PRINTED: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 345143 03/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODS 900 W DOLPHIN ST SILER CITY CENTER SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRCFIX **FEACH CORRECTIVE ACTION SHOULD BE** TAG REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DESICIENCY F 000 INITIAL COMMENTS Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the 2567 Amended 4/3/2014. Date of IJ beginning provider of the truth of the facts alleged or conclusions for Resident #3 changed from 12/30/2013 to

F 323 | 1.

in the forehead. Facility added additional information to the credible allegation to address interventions implemented for Resident #3 after incidents with Resident #2. F 323 483,25(h) FREE OF ACCIDENT SS=J | HAZARDS/SUPERVISION/DEVICES

12/31/2013 when Resident #2 struck Resident #3

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on medical record reviews, staff interviews, and physician interviews the facility failed to prevent resident to resident altercations for one (1) of one (1) residents with aggressive behaviors (Resident #2) exhibited towards two (2) other residents, (Residents #1and #3) which resulted in injury.

The immediate jeopardy (IJ) for Resident #1 began on February 2, 2014 when Resident #1 was hit by Resident #2 in a physical altercation. The immediate jeopardy (IJ) for Resident #3 began on December 31, 2013 when Resident #2 punched Resident #3 on forehead with the resident's fist. The Administrator was notified of Immediate Jeopardy on 3/3/14 at 5:30 PM. The

set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

immediately following the discovery of the incident, Residents in Room 515-1 and 515-2 were assessed by the facility's licensed nursing staff. The residents were immediately separated and one-on-one C.N.A. supervision for each resident was provided until both residents were transported to the local hospital. The resident's physicians were notified and orders were given to transport both residents to the local hospital's emergency room. The responsible parties for each resident were untified as well as the facility's Administrator, Director of Nurses and Assistant Director of Nurses, Under the coordination of the Administrator and Nursing Administration, an investigation of the incident was immediately initiated. A 24-Hour report was transmitted to the Division of Health Services Regulation. The two residents were both transported to the emergency room on 02/02/14. Resident #1's known injuries included bilateral subdural hematoma, facial fractures and lacerations to the face. Resident #1 was hospitalized and then returned to the facility on 02/13/14, Resident #2 was arrested at the hospital and transported to the local jall. As of this date, Resident #2, who was discharged from the facility, has not returned.

The facility reviewed the incident, the resulting outcomes and interventions with the facility's Medical Director via telephone on 02/02/14.

Any deficiency statement ofdigh with an estatisk (*) dannies extensionally which the institution may be excused from correcting providing it is determined that other sateguards 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 disclosuble 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

PRESENTATIVE'S-SIGNATORE

program participation.

Facility (D: 923120

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER RE

PRINTEO: 04/08/2014

DEPART	MENT OF HEALTH A	ND HUMAN SERVICES					D: 04/08/2014 M APPROVED
		MEDICAID SERVICES					D. 0938-0391
Statement And Plan Q	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIOATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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SILER CI	TY CENTER				/ DOLPHIN ST R CITY, NC 27344		
CI (XX) PREFIX DAT	† (EACH DEFICIENC	Atement of deficiencies ly must be preceded by full LSC identifying information)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	96	(NS) COMPLETION DATE
F 323	acceptable credible a was validated through reviews. The facility compliance at a scop harm with the potentit harm that is not imme completion of employ monitoring. The finding of the medical included Aricept for Divice a day, and trilop day.	/5/14 at 5:30 PM after an allegation in staff interviews and record will remain out of the and severity of no actual all for more than minimal adiate jeopardy (D) for the training and implementings included: dmitted to the facility on the as of demential and the following sive decline in condary to Dementia, appropriate sexual and verbal of psychoactive medications, of use interventions for the formalituation as needed, in the activity such as act resident is thoughts to needed. If Minimum Data Set (MDS) is 2/20/14 revealed he had no ward others, had long and appliment, was independent asfers, walking in room and attions for Resident #1 emential, Ativan for anxiety otal (mood stabilizer) twice a	F	t 1	All residents on the facility's Special Ca Unit were Interviewed on 02/02/14 to whether they had been subjected to at facility residents were given a head-to-assessment by the Assistant Director of Day RN Supervisor, the MDS Nurse and Charge Nurses on 02/02/14 for any sign and none were noted. The Plans of Care for all residents in the identified behaviors, were reviewed or the Director of Nurses, the Assistant Di Nurses, the Day RN Supervisor and the Coordinator. The Plans of Care and Recards were updated as appropriate. On 02/02/14, facility staff were re-inseresident abuse and dealing with behaviors for Earlity staff, who were uno2/02/14, were required to be re-inserreturning to work. Additionally, direct staff received education on the development of Nurses, on Ozdination on resident abuse and dealing obhavioral care plans and reporting obtained that require interventions to the Ofrector the Assistant Director of Nurses, on Ozdination on resident abuse and dealing obhaviors is included as part of the orien newly hired facility staff by the Staff Devictor of Nurses, on Ozdinator.	ascertain ny abuse. All toe f Nurses, the four LPN ns of abuse e facility, wit n 02/02/14 b rector of MDS sident Care rviced on ions by the n Day RN available on viced prior to care nursing oment of servations or of Nurses 8/02/14. With tation of	, y
	Resident #2 was adm	illed to the facility on					

PRINTED: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER! COMPLETED A, BUILDING C 345143 B. WNS 03/05/2014 NAME OF PROVIDER OR SUPPLIER SYREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLDHIN ST SILER CITY CENTER SILER CITY, NC 27344 (X4) iD SUMMARY STATEMENT OF DEPICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) GOVPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD US REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 323 | Continued From page 2 The facility's Director of Nurses, or the Assistant F 323 11/20/13 with diagnoses including dementia Director Nurses if unavailable, if not in the facility, secondary to anoxic brain injury from a cardiac will be contacted by telephone for any observed arrest behaviors that require assessment and intervention. The interventions for behaviors are reviewed with The transfer form (FL2) indicated Resident #2 the Director of Nurses or Assistant Director of had dementia, and required a locked unit due to Nurses as the behaviors occur, 7-days per week. wandering. Upon admission, Resident #2 resided in the locked dementia unit. There were no All observed behaviors are reviewed by the facility's identified behaviors of physical or verbal abuse InterDisciplinary Yearn with recommendations for on the FL2. action made as appropriate including modifications of the resident's Plan of Care, at the facility's Clinical Resident #2 was assessed as having short term Morning Meeting S-days per week, Behaviors memory impairment. The "Dementia Functional observed on weekends will be reviewed by the Assessment Tool " dated 11/22/13 indicated InterOlsciplinary Team, utilizing the facility's 24-Hour Resident #2 had "Moderately severe cognitive Report, nurses notes, physician orders if appropriate decline (early dementia). On this assessment, and the Plan of Care, at the Clinical Morning Meeting. Resident #2 was unable to recall most recent on the next business day. avents, had purposeless wandering and could not complete a two-stage command. On 03/05/14, facility direct care staff were reinserviced on identifying behaviors on the Behavior The care plan for Resident #2 dated 12/31/13 Monitoring Sheet, how to complete the Behavior addressed a problem of "exhibits behaviors of Monitoring Sheet and the use of the INTERACT and physical (phys) aggression as evidenced by Stop and Watch Yools as a communication tool from (AEB) recent resident to resident altercations CNA's to licensed nurses by the Staff development involving hitting another resident - related to: Coordinator and the Day RN Supervisor. Facility cognitive impairment." The stated goals included direct care staff, who were unavailable on 03/05/14, the resident would not strike others, he would have reduced incidents of aggression and angry were regulred to be re-inserviced prior to returning outbursts and staff would recognize and prevent to work. Behavior Monitoring Sheet education is behaviors that provoke aggressiveness. The Included in the orientation of all newly hired licensed nurses by the facility's Staff development approaches included document Coordinator. behaviors/interventions as indicated, remove resident from public area when behavior is disruptive, talk with resident in a low pitch, calm The Dehavior Monitoring Sheets for all facility voice to decrease undesired behavior and residents were audited to ensure that all behaviors provide diversional activity and report any change were identified by the Director of Nurses, Assistant in mood or behavior to nurse immediately, Olrector of Nurses, Day RN Supervisor and two Additionally, an update was added for the same charge licensed nurses on 03/05/14. date (12/31/13) for one on one sitter as needed to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING_	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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				Resident #3's Plan of Care was reviewe	d, after	1
F 323	Continued From page	e 3	F 323	exhibiting behaviors on 12/27/13, by t		
	monitor.		' ' ' ' '	Interdisciplinary Team and made the fi		1
	11.50.1441,			addition; Resident to be re-directed to		•
	Review of the Minims	ım Data Set (MDS) a		TV room, Resident #3's Care Card was		1
		4 revealed Resident #2 had	1	the 500 Hall direct care staff provided		<u> </u>
	long term memory in			activities. On 12/31/14, Resident #3's		
		I symptoms directed toward		was reviewed by the facility's Interdisc		
		with bed mobility, transfers,		and made the following addition; Mon	•	1
	walking in room and	halls and eating.		closely and re-direct when resident en		
			l	; ; resident's personal space. Resident #3	's Care Çard	
	Review of Resident #	[‡] 2's nurse' notes dated	į	was updated and the 500 Hall direct ca	ne staff	ļ
1		vealed Resident#2 had a	l	provided re-direction when Resident ii	3 entered the	į
		rith Resident #1. Resident		personal space of other residents. The	facility's	
		s nose and mouth with left		Interdisciplinary Team also updated th	•	1
	ſ	asked by the nurse what		with the following; Conduct a medicat	lon review for	
	''	#1 stated "He (Resident #2)	j	Resident #3 and the medication review	v was	
		was assessed for injuries,	ì	completed on 1/5/14. On 12/31/14, th	e facility's	
		sible party notified and sent		Interdisciplinary Team requested a for	mal meeting	ļ
		Medical Services) to the	i	with Resident #3's Responsible Party.	4 meeting was	
	hospital.		İ	held on 1/10/14 with the facility's inte		
	l Daeintandow with th	e Administrator on 3/5/14 at		Teom, the Assistant Director of Nurses	, the facility's	
	1	pport was transmitted to the		Administrator, Resident #3's attending		
		rvices Regulation, The two		Responsible Party and other family me	imbers to	
		ransported to the emergency		discuss the results of the medication r	eview,	1
		lesident #1 was hospitalized		physician recommendations and famili	y suggestions	
	,	il hematoma, facial fractures	į	for late afternoon and early evening a	tivities and	
	and lacorations to the	face, Resident #2 was		other interventions. The Responsible i	arty informed	
	arrested at the hospi	tal and transported to the		Resident #3's attending physician that	she did not	
	local jail.			want any medication interventions an	d would prefer	1
			1	to take Resident #3 home if adequate	services could	
	Interview with Nurse	#1 on 3/5/14 at 10:15 AM		be obtained. The Responsible Party of	lered no	
	§	nurse that worked the first		suggestions for activities and interven	tions. The staff	
		e #1 explained she was on		scheduling for the Special Care Unit or	the 500 Hall	
		ad been in Resident #1's		was re-aligned starting on 03/04/14 b	the Director	
		dications about ten minutes		of Nurses and the Assistant Director o	f Nurses to	
	t	o indication of a change in		provide for one CNA and one Activity	erson to work	
	t .	lent#1 was asleep, and she		split shifts, i.e. 10:00 a.m. to 6:00 p.m.	, to provide re-	
	planned to return later to give his medications to him. Aide # 7 called to her from Residents ' #1		}	direction and intervention for Residen	t #3 during the	12/2/10
	nimi, Alde # / called	to her from Kosidonis 1 #1	<u> </u>	, late afternoon, when she and other re	sidents on the	13/24/
OUN OND OC	2102 00) Brankova Mickelana Ok	edata Susat 10, 646		secolo il in il room il		

Fig. Special Care Unit on the 500 Half usually exhibit heat Page 4 of 22 more wandering behavlor.

PRINTED: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER! A BUILDING c345143 8. WNG. 03/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY CENTER SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 323 | Continued From page 4 F 323 and 2's room. Upon entering, Resident #1 was sitting on the side of the bad. He had blood from The facility's Performance Improvement Committee his nose and mouth. At first, nurse #1 explained reviewed the incident and the reporting/assessment she thought it was a nose bleed. Upon speaking systems in place, on 02/03/14. The Director of with aide #7 and Resident #1, she was informed Russes and/or the Assistant Director of Nurses will Resident #2 had hit Resident #1 in the face. audit the Plans of Care of residents with identified Nurse #1 said she informed her supervisor, and assessed Resident #1 further. Resident #2 was behaviors on the appropriate documentation and lying in bed with the covers pulled up to his head, approaches on the Plans of Care and Resident Care Resident #2 did not say anything during the Cards weekly for four weeks, starting on 02/03/14, questioning of Resident #1. During the interview, and report to the Performance Improvement Nurse #1 explained Resident #2 responded "yes Committee monthly for a minimum of three months. " when asked if he had hit his roommate. She The Director of Nurses and/or the Assistant Director further explained she asked Resident to see his of Nurses will audit the Behavior Monitoring Sheets hands and found blood on the wet cloth when she weekly for four weeks, starting on 03/05/14. The cleaned his hands. audit reports will be presented quarterly on a continuing basis upon a determination made by the Interview with aide #7 on 3/5/14 at 10:50 AM Performance Improvement Committee. revealed she was working first shift on 2/2/14, 3/6/14 Aide #7 explained it was some time after breakfast, and she saw Resident #2 going into the bathroom in his room. Aide #7 was working in the room next door, making beds. As she went up the hall for linen, she saw Resident #1 sitting on the side of his bad and his nose was bleeding. Aide #7 went into the room and asked Resident #1 what happened. Resident #1 reported his roommate got up and hit him. At that time, Resident #2 was in bed, with the covers pulled up like he was asleep. Aide #7 stated "he wasn't asleep" and I asked him what he did. Resident #2 responded "He disrespected me. " When aide #7 was asked to explain if she knew what the resident meant, she stated Resident #2 told her Resident #1 had called him names, like the "

N" word. Alde #7 continued to explain she had not heard any noise, or commotion coming from their room prior to the incident. Alde #7 was asked if she had heard Resident #1 call Resident DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 323	#2 names before and social worker was inf Interview on 3/5/14 at worker explained she name calling " by Re worker explained she or she would have me communicating between the desk. The social staff had reported the along well. Interview on 3/5/14 at revealed she had infeated the infeat the nurse 's desk. Was reported to the staff had reported to the staff had reported to the staff had revealed she had infeated the nurse 's desk. Was reported to the staff had reported th	Is she stated "yes" and the ormed. It 11:05 AM with the social was not aware of the "sident #1. The social was not been told by staff oved them. The method of sen nursing and the social en notes in her box or under iving report with the staff at worker further explained the atwo residents were getting at 11:15 AM with aide #7 ormed the social worker alling Resident #2 names. It is a the social worker alling Resident #2 names. It is a the social worker alling Resident #2 names. It is a the social worker in the social worker. "It is a the social worker in the social worker. It is a the social worker in the social worker. It is a the social worker in the	F.	323				
	unprovoked. She fu	rther explained nothing was residents (#1 and #2) were				*******		

PRINTED: 04/08/2014 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIERICHA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAYE SURVEY COMPLETED	
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F 323	not getting along, interview revealed what are the trigg staff can ' t watch social worker stat happened, " (Bet Interview with aid revealed she wor Resident #1 and participate in dive span was too she explained Reside about Resident # Interview on 3/4/* physician (the me aware of one resinvolving Resider was asked if the Assessment - Revisits and he stat reviewed as well, been informed at physician was as communicated to and he responde through the week between the nurs During the interview of any injuries for inclident. His expinction was asteroid to a pay injuries for inclident. His expinction was asteroid to a pay injuries for inclident and wou was informed on	it was unprovoked. Further d the social worker would spot ers for residents and explained every single second. The led she "was surprised at what ween Residents #2 and #1) e #1 on 3/4/14 at 12:00 PM ked on the second shift with #2. Resident #2 was not able to irsional activities; his attention ort. During the interview, aide #1 int #1 had made comments	F 323				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDEMIFICATION NUMBER:	1 '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 323	Interview on 3/5/14 worker revealed shame calling "by worker explained sor she would have communicating be worker included wher door and by rethe desk. The soc staff had reported along well. Interview on 3/5/14 revealed she had about Resident #1 She reported the inat the nurse 's dewas reported to the 2. Resident #2 was 11/20/13 with diag secondary to anowarrest, The transfer form had dementia, and wandering. Upon in the locked demidentified behavior on the FL2. Resident #2 was a memory impairmed Assessment Tool Resident #2 had	end both residents to the I at 11:05 AM with the social he was not aware of the " Resident #1. The social he had not been told by staff moved them. The method of tween nursing and the social ritten notes in her box or under ceiving report with the staff at ial worker further explained the the two residents were getting If at 11:15 AM with aide #7 informed the social worker calling Resident #2 names, information during a report time esk. Aide #7 stated again "It	F 3	23			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING		(X3) DATE SURVEY COMPLETED		
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F 323	F 323 Continued From page 8		F 323			
		able to recall most recent less wandering and could not e command.	i de la companya de l			
	addressed a problem physical (phys) aggr (AEB) recent resider involving hilling and cognitive impairmen included the resident would have reduced angry outbursts and prevent behaviors the approaches includent from public disruptive, talk with voice to decrease uprovide diversional in mood or behavior Additionaliy, an upd	sident #2 dated 12/31/13 n of "exhibits behaviors of ession as evidenced by at to resident altercations her resident - related to: i," The stated goals t would not strike others, he incidents of aggression and staff would recognize and lat provoke aggressiveness, uded document one as indicated, remove area when behavior is resident in a low pitch, calm hedesired behavior and activity and report any change to nurse immediately, ate was added for the same one on one sitter as needed to				
	quarterly, dated 1/7/ long term memory is symptoms of physic	num Data Set (MDS) a '14 revealed Resident #2 had mpairment, behavioral al symptoms directed toward with bed mobility, transfers, I halls and eating.				
		mitled to the facility on ses of dementia and 1 brain (umor).				
	antianxiety medical	esident #3 revealed an ion had been administered as becember 2013 and 8 tlmes in				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF PROVIDER OR SUPPLIER	** ***		STREET	ADDRESS, CITY, STATE, ZIP CODE	· + · · · · · · · · · · · · · ·	
SILER CITY CENTER				ÖLPHIN ST CITY, NO. 27344		
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10/17/13. Resident #3 medications. Review of Resident #2 12/27/13 at 3:30 PM in observed striking anoth arm with an open hand was not "nice" and y incident report was proincident in the nurse's An incident report date indicated Resident #2 wheelchair in the door #3 walked up to him arections of constantly reand "touching him." the other pt (patient) or roughly with his open fredirected by the aide. Review of Resident #2 Background Assessme communication and presymptome, signs and dated 12/27/13 indicated 12/27/13 indicated that indiffer on that date at written for Resident #2 physician of the secondicuded keeping the first the condition better, Recombative "and the remonitor pt (patient). Note the back of the form in in the facility, was made and discussed types of the secondicus and discussed types of the form in in the facility, was made and discussed types of the form in the facility, was made and discussed types of the form in the facility, was made and discussed types of the form in the facility, was made and discussed types of the form in the facility, was made and discussed types of the form in the facility, was made and discussed types of the facility.	ginal date of this order was was not on psychotropic 's nurse's notes dated dicated Resident #2 was ner resident (#3) on her to the resident #2 was told that we don't allow it. "No wided by the facility for this sonte. If 12/27/13 at 4:15 PM was sitting in his way to his room. Resident agitated him by her expeating "mame, mame" Resident #2 "touched in the forehead a little hand." Residents were 's "SBAR" (Situation ent Request form) for cogress note for new other changes in condition ed the physician was 4:15 PM. This SBAR was to the SBAR informed the dincident, This form we resident #2 was "becoming esident #2 was "becoming	F	323			

PRINTEO: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI,IA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ C R WING 345143 03/05/2014 STREET ACCRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 W DOLPHIN ST SILER CITY CENTER SILER CITY, NC 27344 (ČX) NOTBLYKOO STAO SUMMARY STATEMENT OF DEFICIENCIES Ю PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 | Continued From page 10 F 323 Review of Resident #2's nurse's notes dated 12/27/13 at 5:00 PM Indicated Resident#2 was observed "touching roughly" another resident (#3) in the face open handed when she went up to him. The nurse informed Resident #2 his hehavior was unacceptable and not allowed. Review of the Incident report dated 12/30/13 at. 4:45 PM revealed Resident #2 was in his room when Resident #3 entered his room. Resident #2 " pushed [Resident #3] onto the floor. " Resident #3 did not receive any injuries. The incident report indicated the physician was notified on that date. There were no entries made in the nurse 's notes for this incident. No SBAR was provided by the facility for this incident. Review of the incident report dated 12/31/13 at 4:20 PM revealed Resident #2 was sitting in a stationary chair in the hallway. He was approached by Resident #3 that "patted resident (#2) on arms, resident (#2) then punched (Resident #3) on forehead with resident 's flat. Due to cognition resident unable to tell staff why he hit [Resident #3], " This incident documented Resident #2 as " the aggressor. " Review of the SBAR for Resident #2 dated 12/31/13 at 5:00 PM revealed Resident #2 had punched female resident on forehead with fist. He had approached "same [Resident #3] each time." The assessment included "more confused," The nurse included documentation

of the incident on the back of the form. Resident #3 was "observed" to have "small bump on (L) left forehead, "No new orders were given. For "Request" the nurse checked the box for "lab work ...other tests" and to "monitor vital"

PRINTED: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DAYE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ Ċ 345143 B. WING _ 03/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE-900 W DOLPHIN ST SILER CITY CENTER SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION DAYE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) GROSS-REFERENCED TO THE APPROPRIATE TAG **YAĢ** DEFICIENCY) F 323 | Continued From page 11 F 323 signs and observe" for Resident #2. Review of the nurse 's notes for Resident #2 dated 12/31/13 at 10:00 PM revealed Resident #2 was on "One-on-one sitter @ (at) all times. No further behavior issues noted. The social worker's notes for Resident #2, dated 12/30/13 and 12/31/13, indicated she was made aware of incidents that occurred on 12/27/13 and 12/30/13. Staff was to monitor the resident's behavior (Resident #2) and the location of Resident #3. The care plan was updated with this approach. Review of the incident reported dated 1/5/14 at 6:30 PM indicated Resident #2 was seated in a straight back chair at the nurses' station. Resident #3 came up to his side and touched his chair. Resident #2 hit Resident #3 on the right side of the head with the back of his hand. No injuries were noted and Resident #2 was identified as the aggressor. There were no entries made in the nurse 's notes for this incident for Resident #2. Review of the SBAR dated 1/5/14 at 7:00 PM revealed the nurse practitioner was notified of the incident with no injuries. There were no new orders at that time. Review of the Minimum Data Set (MDS) dated 1/7/14 indicated Resident #3 had long and short memory problems, severely impaired decision making abilities, wandering behaviors and verbal/physical behaviors towards others. This MDS assessed the resident as being independent

with bed mobility, transfers and walking.

The care plan dated 2/21/14 for Resident #3

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
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F323	indicated behaviors of interventions that includent, provide diversident, provide diversident, provide diversident, provide diversident, provide diversident, provide diversident was con Worker on 3/3/14 at 4 indicated there were Resident #2. He cho of the time, A psychlogenested since his between the first time aggressive, such as a The administrative stomorning meetings. The replied the incident where abouts as sked to between the previous had with a resident, as the replied the incident worker would some residents and explain single second. She cas having patterns of were with just this on the triview with aide #1 revealed she worked Residents #2 and #3 working when Reside the face. At the time	f wandering with uded redirecting the useful activity and munitor ducted with the Social activity and munitor ducted with the Social worker no behaviors exhibited by se to stay in his room, most atric consult was not ehavior was that of ained she would do ne a resident was physically request a psych consult, aff talked about him in the there was one resident that it to most of the residents at #3) She expected the staff all staff was to observe the was pacing. She further daways know her the interview, the social explain the difference altercations Resident #2 and the incident on 2/2/14, and on 2/2/14 was interview revealed the spot what are the triggers for red staff can 't watch every fid not assess Resident #2 behaviors; the altercations	F 323			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

BTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CON A. BUILDING			e survey APLETED
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(X4) ID PREFIX TAG	IFACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST DE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REPERENCED TO THE DEFICIENCY	ON SKOULD BE HE APPROPRIATE	COMPLETION DATE
F 323	Resident #3 was re- activities. Resident in diversional activit short. Aida #1 repo- any interventions in from going into Res- Interview with eide- revealed she was w Resident #3 went in #2 explained what a a resident getting in chair. She further a these situations. D Resident #2 teilling went to Resident # get to them soon a altercation. After ti her own, left the ro of the incident and Resident #3 was in how she monitored explained every tin she checked on th Interview with aide revealed she had Resident #2. Aida behaviors or incide watching him 1:1, had behavior issue pushed Resident #	tervene before she was hit. directed and given diversional #2 was not able to participate ies; his attention span was too inted she did not remember place to prevent Resident #3 ident #2 's room. #2 on 3/4/14 at 12; 11 PM vorking on second shift when no Resident #2 's room. Alde agitated Resident #2 would be in his face or tapping on him/his explained he would hit you in juring her shift, she had heard a resident to "quit." She 12 's room, but was unable to mough to prevent the ne aftercation, Resident #3, on om. The nurse was informed she tried to monitor where located. Aide #2 was asked I Resident #3 and she ne she went by their rooms, em. #3 on 3/4/14 at 12;20 PM provided 1:1 supervision with #3 was not aware of what lents had occurred while She explained she was told ho les, and she had heard he had #3 down.	F 323			
	physician (the me- aware of one incident) #3. The physician	4 at 2:20 PM with the primary dical director) revealed he was dence between Resident #2 and a saw Resident #3 as the nily meeting was held with her		64. ID 024120	(Conthy with	chapt Page 14

04-08-14;11:37 ;From:Siler City Care and RehabTo:15054688058 ;9197424217

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER TY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 W DOLPHIN ST SILER CITY, NC 27344				
(X4) ID PREFIX TAG	(FACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST HE PRECEDED BY FULL IR LSG IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (CACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULDBE	(X5) COMPLETION DATE
F 323	responsible party, incidents between the interview he wareviewed on his vis would be reviewed practitioner had be incidents. The phy information was conurse practioner areach morning through the separating of t	He was not aware of all of the Resident #2 and #3. During is asked if the SBARs were its and he stated yes, the chart as well. The nurse en informed about some of the stein was asked how immunicated to him by the individual he responded they met ugh the week. The "on call" en the nurse practitioner and stations for the nursing staff in the residents, and he would rexa to be given to Resident in included, Resident #2 did it, calmed down after the not require medication. A ston was not ordered; due to the ted tho situation as Resident #2's space. The primary physician had by altercations earlier that day, called one, (incldent on 1/5/14), injuries. Further interview incldent did not seem to "be a and no further information to	F	323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 323	one-on-one sitters of physical behaviors with the AE Nursing) on 3/5/14 at #2 had one-on-one sfor second and third decided to end the one-on-one. Interview on 3/5/14 at administrator roveate #3 as the instigator in expect the staff to me her, but he didn't kn was safe at all times, asked what was donstated he was not the was in his space. The Administrator was Jeopardy on 3/3/14 at compliance was received at legation of conditions of the corrective Plan 1. Address how corrections at 15/14 at 4:38 PM. The Corrective Plan 1. Address how corrections of the correction of the correction occurred Room 515 in the facility and the facility of the facility and the fa	tration decided to stop the ue to no further aggressive were exhibited by Resident #2. DON (Assistant Director of the 4:00 PM revealed Resident sittlers started again on 1/5/14 shift. Nursing administration ne-on-one due to no further behaviors were noted during at 2:40 PM with the additional the facility saw Resident in the altercations. He would onlitor the resident, redirect now if they could assure she approblem, but Resident #3 and he approblem, but Resident #3 as notified of Immediate at 5:30 PM. The allegation of sived on 3/5/14 at 1:40 PM. Inpliance was accepted on of Action: The ective action will be use residents found to have deficient practice: 14, a resident-to-resident between two residents in dity's Special Care as 600 Hall, Following the	F 323			

PRINTED: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDERISUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING C 345143 B. WING 03/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ACCRESS, CITY, SYATE, ZIP CODE 900 W DOLPHIN ST SILER CITY CENTER SILER CITY, NC 27344 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG GROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 323 Continued From page 16 F 323 - Immediately following the discovery of the incident, Residents in Room 515-1 (Resident #2) and 515-2 (Resident #1) were assessed by the facility 's licensed nursing staff. The residents were immediately separated and one-on-one C.N.A. supervision for each resident was provided until both residents were transported to the local hospital. The resident is physicians. were notified and orders were given to transport both residents to the local hospital's emergency room. The responsible parties for each resident were notified as well as the facility 's Administrator, Director of Nurses and Assistant Director of Nurses. Under the coordination of the Administrator and Nursing Administration, an investigation of the incident was immediately initiated. A 24-Hour report was transmitted to the Division of Health Services Regulation, The two residents were both transported to the emergency room on 02/02/14. Resident #1 's known injuries included bilateral subdural hematoma, facial fractures and lacerations to the face. Resident #1 was hospitalized and then returned to the facility on 02/13/14. Resident #2 was arrested at the hospital and transported to the local Jall. As of this date, Resident #2, who was discharged from the facility, had not returned. The facility reviewed the incident, the resulting outcomes and interventions with the facility 's Medical Director via telephone 2/2/14, On February 2, 2014, a resident-to-resident altercation occurred between two residents in Room 515 in the facility 's Special Care

FORM CIAS-2567(02-99) Provious Vorsione Oben'été

following action:

Dementia Unit on the 500 Hall, Following the documented incident, the facility took the

1. Immediately following the discovery of the

Event ID: E18V11

Facility ID: 923120

If continuation shout Page 17 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 04/08/2014 MAPPROVED): 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/SLIA IDENTIFICATION NUMBER:	V BAILDING		(X3) DATE SURVEY COMPLETED	
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SILER CIT	Y CENTER		1	W DOLPHIN ST ER CITY, NC 27344		
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F 323	Continued From pag	e 17	F 323			!
	· ·	n Room 515-1 and 515-2	. 020			
		e facility 's licensed nursing	1			
		vere immediately separated				
		.A. supervision for each				1
		d until both residents were				
		cal hospital. The resident 's	-			
	physicians were notif	fied and orders were given to	}			
	transport both reside	nts to the local hospital 's				
		e responsible parties for				
		notified as well as the facility '				1
		ctor of Nurses and Assistant				1
	Director of Nurses, Under the coordination of the					
	Administrator and Nursing Administration, an					1
		reident was immediately				ļ
		eport was transmitted to the	<u> </u>			
		ervices Regulation. The two transported to the emergency				1
		ransportee te tae emergency Resident #1 's known injuries				
		odural hematoma, facial				
		ions to the face. Resident #1				
		I then returned to the facility				
		nt #2 was arrested at the				
		rted to the local jail, As of this				
		ho was discharged from the				
	facility, has not return					į
		the incident, the resulting				
		entions with the facility 's				
		telephone on 02/02/14.				
		e facility 's Special Care				
	*	interviewed on 02/02/14 to				
		ey had been subjected to any				
	abuse, All facility res	nent by the Assistant Director				
		N Supervisor, the MDS				
		Charge Nurses on 02/02/14				
		se and none were noted.				
		or all residents in the facility, lors, were reviewed on				İ

PRINTED: 04/08/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAYE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ Ċ 345143 B. WING 03/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 960 W DOLPHIN ST SILER CITY CENTER SILER CITY, NC 27344 (X4) IO SUMMARY STATEMENT OF DEFICIENCIES io Prefix PROVIDER'S PLAN OF CORRECTION (X5) COMPLET ON (BACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) YAG DATE TAG DEFICIENCY F 323 Continued From page 18 F 323 02/02/14 by the Director of Nurses, the Assistant Director of Nurses, the Day RN Supervisor and the MDS Coordinator. The Plans of Care and Resident Care Cards were updated as appropriate. On 02/02/14, facility staff were re-inserviced on resident abuse and dealing with behaviors by the Staff Development Coordinator and the Day RN Supervisor. Facility staff, who were unavailable on 02/02/14, were required to be re-inserviced prior to returning to work. Additionally, direct care nursing staff received education on the development of behavioral care plans and reporting observations that require Interventions to the Director of Nurses or the Assistant Director of Nurses, on 02/02/14. Education on resident abuse and dealing with behaviors is included as part of the orientation of newly hired facility staff by the Staff Development Coordinator, The facility's Director of Nurses, or the Assistant Director Nurses if unavailable, if not in the facility, will be contacted by telephone for any observed behaviors that require assessment and intervention. The interventions for behaviors are reviewed with the Director of Nurses or Assistant Director of Nurses as the behaviors occur, 7-days per week. All observed behaviors are reviewed by the facility 's InterDisciplinary Team with recommendations for action made as appropriate including modifications of the resident's Plan of Care, at the facility 's Clinical Morning Meeting 5-days per week. Behaviors observed on weekends will be reviewed by the InterDisciplinary Team, utilizing the facility's 24-Hour Report, nurses notes. physician orders if appropriate and the Plan of

Care, at the Clinical Morning Meeting on the next

CENTE	RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FÇ	EO: 04/08/201- RM APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSYRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C		
NAME OF C	345143		B. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I03/05/2014			
	TY CENTER		1	900 W DOLPHIN ST SILER CITY, NC 27344			
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F 323	Continued From page 19 business day. On 03/05/14, facility direct care staff were re-inserviced on identifying behaviors on the Behavior Monitoring Sheet, how to complete the Behavior Monitoring Sheet and the use of the INTERACT and Stop and Watch Tools as a communication tool from CNA's to licensed nurses by the Staff development Coordinator and the Day RN Supervisor, Facility direct care staff, who were unavailable on 03/05/14, were required to be re-inserviced prior to returning to work. Behavior Monitoring Sheet education is included in the orientation of all newly hired licensed nurses by the facility 's Staff development Coordinator. The Behavior Monitoring Sheets for all facility residents were audited to ensure that all behaviors were identified by the Director of Nurses, Assistant Director of Nurses, Day RN Supervisor and two charge licensed nurses on 03/05/14.		F 323				
					•• • • • •		
1 3 7 3 4 1 1 4 8 8 1 1 9	exhibiting behaviors on interdisciplinary Team a addition; Resident #3's and the 500 Hall direct is e-direction to activities. See Plan of Care was renterdisciplinary Team a addition; Monitor residenthan resident #3's Cane 500 Hall direct care.	On 12/31/14, Resident eviewed by the facility 's and made the following at closely and re-direct the resident 's personal are Card was updated and staff provided re-direction ed the personal space of lifty 's therrischlippy					

PRINTED: 04/08/2014

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES					ED: 04/08/2014 RM APPROVED	
		MEDICAID SERVICES				OMB N	IO. 0938-0391	
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NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
SILER CIT	TY CENTER			1	900 W DOLPHIN ST SILER GITY, NG 27944			
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PREFIX YAĞ	(GACH DEFIDIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG	IX (EACH CORRECTIVE ACTION SH		DBE	CONPLETION COMPLETION DATE	
F 323	Continued From page 20		F	323	,			
		medication review for			1			
	Resident #3 and the	medication review was						
	completed on 1/5/14. On 12/31/14, the facility's							
	Interdisciplinary Team requested a formal							
	meeting with Resident #3 's Responsible Party. A				•			
	meeting was held on 1/10/14 with the facility's		i		•			
	Interdisciplinary Team, the Assistant Director of Nurses, the facility's Administrator, Resident #3's				•		İ	
	attending obvision	the Responsible Party and]	
		s to discuss the results of the						
	medication review, physician recommendations				•			
	and family suggestions for late afternoon and							
	early evening activities and other interventions.							
	The Responsible Par	ty informed Resident #3 's						
	attending physician that she did not want any						-	
		ons and would prefer to take						
	obtained The Reson	adequate services could be insible Party offered no						
	suggestions for activi	Itles and interventions. The					1	
		ne Special Care Unit on the						
		ed starting on 03/04/14 by						
	the Director of Nurse	s and the Assistant Director						
	of Nurses to provide	for one CNA and one Activity						
	person to work split s	shifts, i.e. 10:00 a.m. to 6:00						
	p.m., to provide re-di	rection and intervention for						
		ne late afternoon, when she						
		on the Special Care Unit on exhibit more wandering	-		1			
	behavior.	PARISH HOLD WORLDING						
		Vi on 3/5/14, interviews were						
	conducted with staff members in nursing to						1	
		e, Interviews revealed staff			1			
		se in- services, were able to						
		procedures, use of the Stop to take if aggressive						
		ito take it aggressive ur. As of 5:15 PM the nurses						
	\	interviewed for compliance						
		te aldes on the locked unit						

04-08-14;11:37 ;From:Siler City Care and RehabTo:15054688058 ;9197424217

DEPART CENTER	MENT OF HEALTH A RS FOR MEDICARE 8	ND HUMAN SERVICES MEDICAID SERVICES					FORM	04/08/2014 APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345143	B, VANG		¢				
NAME OF P	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				03/0	5/2014	
SILER CIT	TY CENTER			1	W DOLPHIN ST ER CITY, NO. 27344				
(X4) ID Prefix Tag	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE REFIX (EACH CORRECTIVE ACTION SI- TAG CROSS-REFERENCED TO THE API DEFICIENCY)				(X9) COMPLETION DATE	
F 323	had received inservices. Information was reviewed that was used in the inservice training, the signature lists of all staff, chart audits completed by administrative nursing staff members on 2/2/14, and care plans for residents identified as having behaviors which required interventions. Other information reviewed consisted of the head to toes assessments performed on all residents, the Behavior Monitoring flow sheets and Target Behavior flow sheets to identify behaviors and document the interventions used for those bahaviors. The 24 hour report was reviewed for information given shift to shift regarding resident sheaviors. The QI tool to be used by the DON or ADON to monitor the behavior was reviewed.		F	323					
	revealed one of the the (Resident #4) was related an altercation that has care plans for these r	4, 5 and 7. Record review these the sampled residents moved from the facility after discoursed after 2/2/14. The residents had been updated, were identified and behaviors							