injuries of the facility's sees only in designated of 1/25 and there were now injuries of the facility's sees only in designated of 1/25 and there were now injuries of the facility's sees only in designated of 1/25 and there were now injuries of the facility's sees only in designated of 1/25 and there were now injuries on the sees on the facility's sees on the sees of the facility's sees on the faci	F 68	39				
residents. She also the room several material fire. Resident #1 acroom a week ago. In not supposed to sm safe, and she would but she did not know indicated that her obeen low, which may she reported she with the following she will be supported to the floor mat, but cigarette with her forms.	o reported she had smoked in norths ago, but it did not catch dmitted that she smoked in her She stated she knew she was noke in her room, it was not d break the smoking policy, ow why she did it. She oxygen saturation might have ade her out of it and confused. was sitting on the side of bed ober how the cigarette ended at she tried to stomp on the poot to put the flame out. She						
	CORRECTION ROVIDER OR SUPPLIER Y CENTER SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM PROPERTY CO	CORRECTION 345143 ROVIDER OR SUPPLIER Y CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 roommate denied any physical or mental distress from the incident. The Nurse Supervisor was interviewed on 6/5/23 at 2:50 PM and she verified that her written statements were accurate. The Director of Nursing (DON) was interviewed on 6/5/2 at 2:55 PM. She reported that Residents #1 and #2 were assessed by the Nurse Practitioner on 5/31/23 and there were no injuries	A BUILDING 345143 ROVIDER OR SUPPLIER Y CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 roommate denied any physical or mental distress from the incident. The Nurse Supervisor was interviewed on 6/5/23 at 2:50 PM and she verified that her written statements were accurate. The Director of Nursing (DON) was interviewed on 6/5/2 at 2:55 PM. She reported that Residents #1 and #2 were assessed by the Nurse Practitioner on 5/31/23 and there were no injuries noted. Resident #1 was interviewed on 6/5/23 at 10:15 AM. She reported she had been a smoker for a long time. She was aware of the facility's smoking policy to smoke only in designated smoking areas and not to keep smoking materials including lighters with her. She reported that she was a supervised smoker since she violated the smoking policy by keeping smoking material with her and smoking in undesignated smoking areas. She stated that she had been keeping smoking material just like other residents. She also reported she had smoked in her room several months ago, but it did not catch fire. Resident #1 admitted that she smoked in her room a week ago. She stated she knew she was not supposed to smoke in her room, it was not safe, and she would break the smoking policy, but she did not know why she did it. She indicated that her oxygen saturation might have been low, which made her out of it and confused. She reported she was sitting on the side of bed. She did not remember how the cigarette ended on the floor mat, but she tried to stomp on the cigarette with her foot to put the flame out. She also could not remember if she had the oxygen	ROVIDER OR SUPPLIER Y CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPOILENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC (DENTIFYING INFORMATION) Continued From page 11 The Nurse Supervisor was interviewed on 6/5/23 at 2:50 PM and she verified that her written statements were accurate. The Director of Nursing (DON) was interviewed on 6/5/2 at 2:55 PM. She reported that Residents #1 and #2 were assessed by the Nurse Practitioner on 5/31/23 and there were no injuries noted. Resident #1 was interviewed on 6/5/23 at 10:15 AM. She reported she had been a smoker for a long time. She was aware of the facility's smoking policy to smoke only in designated smoking areas. She stated that she had been keeping smoking materials including lighters with her. She reported that she was a supervised smoker since she violated the smoking policy by keeping smoking materials with her and smoking in undesignated smoking areas. She stated that she had been keeping smoking material with her and smoking in undesignated smoking areas. She stated that she had been keeping smoking material lyust like other residents. She also reported she had smoked in the room several months ago, but it did not catch fire. Resident #1 admitted that she smoked in her room a week ago. She stated she knew she was not supposed to smoke in her room, it was not safe, and she would break the smoking policy, but she did not know why she did it. She indicated that her oxygen saturation might have been low, which made her out of it and confused. She reported she was sitting on the side of bed. She did not remember how the cigarette ended on the floor mat, but she tried to stomp on the cigarette with her foot to put the flame out. She also could not remember if she had the oxygen	A BUILDING 345143 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 roommate denied any physical or mental distress from the incident. The Nurse Supervisor was interviewed on 6/5/23 at 2:50 PM and she verified that her written statements were accurate. The Director of Nursing (DON) was interviewed on 6/5/2 at 2:55 PM. She reported that Residents #1 and #2 were assessed by the Nurse Practitioner on 5/31/23 and there were no injuries noted. Resident #1 was interviewed on 6/5/23 at 10:15 AM. She reported she had been a smoker for a long time. She was aware of the facility's smoking policy to smoke only in designated smoking areas and not to keep smoking materials including lighters with her. She reported that she was a supervised smoker since she violated the smoking policy by keeping smoking material with her and smoking in undesignated smoking areas. She stated that she had been keeping smoking material lyst like other residents. She also reported she had smoked in her room a week ago. She stated she knew she was not supposed to smoke in her room, it was not state, and she would break the smoking policy, but she did not know why she did it. She indicated that the roxygen saturation might have been low, which made her out of it and confused. She reported she was sitting on the side of bed. She did not remember how the cigarette ended on the floor mat, but she tried to stomp on the cigarette with her foot to put the flame out. She		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
		345143	B. WING _			C 06/12/2023	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, 900 W DOLPHIN STREET SILER CITY, NC 2734	Т	00/12/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 689	staff came and helpe of the room. Nurse #3 was interv The Nurse reported PACE twice a week. monitoring or search she came back from #1 was currently on 5/30/23 and she was Nurse #3 added that order for a Nicorette Nurse Aide (NA) #1 9:12 AM. The NA re Resident #1 as a sm supervised smoker, times a day to smok smoking materials w station. A staff memi smoking time to sup smoking area. The 2 cigarettes and ligh residents. NA #1 re Resident #1 with sm possession. On 6/5/23 at 3:50 PI There was no damaceiling. There was a wall on the door side Resident #4, roomm admitted to the facili MDS assessment da Resident #4's cognit was interviewed on the state of the state of the state of the facili MDS assessment da Resident #4's cognit was interviewed on the state of the state of the state of the facili MDS assessment da Resident #4's cognit was interviewed on the state of the state o	Resident #1 stated that the ed her and her roommate out sewed on 6/9/23 at 9:01 AM. that Resident #1 goes to She was not aware of any for smoking materials when PACE. She knew Resident 1:1 due to the incident on so not smoking anymore. It Resident #1 had a physician inhaler. Was interviewed on 6/9/23 at exported that she had known noker. Resident #1 was a and she goes at least 3 -4 e. She indicated residents' ere kept at the nurse's over was assigned during ervise residents in the staff member gives residents at the cigarettes for the ported she had not seen oking materials in her M, room 406 was observed. ge to the floor, walls, or new curtain hanging on the	F	89			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345143	B. WING _			C 06/12/2023
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C 900 W DOLPHIN STREET SILER CITY, NC 27344	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	· ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	pulled between their if she was smoking materials in her possinghttime, she did not and time when she stoommate's side of likesident #1 was tell. She was trying to go member came and a was "okay but angry. A follow up interview Director was conduct The Fire Department Resident #1 and insidiscard the burnt flot from the room. They the smoke. Resider another room that ni Director stated that new oxygen concern on 5/30/23. The Director of Nurson 6/5/23 at 3:10 PM Resident #1 was no smoking policy. She caught in the past trand the resident was materials in her possion the facility's smolthere was no schedumaterials. The DON the 5/30/23 incident caught a small fire. Resident #1 was plates.	rays had the privacy curtain beds and she could not see in bed or had smoking session. She reported it was of remember the exact date saw a flame on her bed through the curtain and ing her to get out of the room. It out of the room when a staff assisted her. She stated she in with the Maintenance sted on 6/5/23 at 4:31 PM. It checked the room of the tructed him to remove and to for mat, curtain, and tubing it brought in fans to get rid of ints #1 and #2 were moved to ght. The Maintenance Resident #1 was provided a trator, tubing, and floor mat with the facility's exact was aware the resident was sying to smoke in the room is also caught with smoking session. She was reeducated king policy. She reported uled monitoring of smoking stated she had investigated where Resident #1's room The DON reported that inced on 1:1 after the 5/30/23 and 1:1 to date. She stated	F	689		

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345143	B. WING			C 6/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 900 W DOLPHIN STREET SILER CITY, NC 27344		6/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Administrator #2 state she was the acting Adadministrator was out had interviewed Residenied smoking or lig room. However, a lit of the floor mat, besid She indicated that the putting out the fire an safe. The Assistant Director interviewed on 6/9/23 Resident #1 was schiq week. She also repof absence (LOA) wit ADON indicated there smoking materials whealth PACE or LOA. Administrator #2 was 9:49 AM. He reported informed him it was a dated October 2022 (physically search a renot doing the search back from LOA or PACAdministrator #2 was jeopardy on 6/5/23 at The corrective action 6/3/23 was as follows 1. Resident #1 noted	as not allowed to smoke. ed on 6/5/23 at 6:05 PM that diministrator since the staff dent #1 and the resident hiting a cigarette in the cigarette was found on top de the burnt oxygen tubing. The staff did a good job in doin keeping the residents or of Nursing (ADON) was at 9:20 AM. She stated that reduled to go to PACE twice corted that she went on leave the a friend on 4/23/23. The rewas no monitoring of the she came back from the interviewed on 6/9/23 at that the Corporate had violation of resident's rights rule of participation) to resident, so the facility was when Resident #1 came CE. notified of immediate 6:19 PM. with a compliance date of	F 68	39			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		NSTRUCTION	(X3) DATE	SURVEY
			7 . BOILD!			l ,	С
		345143	B. WING				12/2023
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00.	12.2020
				900 V	W DOLPHIN STREET		
SILER CIT	Y CENTER			SILE	ER CITY, NC 27344		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	to safety and exting assessments comp RN noting no conceresidents were refecomplete assessments completed on both Therapist on 5/31/2 team examinations for both patients winursing supervisor, ensured that new on Resident #1 and the materials unsecure one-on-one care by immediately following room. The Director nursing supervisor the one-on-one suphas designated diresupervision. The cereical supervision.	ge 15 ed the resident and roommate guished the fire. Skin eleted on both residents with erns on 5/30/23. Both erred to the medical team for ent. Respiratory assessments residents by Respiratory anoting no concerns. Medical were completed on 5/31/23 thout concern noted. The ent. S/30/23 at time of incident exygen tubing was placed for ere were no other smoking d. Resident #1 was placed on the Director of Nursing eng the incident in a private of Nursing or designated is responsible for scheduling ervision for Resident #1 and ext care staff to maintain that enter Director of Nursing et with additional footwear on	F	589			
	The center Administ non-smoking signal it was in place at the smoking assessme smokers by Nurse Managers and Assi 5/31/23 to ensure sprovided as indicated smoke was assess smoking materials as Social Services De The center determines idents that were	trator reviewed the ge in the center and found that e time of the incident. A new nt was completed for all Leadership to include Unit stant Director of Nursing on afe smoking and supervision ed. All current residents that ed to ensure that their were secured per policy by the partment/designee on 5/31/23. ned there were six additional also found to have a history of the the center smoking policy					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345143	B. WING				C / 12/2023
	ROVIDER OR SUPPLIER			STREET ADDRE		, 3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	χ (E/	PROVIDER'S PLAN OF CORRECTI EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	conjunction with the revised their smoking them supervised so Upon completion of evaluation, care play were updated by the Director of Nursing Department. Update were communicated Director of Nursing Nursing at the time 6/1/23, 6/2/23 and conducted by the Report Maintenance Director incident) to ensure unsecured smoking and lighters. Additional coxygen use were recommittee to include Assistant Director of Social Services Department and the center Administrate recommendations of the center Administrate Educator/opolicy (Genesis Heat Procedure named Composition of the procedure of the center Administrate to include the center Administrate Educator/opolicy (Genesis Heat Procedure named Composition of the procedure of the center Administrate Educator/designee at time of education work that have not be educated by the Nurse of the center of the center Administrate to include the center Administrate Educator/designee at time of education work that have not be educated by the Nurse of the center of the	Nursing and Administrator in a Social Services Department in a sessessment(s) to make mokers on 6/2/2023 or prior. If the updated smoking ins for the identified residents in the updated smoking ins for the identified residents in the updated smoking ins for the identified residents in the updated on the care plans in the direct care staff by the and Assistant Director of in the updates on 5/31/23, congoing. Room sweeps were in the updates on 5/31/23, congoing. Room sweeps were in the updates on the updates on 5/30/23 (At time of the updates on the updates of the updates of the updates on the updates on the updates of the updates	F	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345143	B. WING			1	C / 12/2023
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN STREET SILER CITY, NC 27344	1 00/	12/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Nursing. Education utilization of lighting smoking in accordate neuring disposal respective in a smoking areas, mo policy, maintaining the nurse's station abe completed quart changes. Ongoing during New Employ Practice Educator/c smokers are to be eather to be corted to be contained in the center Administ education to be corted by the Admissions Directly of the Admissio	and Assistant Director of included assistance with a cigarettes, supervising ince with assessed needs, eceptacles are available in nitoring compliance with resident smoking materials at and smoking assessments to erly and with significant education to be completed eve Orientation by the Nurse designee. All current resident educated on smoking policy by rator on 5/31/23. Ongoing inpleted with new admissions Director/designee on facility is process was reviewed with ector by the Administrator on Jursing/designee will complete ent smokers, supervised and moking safety and proper materials Daily x4 weeks, weeks, then weekly x1 month, beginning 5/31/23. Results of brought before the Quality ance Improvement Committee tional monitoring or plan monthly for 3 months for endations and to ensure the ompliance.	F	689			
	6/6/23. The plan w Administrator was r	as not thorough, and the notified. An acceptable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		345143	B. WING _		06	C 5/12/2023	
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 900 W DOLPHIN STREET SILER CITY, NC 27344		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
	coom with oxygen in Staff immediately responsible to safety. Skin assessments on with RN noting no contest the sesidents were refer complete assessments on 5/31/23. The nursing supervincident ensured the placed for resident # smoking materials under the sure of the nursing immediately will remain until the no longer a risk to have been one one supervisor is responsible to the supervision. The celebrovided resident (# 5/31/23. Center policy is for the smoking materials and cigarettes, limaterials that one months in the center. Still the staff is the context of the supervision of the celebrovided resident (# 5/31/23.	//23.	F	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345143	B. WING _			C 06/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 W DOLPHIN STREET SILER CITY, NC 27344		00/12/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	the smoking session smoking where the smoking residents to smoking safely including their cigarette or oth policy/process has be prior to this event. 2. All residents have The center Administ non-smoking signagit was in place at the smoking assessmer smokers by Nurse L Managers and Assis 5/31/23 to ensure seprovided as indicate smoke was assesses smoking materials we Social Services Dep The center determineresidents that were non-compliance with center staff noting reunsecured and the I Administrator in con Services Departmer assessment(s) to me smokers on 6/2/202 of the updated smokers on 6/2/202 of the updated smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the smokers on the care plans we direct care staff by the Assistant Director of the care plans we direct care staff by the Assistant Director of the care plans we direct care staff by the Assistant Director of the care plans we direct care staff by the Assistant Director of the care plans we direct care staf	d collect them at the end of a. The center has supervised center staff monitor the center that they are ding but not limited to extinguishing, and handling er smoking apparatus. This even in place at the center	F	689		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	OATE SURVEY OMPLETED
		345143	B. WING _			C 06/12/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP 900 W DOLPHIN STREET SILER CITY, NC 27344	CODE	33,12,232
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		· ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	supervisor and Main (At time of incident) unsecured smoking and lighters. Addition oxygen use were recommittee to include Assistant Director of Social Services Deputhe center Administrate recommendations of Beginning 6/9/23, that steps to assess resigners on upon return that absence from the center of the cen	tenance Director on 5/30/23 to ensure there were no other items to include cigarettes inally, smoking residents with viewed by the QAPI the Director of Nursing, Nursing, Medical Director, artment, Unit Managers, and ator for additional in 5/31/23. The center initiated additional dent, #1, belongings and to the center from any enter or upon any visitation unity members to ensure that is newly acquired smoking session. This process will be rector of Nursing, Assistant Admissions Director, Nursing Practice Educator, Skin infection Preventionist, surse, Social Workers and scheduled by the Director of infector of Nursing/ center Administrator and Nursing met with the uss the additional steps on mpleted by the Nurse esignee on the smoking lthcare Smoking Policy and perations Policy 137) on or staff (activities staff, dietary	F	689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345143	B. WING			C 06/12/2023	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CIT 900 W DOLPHIN STR SILER CITY, NC 27	EET	00.12.2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT DEFICIENCY)		
F 689	unsupervised no stabeing completed. Severbally via phone is Educator/designee at time of education work that have not it educated by the Nu education completic Director of Nursing Nursing. Education utilization of lighting smoking in accordatensuring disposal resmoking areas, more policy, maintaining in the nurse's station as be completed quartichanges. Ongoing eduring New Employ Practice Educator/dismokers to be educated to be completed quartichanges. Ongoing eduring New Employ Practice Educator/dismokers to be educated to be completed quartichanges. Ongoing education and provided provide	smokers, supervised and aff will work prior to education staff members were educated by the Nurse Practice if they were not in the center. Any employees returning to been educated, will be ree Practice Educator and the on will be tracked by the and Assistant Director of included assistance with cigarettes, supervising nee with assessed needs, eceptacles are available in nitoring compliance with resident smoking materials at and smoking assessments to early and with significant education to be completed ee Orientation by the Nurse esignee. All current resident ated on smoking policy by the ron 5/31/23. Ongoing apleted with new admissions Director/designee on facility is process was reviewed with actor by the Administrator on the ewill educate the Director of Nursing, rown, Nursing Supervisors, Nurse Skin Health Team Lead, alst, Minimum Data Set Nurse, allicensed nurses on 6/9/2023 assess resident, #1, upon ence from the center to verify on thave any smoking and staff will work until and calculated the process was reviewed and set of the process of the proc	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345143	B. WING _			C 06/12/2023
	ROVIDER OR SUPPLIER Y CENTER	•		STREET ADDRESS, CITY, STATE, ZIP C 900 W DOLPHIN STREET SILER CITY, NC 27344		33.12.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Nursing/Assistant D responsible for track 4. The Director of Norman audit of all reside unsupervised, for smooth storage of smoking then bi-weekly x2 worked and worked the properties of the Administrator worked by the Director of Norman Admissions Supervisors, Nurse Health Team Lead, Minimum Data Set Norman Loas beginning 6/9, bi-weekly x2 weeks, randomly thereafter	ted and the Director of rector of Nursing will be ing the staff education. ursing/designee will complete nt smokers, supervised and noking safety and proper materials Daily x4 weeks, eeks, then weekly x1 month, beginning 5/31/23. Ill audit the resident (#1) dent assessments completed ursing, Assistant Director of Director, Nursing Practice Educator, Skin infection Preventionist, Jurse, Social Workers, and in resident, #1, return from 1/2023 daily x4 weeks, then then weekly x1 month,	F	689	CY)	
	any additional monit plan monthly for 3 m recommendations a remains in complian Date of IJ Removal: On 6/12/23, the facil immediate jeopardy facility's corrective a of 100% staff educa policy and that all sr	nd to ensure the facility ce.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		ATE SURVEY MPLETED
		345143	B. WING _			C 06/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 900 W DOLPHIN STREET SILER CITY, NC 27344		J6/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	5/31/23. The facility p Quality Assurance au materials returned aft 5/31/23 and ongoing. additional in-servicing assessing Resident # return to the facility fro appointment, leave of for smoking materials evidence of daily Qua regarding Resident # smoking materials sta Observations and inte storage of smoking m	aterials on 5/30/23 and rovided evidence of daily diting regarding smoking er smoke break starting The facility also provided beginning 6/9/23 on and her belongings, upon	F6	589		