	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES					<u>D. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COMF	E SURVEY PLETED
		345175	B. WING				C / 06/2017
NAME OF PI	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SMITHFIE	LD MANOR NURSING A	ND REHAB			02 BERKSHIRE ROAD MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	F	000			
		encies cited as a result of gation of 10/06/2017 Event					
		ey was conducted from 06/17. Immediate Jeopardy					
	(J)	221 at a scope and severity 323 at a scope and severity					
	The tags F221 and F Quality of Care.	323 constituted Substandard					
	resident #167 and on	began on 06/27/17 for 10/02/17 for resident #19 10/06/17. An extended d.					
F 221 SS=J			F 2	221			10/28/17
	§483.10(e) Respect a	and Dignity.					
		ght to be treated with respect					
	and dignity, including §483.10(e)(1) The rig	ht to be free from any					
		restraints imposed for e or convenience, and not					
		esident's medical symptoms,					
	consistent with §483.12(a)(2).						
	42 CFR §483.12, 483	3.12(a)(2)					
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ē		TITLE		(X6) DATE
	cally Signed						10/24/2017

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/11/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345175	B. WING		C 10/06/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
SMITHEIE	LD MANOR NURSING A		9	02 BERKSHIRE ROAD	
			S	SMITHFIELD, NC 27577	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 221	Continued From page	o 1	F 221		
1 221			F 221		
		right to be free from abuse, ation of resident property,			
		efined in this subpart. This			
	includes but is not lin	•			
		involuntary seclusion and			
		ical restraint not required to			
	treat the resident's sy	•			
	(a) The facility must-				
	(1) Ensure that the re	esident is free from physical			
		s imposed for purposes of			
	discipline or convenie	ence and that are not			
	required to treat the r				
	symptoms. When the				
	· · · ·	must use the least restrictive			
		st amount of time and			
		e-evaluation of the need for			
	restraints.	L is not mot as ovidenced			
	by:	Γ is not met as evidenced			
		ons, record review and staff		The process leading to cited deficience	NV.
		/ utilized a device without		was: 1. Resident #167 was diagnosed	
		restraint and without a		a having cerebral infarction, dementia	
		2 of 4 residents (Resident		and cognitively impaired. He was	
	•••	19) when Resident #167 was		extensive assist with two person assis	
	-	h his legs between the side		required in bed mobility. He was noted	l to
		staff assistance to remove		be anxious and restless moving body/	•
	-	e rail and for Resident #19		across bed. Resident found with both	
		ith both legs between the		legs in between side rail on numerous	
		equired staff assistance to		occasions on 6/27/17.	
	remove her legs and	sustained a skin tear.		2. Resident # 19 was diagnosed has	tio
	Immediate leonardu	began on 6/27/2017 when		having functional quadriplegia, demen and depressive disorder. The resident	
		bserved by staff with his legs		was cognitively impaired. The resident	
		bars. Immediate Jeopardy		was assessed as being total care two	
		for Resident #19 both of the		person assist in bed mobility. She wa	
	-	between the side rail bars		found to have both legs between the	-
		sistance to remove. The		side-rail on 10/2/17. While repositioni	na

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CC	DNSTRUCTION		NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	, <i>i</i>) ´co	MPLETED
							С
		345175	B. WING		1	0/06/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
SMITHFIE	LD MANOR NURSING A	ND REHAB	902 BERKSHIRE ROAD				
	1			SMI	THFIELD, NC 27577		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 221	Continued From page	e 2	F 2	21			
	Immediate Jeopardy	was removed on 10/6/2017		r	resident to remove legs from side-rai	l by	
		ided a credible allegation of			C.N.A., a skin tear to the right lower l		
	compliance. The facil				was sustained.		
		er scope and severity level of			The plan of correcting the specific		
	-	th the potential for more than			deficiency included as follows: On	- 4	
	complete employee e	not immediate jeopardy) to			October 5th, 2017 the Assistant Direct of Nursing and Staff Development	Ctor	
		are in place that are effective.			Coordinator re-assessed Resident #	167	
					and #19 using the Side Rail Rational		
	Findings included:				Screen assessment tool. The side ra		
	-	ealed resident #167 was		\ \	were discontinued and removed by		
	admitted to the facility	-			Environmental Services for both Res	ident	
	-	uded Cerebral Infarction and			#167 and Resident #19 s beds.		
	Anxiety Disorder.				Resident #167 and Resident #19 s		
	Record review reveal	led the Care Plan initiated			plans were reviewed by the Resident Coordinator to ensure safety measur		
		problem of the risk for falls			and the level of assistance required f		
		ility and severely impaired			activities of daily living (emphasis on		
		ns included the bed in low			mobility and transfer) accurately refle		
		ift for transfers, mat at		t	the resident(s) status. There were no		
	-	sident verbal reminders not			changes made to the resident care p		
	to transfer without as	sistance.			since safety measures and fall preve		
	The last seven as here a				interventions were already in place a		
	-	vive (Admission) Minimum			remained applicable. There were also changes in the level of assistance ne		
		essment dated 8/2/2017			as documented in the residents plan		
		nt #167 was rarely/never			care. The side rails were removed or		
		rt and long term memory			10/5/17 and the care plan was update		
		everely impaired for daily			the same date.		
	decision making. The	MDS indicated the resident			The procedure for implementing the		
		total assistance of 1 to 2			acceptable plan of correction for the		
	1 .	ities of daily living (ADLs)			specific deficiency cited included as	hair	
		uired total assistance for impairment to upper or			follows: Based on the root cause ana findings, we determined a more	IIYSIS	
		had no impairment to upper			comprehensive side rail-screening		
		The MDS indicated physical			process was needed to assist the		
	restraints which inclu				interdisciplinary team in deciding whe	en	
		traints were not used for the			side rails would be utilized. This prod		
	resident.			F	helped to assure through assessmen	t tho	

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		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
						С
		345175	B. WING			/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 221	Continued From pag	e 3	F 22	1		
				purpose of the side rails so	that they did	
	The Care Area Asses	ssment (CAA) dated		not pose safety risks such	•	
		the Resident #167 was at a		for the resident(s). The pro		
		significantly and severely		to identify bed rails as phy		
		The CAA indicated falls and		particularly in cognitively in	•	
	cognition would trigg	er to the care plan.		residents as they were not		
				medical symptoms for thes		
		rsing notes revealed a note		residents. Individual interve		
		1:15 PM which reported the awake the entire shift, was		implemented based on the of the two residents. Staff		
		and was observed with his		re-educated on all shifts for		
		e rail bars frequently during		residents and for all existin		
	-	dicated the resident was		residents. Education include	-	
		us times. The note further		instruction from CMS's RAI	manual with	
	indicated the nurse v	vould request an order for		emphasis on section (P)Re	straints and	
	padded side rails. A	physicians order dated		Alarms and the definitions	of restraints as	
		ck side rail to be padded was		well as Bed Rails and facili		
	in the medical record	1.		"Proper Use of Side Rails."		
	Bocord roviow rovoa	led a Side Rail Rationale		monitoring procedure to en plan of correction is effective		
		dated 8/4/17 for Resident		specific deficiency cited rer		
	#167. The resident w			and/or in compliance with r		
		an alteration in safety		On October 6th, 2017, the	• •	
		gnition. The assessment		Compliance amended the		
		resident demonstrated		Proper Use of Side Rails to		
		sitting position, difficulty with		completion of the Side Rail		
		nk control, and was on		Screen upon admission, q	•	
		equired increased safety		annually and with significar	-	
	1 ·	sessment screen indicated		relates to the assurance of		
		d for positioning and back		on-going assessment of the		
	enabler which promo	licated for the resident as an		rails for resident #167 and all existing and future resid		
				Quality Assurance Coordin		
	An observation was	conducted of the Resident		complete Audits entitled "S		
		8:53 AM. The resident was		Rationale Screen Audit" we		
		ping. The head of the bed		month, monthly X 1 quarter	•	
		ately 35 degrees. A full side		thereafter as to ensure acc		
		side of the bed in a raised		completion of the "Side Ra	il Rationale	
		grey colored foam- like thin		Screen" upon admission, q		

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						NO. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	ATE SURVEY DMPLETED		
						С		
		345175	B. WING			10/06/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE			
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 221	Continued From page	e 4	F 22	1				
		ound the bar at the top of the		annually and with significa	nt change for			
		id the bottom rail. The		each resident. The Direct	-			
		as observed to be leaning		shall be responsible for im				
	against the right side	rail.		acceptable plan of correcti				
	An intonviow was con	ducted on 10/05/2017 at		completed no later than 10)/28/2017			
	11:53 AM with the Re							
	member. The family r	-						
		g the interview. The family						
		e visited the resident daily.						
		ly member indicated the						
		on the resident's bed upon ity. The family member						
		as usually very busy and						
		bed. The family member						
		t often put his feet, legs and						
		through the spaces in the						
	side rail. The family n							
		uises in the past which she from the rail. The family						
		esident did not use the rails						
		he family member stated the						
	-	re to keep him from falling						
	out of the bed. During	g the interview the resident						
		gs toward the rail and						
		e in the space between the						
		. The resident's family e right side of the bed and						
		e right side of the bed and eeded to be still. The family						
		nee out of the rail space.						
	An interview was con	ducted with Nurse #2 on						
		1. Nurse #2 was the nurse on						
		/27/2017 and verified she						
		rote the note on 6/27/2017.						
		worked with the Resident						
		k on the evening shift. Nurse						
	$\pm \pi$ renorted the recirc	ent is very agitated at times						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345175	B. WING				C /06/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
OMITUEIE				9	002 BERKSHIRE ROAD		
SIVILLE	LD MANOR NURSING AI	ND REMAD		S	SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	was capable of movin physically capable of the spaces between t Nurse #2 indicated th require frequent moni cognition impairment follow/understand dire indicated since there was not considered a An interview was com Assistant (NA) #2 on #2 indicated she work and was familiar with the resident would oft spaces in the side rail remove them. NA #2 position his right knee of the rail and she wo indicated usually whe in the space he would unable to shift in bed #2 indicated the resid impaired and was una An interview was com on 10/05/2017 at 3:11 indicated she comple Resident # 167 on 8/2 she assessed the rail and promoted indepe was severely cognitiv indicated the full rail v it was an enabler and positioning. MDS Nur	indicated since the resident ag his extremities, he was getting his limbs caught in he bars of the side rail. e resident continued to toring due to his severe and the inability to ections. Nurse #2 also was only 1 full side rail, it restraint. ducted with Nursing 10/5/2017 at 2:58 PM. NA ked with Resident #167 often his care. NA #2 indicated ten get his feet through the I and she would have to stated he would also e in the space on the bottom uld have to get it out. NA#2 In his right knee was caught d yell because he would be and that agitated him. NA ent was severely cognitively able to follow directions. ducted with MDS Nurse #3 I PM. MDS Nurse #3 ted the last assessment on 2/2017. MDS Nurse #3 said to be safe for the resident Indence, even though he ely impaired. MDS Nurse #3 vas not a restraint because the resident used it for se #3 further indicated the the MDS because it was	F	221			

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CENTER STATEMENT (S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		FORM OMB NO (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMP	LETED
		345175	B. WING		_	(10/	C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING AI	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	Director of Nursing (A PM. The ADON indica Resident #167 and re- resident would have r ADON indicated invest and the facility and th concluded the bruises hitting his limbs on the ADON stated he was and the resident would he was agitated. The was only 1 full rail on considered a restraint 2-Record review reveal diagnoses which includ Disorder and function Record review reveal Screen assessment of #19. The resident was non-ambulatory with a awareness due to cool screen indicated the re difficulty moving to a side and poor trur falls, and was on mediated the re get out of bed due to side rail was used for support. The assessment awhich promoted indep	ducted with the Assistant DON) on 10/5/2017 at 3:20 ated he was familiar with called instances when the new bruised areas. The stigations were conducted, e resident's family member a were from the resident e bars of the side rail. The familiar with the resident, d flail around in bed when ADON indicated since there the bed, it was not t. aled resident #19 was y on 12/11/2012 with uded Dementia, Anxiety al Quadriplegia. ed a Side Rail Rationale lated 7/11/2016 for Resident is assessed as an alteration in safety gnition. The assessment resident demonstrated sitting position, difficulty with hk control, had a history of lications which required autions. The assessment resident could not voluntarily physical limitations, and the positioning and back nent form indicated side nd served as an enabler pendence. The form further expressed a desire to have	F 22				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 12/11/2017 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345175	B. WING			_		C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING AN	ND REHAB			02 BERKSHIRE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	(Significant Change) I dated 12/15/2016 and MDS dated 7/14/2017 significantly cognitivel understood, and seve making. The MDS ind total assistance for all (ADLs), and restraints The Care Area Assess 12/15/2016 indicated falls and was significat impaired. The CAA in would trigger to the ca Record review reveals 7/17/2017 included pr due to no personal sa resident's confusion a significant compromis understanding. Interv low position, depende bedside, and make fre when resident in bed An Incident/Accident I reviewed and reveale by Nursing Assistant of both of her legs caugh The report indicated t tear to her right lower the resident's legs fro was initiated. The rep condition before the ir indicated no restraint	ed the last comprehensive Winimum Data Set (MDS) It the most recent quarterly Vindicated the resident was y impaired, rarely/never rely impaired for decision licated the resident required activities of daily living were not used. Sment (CAA) dated the resident was at a risk for antly and severely cognitively dicated falls and cognition are plan. ed the Care Plan updated roblems of the risk for falls fety recognition and, the and disorientation with we to functional abilities and ventions included the bed in ent lift for transfers, mat at equent positioning checks and noted with agitation. Report dated 10/2/2017 was d Resident #19 was found (NA) #5 at 9:40 PM with ht between the side rails. he resident sustained a skin leg when NA #5 removed m the rail, and treatment port listed the resident's ncident as confused and was in use. There was no edical record on 10/2/2017	F	221				

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/11/2017 RM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345175	B. WING			1	C 0/06/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING A	ND REHAB			902 BERKSHIRE ROAD		
					SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221	#19 revealed an order left lower leg skin teal order to pad the back An observation was m 10/5/2017 at 8:10 AM observed lying in a lo A full side rail was on raised position. There the side rail. The resid her left side facing the An interview was con 10/05/2017 at 3:03 Pl worked with Resident revealed the resident through the spaces in mattress and the rail NA indicated the resident the bed. The NA fut the resident's feet and spaces several times resident was agitated An interview was con on 10/05/2017 at 3:10 verified she complete	cian's orders for Resident r for daily treatment to the r dated 10/2/2017 and an side rail on 10/3/2017. In the resident was w bed with her eyes closed. the left side of the bed in a e were 3 horizontal bars on dent was observed lying on e full rail. ducted with NA #2 on M. NA #2 indicated she t #19 regularly. NA #2 would put her feet and legs the rail and between the when she was agitated. The dent would wiggle all around rther indicated she removed d legs from the side rail and would tell the nurse the ducted with MDS Nurse #1	F	221			
	#19. MDS Nurse #1 usually updated even why there was not an resident. MDS Nurse not know why she inc expressed a desire to because the resident expressing that desire	indicated the screens were y quarter and did not know updated screen for the #1 also indicated she did dicated the resident b have the side rails up was not capable of e, due to her significant MDS Nurse #1 further					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 12/11/2017 MAPPROVED O. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345175	B. WING			10	C)/06/2017
NAME OF PI	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING A	ND REHAB			902 BERKSHIRE ROAD SMITHFIELD, NC 27577		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 221	Continued From page	9	F	221	1		
		resident, but she did not					
	Director of Nursing (A PM. The ADON indica Incident/Accident Rep evaluate the need for ADON reported if the rails, the clinical team needed to be padded injury. The ADON sta each incident on an ir indicated since there bed, it was not consid An interview was con PM with NA #5. NA # Resident #19's room and found the residen with her legs criss- cri through the bottom ra #5 indicated the residen the resident was tryin not. The NA stated th of the left leg, so she and the resident's righ lower leg and caused she immediately notif the resident out of the bed. An interview was con 10/5/2017 at 4:15 PM	borts are reviewed daily to follow up actions. The re were issues with the bed a would indicate the rails to reduce further risk of ted the facility looked at individual basis. The ADON was only 1 full rail on the dered a restraint. ducted on 10/5/2017 at 4:07 5 stated she went into after dinner on 10/2/2017 in turned sideways in bed ossed and completely ill space on the bed rail. NA ent's legs were stuck and g to get them out but could e right leg was over the top pulled the right leg out first, in theel scraped over the left a skin tear. NA #5 stated ied the nurse after she got e rail and situated back in					
	evening of 10/2/2017 came to her during th resident's legs were i	y for Resident #19 on the . Nurse #4 revealed NA #5 e shift and reported the n the rail and when the NA dent sustained a skin tear.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			
		345175	B. WING				C 106/2017
NAME OF PI	ROVIDER OR SUPPLIER	I		;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SMITHFIE	LD MANOR NURSING AI	ND REHAB			902 BERKSHIRE ROAD		
					SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 221	Continued From page	e 10	F	221	1		
		ne immediately assessed the	•				
		ported the resident was in					
		d the room and was in no t was noted with a skin tear					
	to her left shin and tre	eatment was initiated. Nurse					
		lent did not have any other rse #4 stated she was					
	-	ot document the incident in					
	the nurse's notes but						
		ort. Nurse #4 indicated the any other issues during the					
	shift.	, ,					
	The Administer and th	ne Director of Nursing					
	(DON) were notified of	of the Immediate Jeopardy					
	on 10/5/2017 at 6:12	PM.					
	The facility provided a	a credible allegation of					
	-	2017. The Allegation of					
	Compliance indicated	1:					
		g the specific deficiency.					
	The plan should addr to the deficiency cited	ess the processes that lead					
		a 1					
	The process leading t	to cited deficiency was 1.					
	Resident #167 was di	iagnosed as having					
	impaired. He was exte	ementia and cognitively ensive assist with two					
		ed in bed mobility. He was					
		surveyor during the week of					
		observed with an uncoded rail in place with potential					
	risk for injury at time of	of observations. Resident					
		fused and unable to request					
	need or expressed de intended usage at that						

Facility ID: 923459

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345175	B. WING				C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING AI	ND REHAB			2 BERKSHIRE ROAD MITHFIELD, NC 27577		
(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 221	Continued From page	9 11	F 2	221			
	functional quadriplegi disorder. The residen The resident was ass two person assist in b during the week of 10 observed with an unce rail in place with the p of observations. Res confused and unable expressed desire for usage at that time. On October 5th, 2017 Nursing and Staff Dev re-assessed Residen "Side Rail Rationale S The side rails were di Environmental Servic and Resident #19's b Resident #167 and R were reviewed by the to ensure safety meas assistance required for (emphasis on bed mo accurately reflected th There were no chang care plans updated O safety measures and were already in place There were also no cl assistance needed as residents plan of care removed on 10/5/17	oded physical restraint/bed optential risk for injury at time ident #19 noted to be to request need or side rail or its intended The Assistant Director of velopment Coordinator t #167 and #19 using the Screen" assessment tool. scontinued and removed by es for both Resident #167 eds. esident #19's care plans Resident Care Coordinator sures and the level of or activities of daily living obility and transfer) ne resident(s) status. es made to the resident october 5th, 2017 since fall prevention interventions and remained applicable. hanges in the level of a documented in the a. The side rails were					
	"The procedure for im	plementing the acceptable					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345175	B. WING			C 10/06/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SMITHFIE	LD MANOR NURSING AI	ND REHAB			002 BERKSHIRE ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 221	Based on the root cau determined a more co rail-screening process interdisciplinary team would be utilized. Thi through assessment to so that they did not po- entrapment for the res- helped to identify bed particularly in cognitive they were not utilized for these two residents were implemented bat the two residents. St shifts for the two resident were implemented bat the two residents. St shifts for the two resident "The monitoring proce of correction is effectif deficiency cited remain compliance with the re- On October 6th, 2017 amended the policy effective Rails" to require comp Rationale Screen" up annually and with sign to the assurance of effort of the need for side ra- resident #19. "The title of the perso implementing the acc The Administrator st	the specific deficiency cited; use analysis findings, we omprehensive side is was needed to assist the in deciding when side rails is process helped to assure the purpose of the side rails ose safety risks such as sident(s). The process also rails as physical restraints, rely impaired residents as to treat medical symptoms is. Individual interventions used on the reassessment of aff were re-educated on all dents. edure to ensure that the plan ve and that specific ins corrected and/or in egulatory requirements; r, the Director of Compliance ntitled "Proper Use of Side obletion of the "Side Rail oon admission, quarterly, hificant change as it relates ffective ongoing assessment ails for resident #167 and n responsible for eptable plan of correction. hall be responsible for ve actions to include an	F	221			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345175	B. WING			C 10/06/2017			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
SMITHFIE	LD MANOR NURSING AI	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577					
(X4) ID PREFIX TAG			ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 221	compliance on 10/6/2 Allegation of Complia The Credible Allegatio 1-On 10/5/2017 Resid	a credible allegation of 017 at 6:48 PM. The nce indicated: on was verified by: dent #167 and Resident #19	F	221	1				
	 were reassessed by the ADON and the Staff Development Coordinator using the Side Rail Rationale Assessment Screens and the side rails were removed for both residents. Both residents were observed on 10/6/2017 at 8:01 AM in bed without side rails. 2-Documentation of the reassessments for every resident in the facility using the Side Rail Rationale Screen was reviewed by the survey team on 10/6/2017. The assessments were 								
	Side rails which were hazard were documen Observations of the re as not appropriate for	esidents who were assessed							
	was reviewed on 10/2 included the safe use as restraints when no	ricing was completed by the							
	the facility on 10/6/20	ucted with staff present in 17. The staff interviewed inservice regarding said entrapment.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF		
		345175	B. WING			10/06/2017		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SMITHFIE	LD MANOR NURSING AI	ND REHAB			02 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 272 F 272 SS=J	Continued From page COMPREHENSIVE A CFR(s): 483.20(b)(1) (b) Comprehensive A (1) Resident Assess must make a comprehensive assessment must incl (i) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication and (ii) Customary routin (iii) Cognitive pattern (iv) Communication and (iv) Cognitive pattern (iv) Communication and (iv) Communication and (vii) Psychological we (viii) Psychological we (viii) Physical fund problems. (ix) Continence. (x) Disease diagnos (xi) Dental and nutriti (xii) Skin Conditions. (xiii) Activity purs (xiv) Medications (xv) Special treatmen (xvi) Discharge physical (xvii) Documentat	e 14 ASSESSMENTS ssessments ment Instrument. A facility hensive assessment of a ngths, goals, life history and e resident assessment cified by CMS. The ude at least the following: demographic information le. is. demographic information le. is. ior patterns. ell-being. ctioning and structural is and health conditions. ional status. uit. ts and procedures. anning. ion of summary information	F:	272			10/28/17	
	on the care areas of the Minimum Data (xviii) Documentat assessment. The ass include direct	al assessment performed triggered by the completion Set (MDS). ion of participation in sessment process must and communication with						

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/11/2017 MAPPROVED D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 10/06/2017		
		345175						
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				902 BERKSHIRE ROAD				
SMITHFIE	LD MANOR NURSING A	ND REHAB		S	MITHFIELD, NC 27577			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENC			ON SHOULD BE COMPLETIC HE APPROPRIATE DATE		
F 272	Continued From page	e 15	F 2	272				
	the resident, as well a licensed and	as communication with						
	non-license on all shifts.	ed direct care staff members						
	observation and com	cess must include direct munication with the resident,						
	non-licensed direct ca shifts.	ation with licensed and are staff members on all 「 is not met as evidenced						
	by:	ns, record review and staff			The process leading to cited deficier	ю		
		failed to accurately assess			was: 1. Resident #167 was diagnose			
		rail as a physical restraint for			having cerebral infarction, dementia			
	2 of 4 residents (Resi #19).	ident #167 and Resident			cognitively impaired. He was extensiv assist with two person assist, require bed mobility. He had 14 day MDS			
		began on 6/27/2017 when bserved by staff with his legs			assessment completed by MDS staff member, dated 5-30-17 which failed			
		bars. Immediate Jeopardy			code resident with presence of physic			
	began on 10/2/2017 1	for Resident #19 both of the			restraints/bed rails. Resident also ha	d		
	•	between the side rail bars			side rail assessment screen complete	•		
	-	sistance to remove. The			MDS staff member, dated 8-4-17 whi			
		was removed on 10/6/2017 facility provided a credible			failed to accurately assess facility us of single full side rail. 2. Resident #	•		
		nce. The facility will remain			was diagnosed has having functional			
		a lower scope and severity			quadriplegia, dementia and depressiv			
	•	harm with the potential for			disorder. The resident was cognitivel			
		arm that is not immediate			impaired. The resident was assesse			
		e employee education to			being total care, two person assist in	bed		
		stems are in place that are			mobility. She had a quarterly MDS			
	effective.				assessment completed by MDS staff			
	Findings included:				member dated 7-14-17 which failed t accurately code resident with presen physical restraints/bed rails. Resider	ce of		
	1-Record review reve	ealed Resident #167 was			also had side rail assessment screen			
	admitted to the facility				completed by MDS staff member, da			
		uded Cerebral Infarction and			7-11-16 which failed to accurately as			

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		MEDICAID SERVICES			OMB NO. 0938	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	ſ
			A. BUILDING	3	С	
		345175	B. WING			. 7
	ROVIDER OR SUPPLIER	0-101110		STREET ADDRESS, CITY, STATE, ZI	R CODE	1
	KONDER OR SOLT EIER			902 BERKSHIRE ROAD	I CODE	
SMITHFIE	LD MANOR NURSING A	ND REHAB		SMITHFIELD, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMP TO THE APPROPRIATE DA	
F 272	Continued From page	e 16	F 27	2		
	Anxiety Disorder.		. 21	facility usage of single fu	Ill side rail and	
				residents ability to indica		
	Record review reveal	led Resident #167's Care		desire to have side rails	-	
	Plan initiated 4/25/20	•		The plan for correcting the		
	-	problem of the risk for falls		deficiency is as follows:		
		lity and severely impaired		2017 the Assistant Direc	5	
	•	ns included the bed in low		Staff Development Coor		
		ift for transfers, mat at sident verbal reminders not		re-assessed Resident # the Side Rail Rationale S	0	
	to transfer without as			assessment tool. The si		
				discontinued and remove		
	The last comprehens	ive (Admission) Minimum		Environmental Services	-	
	Data Set (MDS) date	d 4/28/2017 and the most		#167 and Resident #19	s beds.	
		ssment dated 8/2/2017		Resident #167 and #19		
	indicated Resident #1			assessment and Side Ra		
		t and long term memory		Screen were reviewed b	-	
		everely impaired for daily MDS indicated the resident		Coordinator to ensure ad resident assessment wit		
		total assistance of 1 to 2		section P of the MDS as	•	
		ities of daily living (ADLs),		review and utilization of		
	and had no impairme			assessment with empha		
		S indicated bed rails were not		#167 and resident #19		
	used for the resident.			to accurately assess for		
				physical restraints/bed ra	ails for these	
	The Care Area Asses			residents.		
		Resident #167 was at a risk ificantly and severely		The monitoring procedur the plan of correction is		
	-	The CAA indicated falls and		specific deficiency cited		
	cognition would trigge			and/or in compliance wit		
				requirements is as follow		
	Record review of nurs	sing notes revealed a note		shall have current MDS		
	dated 6/27/2017 at 1	1:15 PM which reported		"Side Rail Rational Scree		
		wake the entire shift, was		reviewed and/or revised		
	-	and was observed with his		Administration staff,(Zon		
	-	e rail bars frequently during		ascertain the need for re		
		dicated the resident was us times. The note further		All residents with discover rail modification or remo		
	-	ould request an order for		reported to environment		
	padded side rails. A p			correct application or rer		

Facility ID: 923459

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			0.00			NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		· · ·	OATE SURVEY
			A. BUILDIN	G		С
		345175	B. WING			10/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
				902 BERKSHIRE ROAD		
SMITHFIE	LD MANOR NURSING A	AND REHAB		SMITHFIELD, NC 27577		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 272	Continued From pag	ne 17	F 2	72		
	1.5	ck side rail to be padded was		corresponding bed rails.	Any existing hed	
	in the medical record	-		rails shall have the FDA "		
				System Dimensional and		
	Record review revea	aled a Side Rail Rationale		Guide to Reduce Entrapm		
	Screen assessment	dated 8/4/17 for Resident		use" completed by Environ	nmental	
	#167. The resident v			Services for those rails.		
		an alteration in safety		Additionally, the Nurse Co		
		ognition. The assessment		educate the Resident Car		
		resident demonstrated		and MDS staff nurses on t		
		i sitting position, difficulty with unk control, and was on		restraints and coding guid using the RAI Manual and		
		equired increased safety		Myths and Facts about Sid		
		sessment screen indicated		staff shall utilize education		
		ed for positioning and back		complete ongoing MDS as		
		dicated for the resident as an		Side Rail Rationale Scree		
	enabler which promo	oted independence.		Resident #167, #19, and a	all existing and	
				future residents so as to e		
		conducted of the Resident		accuracy of completed as		
		8:53 AM. The resident was		relates to regulatory requi		
		eping. The resident's right leg		The Staff Development Co		
		leaning against the right side colored foam- like thin		educate nursing staff as it		
		round the bar at the top of the		assessment and utilization restraint/bed rail application		
	rail, the center bar a	-		emphasis on the definition		
				and bed rails as well as po		
	An interview was co	nducted on 10/05/2017 at		"Proper Use of Side Rails	•	
	11:53 AM with Resid	lent #167's family member.		Assurance Coordinator sh	all complete	
		was in the resident's room		Audits entitled "Side Rail F		
		The family member indicated		Screen Audit" weekly X 1	· · ·	
		ent daily. The family member		X 1 quarter and quarterly		
		vas usually very busy and		ensure accurate completion		
		e bed. The family member		Rail Rationale Screen" up		
		nt often put his feet, legs and through the spaces in the		quarterly, annually and with change for each resident.		
		member stated the resident		Nursing shall be responsib		
		to position himself. The		implementing the accepta		
		the rail was probably there		correction and shall be co		
	-	ling out of the bed. During the		than 10/28/2017		
		nt started moving his legs				

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						D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· /	SURVEY PLETED
			A. BUILDING	J	с	
		345175	B. WING			
		340170		STREET ADDRESS, CITY, STATE, ZIP CODE	10/06/2017	
NAME OF P	ROVIDER OR SUPPLIER					
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577		
						1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 272	Continued From pag	e 18	F 27	72		
1 212			Γ 27			
		redged his right knee in the enter and lower bar. The				
	-	mber walked to the right side				
		he resident he needed to be				
		ber moved his knee out of				
	the rail space.					
	An interview was cor	nducted with Nurse #2 on				
	10/5/2017 at 2:46 PN	A. Nurse #2 was the nurse on				
		6/27/2017 and verified she				
		vrote the note on 6/27/2017.				
		worked with the Resident				
	-	ek on the evening shift. Nurse				
		lent is very agitated at times s in the air at times when he				
		indicated the right side rail				
		while the resident was in bed.				
	-	he was unsure of the exact				
		itilized for the resident, but				
		obably to keep him from				
		Nurse #2 indicated the				
	resident continued to	require frequent monitoring				
	due to his severe coo	gnition impairment and the				
	inability to follow/und	lerstand directions.				
	An interview was cor	aducted with Nursing				
		10/5/2017 at 2:58 PM. NA				
		ked with Resident #167 often				
		his care. NA #2 indicated				
		ften get his feet through the				
		il and she would have to				
		stated he would also				
		e in the space on the bottom				
		ould have to get it out. NA#2				
		en his right knee was caught				
		d yell because he would be				
		I and that agitated him. NA				
	#2 indicated the resid	dent was severely cognitively hable to follow directions.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345175	B. WING			C 10/06/2017			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
SMITHFIE	LD MANOR NURSING AI	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577					
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 272	Continued From page	9 19	F	272	2				
	on 10/05/2017 at 3:11 indicated she comple Resident # 167 on 8/2 she assessed the rail and promoted indepe was severely cognitiv indicated the full rail v it was used as an ena MDS Nurse #3 furthe coded on the MDS be or assessed as a rest An interview was con Director of Nursing (A PM. The ADON state resident, and the resid bed when he was agi on the bed as an ena	ted the last assessment on 2/2017. MDS Nurse #3 said to be safe for the resident ndence, even though he ely impaired. MDS Nurse #3 was not a restraint because abler and for positioning. r indicated the rail was not ecause it was not considered traint. ducted with the Assistant ADON) on 10/5/2017 at 3:20 d he was familiar with the dent would flail around in tated and the side rail was bler. The ADON indicated 1 full rail on the bed, it was							
	admitted to the facility diagnoses which inclu Disorder and function Record review reveal Screen assessment of #19. The resident was non-ambulatory with a	uded Dementia, Anxiety al Quadriplegia. ed a Side Rail Rationale lated 7/11/2016 for Resident s assessed as							
	screen indicated the r difficulty moving to a balance and poor trur falls, and was on med	resident demonstrated sitting position, difficulty with nk control, had a history of dications which required sautions. The assessment							

Facility ID: 923459

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	DATE SURVEY OMPLETED C 10/06/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SMITHFIELD MANOR NURSING AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 902 BERKSHIRE ROAD SMITHFIELD, NC 27577 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
SMITHFIELD MANOR NURSING AND REHAB 902 BERKSHIRE ROAD SMITHFIELD, NC 27577 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
SMITHFIELD MANOR NURSING AND REHAB SMITHFIELD, NC 27577 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY) DEFICIENCY)	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	(X5) COMPLETION DATE
F 272 Continued From page 20 F 272 screen indicated the resident could not voluntarily get out of bed due to physical limitations, and the side rail was used for positioning and back support. The assessment form indicated side rails were indicated and served as an enabler which promoted independence. The form further indicated the resident expressed a desire to have side rails used while in bed. Record review revealed the last comprehensive (Significant Change) Minimum Data Set (MDS) dated 12/15/2016 and the most recent quarterly MDS dated 71/4/2017 indicated the resident was significantly cognitively impaired, rarely/never understood, and severely impaired for decision making. The MDS indicated the resident required total assistance for all activities of daily living (ADLs), and restraints were not used. The Care Area Assessment (CAA) dated 12/15/2016 indicated the resident was at a risk for falls and was significantly and severely cognitively impaired. The CAA indicated falls and cognition would trigger to the care plan. Record review revealed the Care Plan updated 7/17/2017 included problems of the risk for falls due to no personal safety recognition with significant compromise to functional abilities and understanding. Interventions included the bed in low position, dependen	
Nursing Assistant (NA) #5 at 9:40 PM with both of her legs caught between the side rails. The report	
indicated the resident sustained a skin tear to her	

If continuation sheet Page 21 of 45

		MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		B NO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:		G	,	COMPLETED		
						С		
		345175	B. WING		_	10/06/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	E		
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 272	right lower leg when I resident's legs from th initiated. The report I before the incident as restraint was in use. the medical record or regarding the inciden A review of the physic order for daily treatment tear dated 10/2/2017 back side rail on 10/3 An observation was r 10/5/2017 at 8:10 AM observed lying in a lo A full side rail was on raised position. There the side rail. There we thin covering wrapped of the rail, the center resident was observe the full rail. An interview was con 10/05/2017 at 3:03 P	NA #5 removed the he rail, and treatment was listed the resident's condition is confused and indicated no There was no nursing note in the 10/2/2017 and no note t. cian's orders revealed an ent to the left lower leg skin and an order to pad the b/2017.	F 2	72				
	revealed the resident through the spaces ir mattress and the rail NA indicated the resid in the bed. The NA fu the resident's feet and	would put her feet and legs to the rail and between the when she was agitated. The dent would wiggle all around orther indicated she removed d legs from the side rail and would tell the nurse the						
	on 10/05/2017 at 3:10	ducted with MDS Nurse #1 0 PM. MDS Nurse #1 ed the Side Rail Rationale						

If continuation sheet Page 22 of 45

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/11/2017 RM APPROVED O. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	TE SURVEY IPLETED	
		345175	B. WING		10/06/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272	#19. MDS Nurse #1 usually updated ever why there was not an resident. MDS Nurse not know why she ind expressed a desire to because the resident expressing that desir decreased cognition. indicated the side rail independence for the consider the rail a sa #1 further indicated th definition of a restrain therefore was not ass An interview was com Director of Nursing (A PM. The ADON indic Incident/Accident Rej evaluate the need for ADON stated the fact on an individual basis there was only 1 full assessed as a restra An interview was com PM with NA #5. NA # Resident #19's room and found the residen with her legs criss- or through the bottom ra #5 indicated the reside the resident was tryin not. The NA stated th of the left leg, so she and the resident's rig	dated 7/11/2016 for Resident indicated the screens were y quarter and did not know updated screen for the #1 also indicated she did dicated the resident o have the side rails up was not capable of e, due to her significant MDS Nurse #1 further did not promote resident, but she did not fety hazard. The MDS Nurse he side rail did not meet the to for the resident so sessed as a restraint. ducted with the Assistant ADON) on 10/5/2017 at 3:20 ated the facility ports are reviewed daily to follow up actions. The lity looked at each incident s. The ADON indicated since rail on the bed, it was not	F 272				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		345175	B. WING			10/06/2017		
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1		
SMITHFIE	LD MANOR NURSING AI	ND REHAB			902 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG			ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		3E	(X5) COMPLETION DATE	
F 272	she immediately notif the resident out of the bed. An interview was con 10/5/2017 at 4:15 PM was the nurse on duty evening of 10/2/2017 came to her during th resident's legs were in got them out the resid Nurse #4 indicated sh resident. Nurse #4 rej bed when she entered distress. The resident to her left shin and tre #4 indicated the resid injuries observed. Nu unsure why she did n the nurse's notes but Incident/Accident repo- resident did not have shift. The Administer and th (DON) were notified of on 10/5/2017 at 6:12 The facility provided a compliance on 10/6/2 Allegation of Complia "The plan of correctin The plan should addr to the deficiency cited The process leading the Resident #167 was di	ied the nurse after she got e rail and situated back in ducted with Nurse #4 on I. Nurse #4 indicated she y for Resident #19 on the . Nurse #4 revealed NA #5 e shift and reported the n the rail and when the NA dent sustained a skin tear. he immediately assessed the ported the resident was in d the room and was in no t was noted with a skin tear eatment was initiated. Nurse lent did not have any other rse #4 stated she was ot document the incident in she did fill out an ort. Nurse #4 indicated the any other issues during the he Director of Nursing of the Immediate Jeopardy PM. a credible allegation of 2017 at 6:48 PM. The nce indicated: g the specific deficiency. ess the processes that lead d; to cited deficiency was 1.	F	272	2			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345175	B. WING				C / 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SMITHFIE	LD MANOR NURSING AI	ND REHAB			02 BERKSHIRE ROAD MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	impaired. He was exterperson assist, required day MDS assessment member, dated 5-30- resident with presence rails. Resident also he screen completed by 8-4-17 which failed to usage of single full sid was diagnosed has he quadriplegia, dementi The resident was cog resident was assesse person assist in bed re quarterly MDS assess staff member dated 7 accurately code resid physical restraints/be side rail assessment a staff member, dated 7 accurately assess face rail and residents abil desire to have side rai "The procedure for im- plan of correction for On October 5th, 2017 Nursing and Staff Dev re-assessed Resident "Side Rail Rationale S The side rails were di Environmental Servic and Resident #167 and #7 assessment and "Side were reviewed by Res	ensive assist with two ed in bed mobility. He had 14 t completed by MDS staff 17 which failed to code e of physical restraints/bed had side rail assessment MDS staff member, dated o accurately assess facility de rail. 2. Resident #19 aving functional ia and depressive disorder. Initively impaired. The ed as being total care, two mobility. She had a sment completed by MDS -14-17 which failed to ent with presence of d rails. Resident also had screen completed by MDS 7-11-16 which failed to cility usage of single full side ity to indicate expressed also while in bed. Inplementing the acceptable the specific deficiency cited; T the Assistant Director of velopment Coordinator t #167 and #19 using the Screen" assessment tool. scontinued and removed by es for both Resident #167 eds.	F	272			

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDI	ING .			С
		345175	B. WING				06/2017
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING AI	ND REHAB		9	902 BERKSHIRE ROAD		
					SMITHFIELD, NC 27577		
(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 E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 070		0.5					
F 272	Continued From page		F	272	2		
	This review and utilization	P of the MDS assessment. ation of the MDS					
	assessment with emp	bhasis on resident #167 and					
		helped to accurately assess					
	these residents.	cal restraints/bed rails for					
		edure to ensure that the plan					
	of correction is effective and that specific deficiency cited remains corrected and/or in						
	-	egulatory requirements					
		se Consultant educated the					
	on the definition of res	inator and MDS staff nurses straints and coding					
		using the RAI Manual and					
		and Facts about Side					
	Rails." MDS staff sha monitor and complete						
		de Rail Rationale Screen" of					
		19 so as to ensure continued					
	accuracy of complete to regulatory requiren	d assessments as it relates					
		nonto.					
	"The title of the perso implementing the acc	n responsible for eptable plan of correction.					
		nall be responsible for ve actions to include an					
	acceptable plan of o						
	The Credible Allegation	on was verified by:					
	1-On 10/5/2017 Resid	dent #167 and Resident #19					
	-	he ADON and the Staff					
	-	nator using the Side Rail nt Screens and the side rails					
	were removed for bot						

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
			A. DOILDING			С
		345175	B. WING		1	0/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	Continued From page	e 26	F 272			
	Both residents were of 8:01 AM in bed witho	observed on 10/6/2017 at ut side rails.				
	 2-Documentation of the reassessments for every resident in the facility using the Side Rail Rationale Screen was reviewed by the survey team on 10/6/2017. Side rails which were assessed as a safety hazard were documented as removed. Observations of the residents who were assessed as not appropriate for the side rails per the screening form were observed to have their side rails removed. 					
	was reviewed on 10/6	Side Rail Safety Inservicing 6/2017 and the inservicing ntrapment for residents with				
	MDS staff nurses was of restraints and codi	sident Care Coordinator and s reviewed on the definition ng guidelines for P0100 I and education tool "Myths				
F 280	the facility on 10/6/20 confirmed the recent safety/entrapment.	lucted with staff present in 17. The staff interviewed inservice regarding said rail	F 280			10/28/17
SS=D	CARE-REVISE CP	(i-ii,iv,v)(3),483.21(b)(2)				
		rticipate in the development of his or her person-centered				

Facility ID: 923459

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345175	B. WING				C 106/2017
NAME OF P	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING AI	ND REHAB			902 BERKSHIRE ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	BE IATE	(X5) COMPLETION DATE	
F 280	 plan of care, including (i) The right to participincluding the right to i be included in the plarequest meetings and revisions to the perso (ii) The right to participe expected goals and o amount, frequency, a other factors related the plan of care. (iv) The right to receivincluded in the plan of care. (iv) The right to see the right to sign after sign of care. (c)(3) The facility shall right to participate in head shall support the resident representative (ii) Facilitate the incluse resident representative (iii) Include an assess strengths and needs. (iii) Incorporate the resident representative 	g but not limited to: pate in the planning process, dentify individuals or roles to nning process, the right to I the right to request n-centered plan of care. pate in establishing the utcomes of care, the type, nd duration of care, and any o the effectiveness of the ve the services and/or items f care. e care plan, including the ificant changes to the plan Il inform the resident of the his or her treatment and dent in this right. The st sion of the resident and/or ve. ment of the resident's sident's personal and n developing goals of care.	F	280			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 APPROVED D: 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345175	B. WING				C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING AI	ND REHAB	902 BERKSHIRE ROAD SMITHFIELD, NC 27577				
		ATEMENT OF DEFICIENCIES		5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page 28		F:	280			
	(2) A comprehensive						
	(i) Developed within 7 the comprehensive as	' days after completion of ssessment.					
	(ii) Prepared by an inf includes but is not lim	terdisciplinary team, that ited to					
	(A) The attending phy	vsician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	and nutrition services staff.					
	the resident and the r	ticable, the participation of esident's representative(s). be included in a resident's					
		participation of the resident					
	and their resident rep not practicable for the	resentative is determined e development of the					
	resident's care plan.						
		staff or professionals in ined by the resident's needs e resident.					
	team after each assest comprehensive and q assessments.	vised by the interdisciplinary ssment, including both the uarterly review					
	by: Based on observatio interviews and record	n, resident, staff and family review, the facility failed to istant in the interdisciplinary			The Process leading to the cited deficiency was: Resident #45 which want to have diagnoses of hip fracture		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345175	B. WING				C 106/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHEIE	LD MANOR NURSING A			90	2 BERKSHIRE ROAD		
SMITTIL		REHAD		S	MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	F 280Continued From page 29 care team planning for one of two residents reviewed for care plan meetings (Resident #45). Findings included:A review of the medical record revealed Resident #45 was admitted 5/8/2017 with diagnoses of right hip fracture, acute pain, anxiety and dementia.The Quarterly Minimum Data Set (MDS) dated 10/4/2017 noted Resident #45 was cognitively intact and needed extensive assistance all Activities of Daily Living (ADLs).A review of care plan meeting sign in sheets revealed two care plan meetings were documented on 5/31/2017 and 8/31/2017, with no nursing assistant noted to be in attendance.		F	280	acute pain, anxiety and dementia had care plan conferences completed on dates 05/03/2017 and 08/31/2017. Theses meeting were noted by facility state surveyor on 10/04/2017 to not h included a nursing assistant directly related to resident #45's care in attendance. Nursing assistants interviewed by state surveyor on 10/05/2017 and 10/06/2017 were note not have been asked to participate in planning nor been part of the care planning team. The plan of correcting this deficiency be to update the care plan for resident #45 to include a nursing assistant direction involved for the care of resident #45. procedure for completing this plan sha be that the Resident Care Coordinato and/or her designee invited a nursing	eted on 2017. by facility to not have directly in tts on vere noted to sipate in care care ficiency shall resident stant directly ent #45. The plan shall	
	MDS co coordinator r plan meeting, and a r noted to be there. The she was not aware of On 10/5/2017 at 3:43 Assistant (NA) #1 sta asked to be part of ca In an interview on 10/ stated she had never planning team. On 10/6/2017 at 11:3 never been asked to team. In an interview on 10/	PM in an interview, Nursing ted she had never been are planning. 75/2017 at 3:55 PM, NA #2			assistant directly involved in the care resident #45 to a multidisciplinary car plan conference. The nursing assista attendance shall be recorded on the " Plan Conference sign in" form. The Resident Care Coordinator and MDS nurses shall receive education by the nurse consultant focusing on RAI Mar instruction and planning of resident ca to include concentration of inclusion of nursing assistants in the care planning conference. Nursing staff shall receive education by the Staff Development Coordinator as it relates to F 483.21(i A comprehensive care plan must be prepared by an interdisciplinary team includes a nurse aide with responsibil for the resident. The monitoring procedure to ensure that the plan of	for e int's 'Care staff nual are, of g ve i) (C) that	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/11/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345175	B. WING		C 10/06/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
SMITHFIE	LD MANOR NURSING AI	ND REHAB		02 BERKSHIRE ROAD SMITHFIELD, NC 27577	
(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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 280	team. On 10/6/2017 at 11:4 stated she had never team. An interview with the conducted on 10/6/20	0 AM, in an interview, NA #5 been part of a care planning Administrator was 017 at 12:10 PM. The his expectation was the NAs	F 280	correction is effective and that the spectific deficiency cited remains corrected and compliance with regulatory requirement shall be that the Quality Assurance Coordinator will conduct audits entitled "Nursing Assistant Care Plan involvem Audit." These audits shall be complet weekly X 1 month, monthly X 1 quarter and quarterly thereafter and should monitor for the involvement of nursing assistants which are directly related to resident care for whom care plans are being completed. This monitoring sha utilize the "Care Plan Conference Sign form and the "CNA Care Plan Input fo Resident Care Conference" form. The Director of Nursing shall be responsib for implementing the acceptable plan of correction and shall be completed no 1	d in hts d hent ed r, r, e h h n n" r e h l l h n" r e h l h
	from accident hazard (2) Each resident reco and assistance device (n) - Bed Rails. The f appropriate alternativ bed rail. If a bed or s must ensure correct in	SION/DEVICES (2)(n)(1)-(3) ure that - ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility	F 323		10/28/17

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		ND HUMAN SERVICES				FORM	D: 12/11/201 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345175	B. WING				C / 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				90	2 BERKSHIRE ROAD		
SMITHFIE	LD MANOR NURSING A	ND REHAB		S	MITHFIELD, NC 27577		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 31	F 3	23			
. 020				23			
	to the following eleme	ents.					
	(1) Assess the resident for risk of entrapment from bed rails prior to installation.						
	(2) Review the risks a the resident or reside informed consent price						
(3) Ensure that the bed's dimens appropriate for the resident's siz This REQUIREMENT is not me		sident's size and weight.					
	by: Based on observatio	ons, record review and staff			The process leading to cited deficience	ÿ	
	interviews, the facility	/ failed to identify a full side			was: 1. Resident #167 was diagnosed	as	
	rail as an accident ha	azard for 2 of 4 residents			a having cerebral infarction, dementia		
	(Resident #167 and F				and cognitively impaired. He was		
		bserved by staff with his legs			extensive assist with two person assis		
		he side rail bars and required			required in bed mobility. He was noted		
		move his legs from the side			be anxious and restless moving body/l	egs	
		to implement interventions			across bed. Resident found with both		
		opening again and for			legs in between side rail on numerous		
		as observed with both legs he side rail bars which			occasions on 6/27/17. 2. Resident # 19 was diagnosed has		
		nce to remove her legs and			having functional quadriplegia, demen	tia	
	-	while staff removed her legs			and depressive disorder. The resident		
		ent interventions to prevent it			was cognitively impaired. The residen		
	from happening again	n.			was assessed as being total care two	_	
	Immodiate leanardy	bagan on 6/27/2017 when			person assist in bed mobility. She was	5	
		began on 6/27/2017 when bserved by staff with his legs			found to have both legs between the side-rail on 10/2/17. While repositionir	na	
		bars. Immediate Jeopardy			resident to remove legs from side-rail l		
		for Resident #19 both of the			C.N.A., a skin tear to the right lower le	-	
		between the side rail bars			was sustained.	3	
		sistance to remove. The			The plan of correcting the specific		
		was removed on 10/6/2017			deficiency included as follows: On		
		facility provided a credible			October 5th, 2017 the Assistant Direct	or	
		nce. The facility will remain			of Nursing and Staff Development		
	out of compliance at	a lower scope and severity			Coordinator re-assessed Resident #16	67	

Facility ID: 923459

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		MEDICAID SERVICES				0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SU COMPLE	
			A. BUILDING	G	с	
		345175	B. WING			6/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		0/2017
				902 BERKSHIRE ROAD		
SMITHFIE	LD MANOR NURSING A	ND REHAB		SMITHFIELD, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	TO THE APPROPRIATE	COMPLETIO DATE
F 323	Continued From page	e 32	F 32	23		
	level of D (no actual l	harm with the potential for		and #19 using the Side	Rail Rationale	
		arm that is not immediate		Screen assessment tool	. The side rails	
		e employee education to		were discontinued and r	-	
		stems are in place that are		Environmental Services		
	effective.			#167 and Resident #19		
	Findingo included:			Resident #167 and Resi		
	Findings included:	ealed resident #167 was		plans were reviewed by Coordinator to ensure sa		
	admitted to the facility			and the level of assistan	-	
	-	uded Cerebral Infarction and		activities of daily living (-	
	Anxiety Disorder.			mobility and transfer) ac	-	
				the resident(s) status. T	here were no	
		ed the Care Plan initiated on		changes made to the re-	sident care plans	
		problem of the risk for falls		since safety measures a	-	
	-	lity and severely impaired		interventions were alrea		
	•	ns included the bed in low		remained applicable. Th		
		ift for transfers, mat at sident verbal reminders not		changes in the level of a as documented in the re		
	to transfer without as			care. The side rails were		
				10/5/17 and the care pla		
	The last comprehens	ive (Admission) Minimum		the same date.		
	-	d 4/28/2017 and the most		The procedure for imple	menting the	
		ssment dated 8/2/2017		acceptable plan of corre		
		nt #167 was rarely/never		specific deficiency cited		
		t and long term memory		follows: Based on the ro	-	
		everely impaired for daily		findings, we determined		
	•	MDS indicated the resident		comprehensive side rail	0	
		total assistance of 1 to 2 ities of daily living (ADLs)		process was needed to interdisciplinary team in		
		uired total assistance for		side rails would be utilize		
		impairment to upper or		helped to assure through	•	
		ne MDS indicated bed rails		purpose of the side rails		
	were not used for the	resident.		not pose safety risks su	-	
				for the resident(s). The		
	The Care Area Asses			to identify bed rails as p	-	
		Resident #167 was at a risk		particularly in cognitively		
	for falls and was sign			residents as they were r		
		The CAA indicated falls and		medical symptoms for th		
	cognition would trigge	er to the care plan.		residents. Individual inte	erventions were	

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(V2) D	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	· · ·	DMPLETED
			A. BUILDING	J		С
		345175	B. WING			10/06/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		10/00/2017
				902 BERKSHIRE ROAD		
SMITHFIE	LD MANOR NURSING A	ND REHAB		SMITHFIELD, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	D THE APPROPRIATE	COMPLETIC
F 323	Continued From page	e 33	F 32	23		
		sing notes revealed a note		implemented based on th	e reassessment	
		1:15 PM which reported		of the two residents. Stat		
		wake the entire shift, was		re-educated on all shifts f	or these two	
		and was observed with his		residents and for all exist	ing and future	
	legs between the side	e rail bars frequently during		residents. Education incl	uded direct	
	the shift. The note inc	dicated the resident was		instruction from CMS's R	AI manual with	
	repositioned numerou	us times. The note further		emphasis on section (P)F	Restraints and	
	indicated the nurse w	ould request an order for		Alarms and the definitions	s of restraints as	
	padded side rails. A p	physicians order dated		well as Bed Rails and fac	ility policy	
	6/28/2017 for the bac	k side rail to be padded was		"Proper Use of Side Rails	s." The	
	in the medical record			monitoring procedure to e	ensure that the	
				plan of correction is effect	tive and that the	
	Record review reveal	ed a Side Rail Rationale		specific deficiency cited r	emains corrected	
	Screen assessment c	dated 8/4/17 for Resident		and/or in compliance with		
	#167. The resident w			On October 6th, 2017, the		
	non-ambulatory with			Compliance amended the		
		gnition. The assessment		Proper Use of Side Rails	•	
		resident demonstrated		completion of the Side Ra		
		sitting position, difficulty with		Screen upon admission,		
		nk control, and was on		annually and with signific		
		quired increased safety		relates to the assurance of		
	-	essment screen indicated		on-going assessment of t		
		for positioning and back		rails for resident #167 and		
		icated for the resident as an		all existing and future res		
	enabler which promot	tea independence.		Quality Assurance Coord		
	An abaam atian	and used of Desident #407		complete Audits entitled "		
		conducted of Resident #167		Rationale Screen Audit" v	•	
	on 10/05/2017 8:53 A			month, monthly X 1 quart	· ·	
		ping. The head of the bed ately 35 degrees. A full side		thereafter as to ensure ac		
				completion of the "Side R Screen" upon admission,		
		ide of the bed in a raised 3 horizontal bars on the side		annually and with signific		
		ch space between the		each resident. Any existi	-	
		ar and the top bar of the rail		be evaluated by environm	-	
		space between the center		using the FDA "Hospital E		
		on the side rail. There was		Dimensional and Assessr	•	
		e thin covering wrapped		Reduce Entrapment for B		
		top of the rail, the center bar		Any existing bed rails dee	-	
		The foam padding did not		that pose safety or entrap		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	E SURVEY PLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING			C
		345175	B. WING		10	0/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
SMITHFIE	LD MANOR NURSING A	ND REHAB		902 BERKSHIRE ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 323	Continued From page	e 34	F 32	3		
	Continued From page 34 lessen the amount of space between the horizontal bars on the side rail. The Resident #167's resident's right leg was observed to be leaning against the right side rail.			be disposed of immediately. of Nursing shall be responsit implementing the acceptable correction and shall be comp than 10/28/2017	ole for e plan of	
	11:53 AM with Reside Resident #167's fami resident's room durin member indicated sh and was with Reside admitted to the facilit #167's family member rail was on the reside the facility. The family was usually very bus	nducted on 10/05/2017 at ent #167's family member. ily member was in the ng the interview. The family ne visited the resident daily nt #167 when he was by from the hospital. Resident er indicated the right full side ent's bed upon admission to y member stated the resident by and moved around in the mber indicated the resident				
	through the spaces in member indicated Re bruises in the past w were from the rail. Th the staff put the cove weeks ago to help wi	is and sometimes his arms in the side rail. The family esident #167 had some hich she and the staff felt the family member reported ering on the rail bars a few ith the rail being so hard if he g didn't make the space y smaller. The family				
	member stated the re to position himself. T stated the rail was pr from falling out of the the resident started r rail and wedged his r between the center a family member walke and told the resident	esident did not use the rails the family member further robably there to keep him be bed. During the interview moving his legs toward the right knee in the space and lower bar. The resident's ed to the right side of the bed he needed to be still. The ed his knee out of the rail				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _			C	
		345175	B. WING			10/	06/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SMITHFIE	LD MANOR NURSING AI	ND REHAB			002 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 323	10/5/2017 at 2:46 PM duty the evening of 6/ was the nurse who with Nurse #2 stated she with five days a week on the reported the resident will flail his limbs in the agitated. Nurse #2 into order for his side rail to the possibility of injury padding the bars on to for entrapment. Nurse resident was capable he was physically cap caught in the spaces rail. Nurse #2 indicate require frequent monit cognition impairment follow/understand dire An interview was con- #2 on 10/5/2017 at 2: worked with Resident with his care. NA #2 in often get his feet thro- rail and she would has stated he would also space on the bottom of have to get it out. NA his right knee was can yell because he would and that agitated him resident was severely was unable to follow of An interview was com- on 10/05/2017 at 3:11 indicated she complet	 Nurse #2 was the nurse on 27/2017 and verified she rote the note on 6/27/2017. worked with Resident #167 he evening shift. Nurse #2 is very agitated at times and e air at times when he is dicated she requested an to be padded to assist with y. Nurse #2 indicated he rail did not lessen the risk e #2 indicated since the of moving his extremities, bable of getting his limbs between the bars of the side ad the resident continued to toring due to his severe and the inability to ections. ducted with Nurse Aide (NA) 58 PM. NA #2 indicated she #167 often and was familiar indicated the resident would ugh the spaces in the side ve to remove them. NA #2 position his right knee in the of the rail and she would #2 indicated usually when ught in the space he would do be unable to shift in bed . NA #2 indicated the resident and directions. ducted with MDS Nurse #3 	F	323				

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		MEDICAID SERVICES				O. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345175 NAME OF PROVIDER OR SUPPLIER			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 10/06/2017		
		B. WING		10			
			STREET ADDRESS, CITY, STATE, ZIP COD				
SMITHFIELD MANOR NURSING AND REHAB				902 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page	e 36	F 32	3			
	the right side rail was upon his admission to	on Resident #167's bed					
	-	be safe for the resident and					
	promoted independent severely cognitively in	nce, even though he was mpaired.					
	An interview was conducted with the Assistant Director of Nursing (ADON) on 10/5/2017 at 3:20 PM. The ADON indicated he was familiar with Resident #167 and recalled instances when the resident would have new bruised areas. The ADON indicated investigations were conducted, and the facility and the resident's family member concluded the bruises were from the resident hitting his limbs on the bars of the side rail. The ADON stated he was familiar with the resident, and the resident would flail around in bed when he was agitated. The ADON reported if there were issues with the bed rails, the clinical team would indicate the rails needed to be padded to reduce further risk of injury and the rails would be covered on the day the decision was made. The ADON indicated when the rails were padded, a thin foam-like covering was placed on the horizontal bars of the side rails. The ADON further indicated when the bed rails were padded, a the spaces between the bars of the rails were not affected. The ADON stated the facility looked at each incident on an individual basis.						
	admitted to the facility	y on 12/11/2012 with uded Dementia, Anxiety					
		led a Side Rail Rationale dated 7/11/2016 for Resident					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		345175	B. WING			C 10/06/2017		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
SMITHFIE	LD MANOR NURSING A	ND REHAB			002 BERKSHIRE ROAD			
	1			S	SMITHFIELD, NC 27577		1	
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	PROVIDER OR SUPPLIER ELD MANOR NURSING AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	323				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345175 NAME OF PROVIDER OR SUPPLIER SMITHFIELD MANOR NURSING AND REHAB			. ,	PLE CONSTRUCTION G STREET ADDRESS, CITY, ST 902 BERKSHIRE ROAD	0 (x) 	PRINTED: 12/11/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 10/06/2017 , ZIP CODE		
				SMITHFIELD, NC 27577	7			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE	
F 323	when resident in bed An Incident/Accident I reviewed and reveale by Nurse Aide (NA) # her legs caught betwee indicated the resident right lower leg when N resident's legs from th initiated. The report lib before the incident as restraint was in use. The medical record on regarding the incident A review of the physic order for daily treatment tear dated 10/2/2017 back side rail on 10/3. An observation was in 10/5/2017 at 8:10 AM observed lying in a low A full side rail was on raised position. There the side rail. There was the center bar and the same amount of space and the lower bar on f colored foam-like thin the bar at the top of th the amount of space I on the side rail. The re on her left side facing An interview was cond	equent positioning checks and noted with agitation. Report dated 10/2/2017 was d Resident #19 was found 5 at 9:40 PM with both of een the side rails. The report sustained a skin tear to her NA #5 removed the he rail, and treatment was isted the resident's condition of confused and indicated no There was no nursing note in a 10/2/2017 and no note t. cian's orders revealed an ent to the left lower leg skin and an order to pad the /2017. nade of Resident #19 on . The resident was w bed with her eyes closed. the left side of the bed in a e were 3 horizontal bars on as a 4 inch space between e top bar of the rail and be between the center bar the side rail. There was grey covering wrapped around he rail, the center bar and bam padding did not lessen between the horizontal bars esident was observed lying the full rail.	F 3	23				

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			0.00			O. 0938-039			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345175 NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	E SURVEY IPLETED			
			A. BUILDING			С			
		B. WING		10	0/06/2017				
			STREET ADDRESS, CITY, STATE, ZIP COL		5/00/2017				
SMITHFIELD MANOR NURSING AND REHAB				902 BERKSHIRE ROAD					
SMITHFIE	LD MANOR NURSING A	ND REHAB		SMITHFIELD, NC 27577					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE			
F 323	Continued From page	e 39	F 32	23					
	worked with Resident	t #19 regularly. NA #2							
		would put her feet and legs							
		n the rail and between the							
		when she was agitated. The							
		dent would wiggle all around							
		In the removed							
		d legs from the side rail and would tell the nurse the							
	resident was agitated								
	An interview was con	ducted with MDS Nurse #1							
	on 10/05/2017 at 3:10	0 PM. MDS Nurse #1							
		ed the Side Rail Rationale							
		dated 7/11/2016 for Resident							
		indicated the screens were							
		y quarter and did not know							
	•	updated screen for the #1 also indicated she did							
	not know why she inc								
		b have the side rails up							
	because the resident								
		e, due to her significant							
		MDS Nurse #1 further							
	indicated the side rail	l did not promote							
		resident, but she did not							
	consider the rail a sar	fety hazard.							
		ducted with the Assistant							
		ADON) on 10/5/2017 at 3:20							
	PM. The ADON indic								
		ports were reviewed daily to							
		follow up actions. The							
		re were issues with the bed n would indicate the rails							
		I to reduce further risk of							
		licated when the rails were							
		like covering was placed on							
		the side rails and Resident							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
345175		B. WING				。 06/2017	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE		
SMITHFIELD MANOR NURSING AND REHAB				902 BERKSHIRE ROAD SMITHFIELD, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	the spaces between t affected. The ADON s each incident on an in PM with NA #5. NA #8 Resident #19's room a and found the resident with her legs criss-cro through the bottom ra #5 indicated the resid the resident was trying not. The NA stated the of the left leg, so she and the resident's righ lower leg and caused she immediately notifit the resident out of the bed. An interview was com 10/5/2017 at 4:15 PM was the nurse on duty evening of 10/2/2017. came to her during the resident's legs were in got them out the resident Nurse #4 indicated she resident. Nurse #4 rep bed when she entered distress. The resident to her left shin and tre #4 indicated the resid injuries observed. Nur unsure why she did not the nurse's notes but Incident/Accident report	the bed rails were padded, the bars of the rails were not stated the facility looked at advividual basis. ducted on 10/5/2017 at 4:07 5 stated she went into after dinner on 10/2/2017 thurned sideways in bed assed and completely il space on the bed rail. NA ent's legs were stuck and g to get them out but could e right leg was over the top pulled the right leg out first, theel scraped over the left a skin tear. NA #5 stated ed the nurse after she got e rail and situated back in ducted with Nurse #4 on . Nurse #4 indicated she v for Resident #19 on the Nurse #4 revealed NA #5 e shift and reported the n the rail and when the NA lent sustained a skin tear. the immediately assessed the ported the resident was in d the room and was in no was noted with a skin tear thatment was initiated. Nurse ent did not have any other rse #4 stated she was ot document the incident in she did fill out an port. Nurse #4 indicated the	F 32	23			
	the nurse's notes but Incident/Accident repo	she did fill out an					

Facility ID: 923459

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345175		B. WING			C 10/06/2017			
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	1		
SMITHFIELD MANOR NURSING AND REHAB					902 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From page shift.	2 41	F	323	3			
	The Administer and th (DON) were notified of on 10/5/2017 at 6:12	of the Immediate Jeopardy						
	The facility provided a compliance on 10/6/2 Allegation of Complia							
		the specific deficiency. The he processes that lead to						
	Resident #167 was di cerebral infarction, de impaired. He was exte person assist required noted to be anxious a	ementia and cognitively ensive assist with two d in bed mobility. He was and restless moving						
	legs in between side on 6-27-17. 2. Resident # 19 was functional quadriplegi	. Resident found with both rail on numerous occasions diagnosed has having a, dementia and depressive						
	The resident was ass two person assist in b to have both legs betw							
	legs from side rail by right lower leg was su							
	Nursing and Staff Dev re-assessed Residen "Side Rail Rationale S	' the Assistant Director of velopment Coordinator t #167 and #19 using the Screen" assessment tool. scontinued and removed by						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
345175			B. WING			10/06/2017		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
SMITHFIE	LD MANOR NURSING AI	ND REHAB			902 BERKSHIRE ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 323	Environmental Servic and Resident #19's by Resident #167 and Re were reviewed by the to ensure safety meas assistance required for (emphasis on bed mo accurately reflected th were no changes mad since safety measure interventions were all applicable. There wer level of assistance ne residents' plan of care removed on 10/5/17 a updated on the same "The procedure for im plan of correction for Based on the root cau determined a more co rail-screening process interdisciplinary team would be utilized. The through assessment of so that they did not po entrapment for the res- interventions were im reassessment of the to re-educated on all shi residents. "The monitoring process of correction is effection deficiency cited remained	es for both Resident #167 eds. esident #19's care plans Resident Care Coordinator sures and the level of or activities of daily living obility and transfer) he resident(s) status. There de to the resident care plans s and fall prevention ready in place and remained re also no changes in the eeded as documented in the e. The side rails were and the care plan was date. use analysis findings, we omprehensive side s was needed to assist the in deciding when side rails e process helped to assure the purpose of the side rails ose safety risks such as sident(s). Individual plemented based on the two residents. Staff were ifts for the two identified	F	323	3			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
0.15475		345175	B. WING			С	
		545175	D. WING	_		10/	06/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIE	LD MANOR NURSING A	ND REHAB			902 BERKSHIRE ROAD		
					SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	On 10/6/17 the FI Dimensional and Asse Entrapment" for bed r Environmental Servic The Social Worker no and responsible party "The title of the perso implementing the acc The Administrator sh implementing all abov acceptable plan of co The Credible Allegatio 1-On 10/5/2017 Resid were reassessed by t Development Coordin Rationale Assessmen were removed for bot Both residents were of 8:01 AM in bed withou 2-Documentation of th resident in the facility Rationale Screen was team on 10/6/2017. Side rails which were hazard were documen Observations of the re as not appropriate for screening form were of rails removed. 3-Documentation of S was reviewed on 10/6 included the risk of er unsafe side rails. Interviews were condit the facility on 10/6/20	DA "Hospital Bed System essment Guide to Reduce rail use was completed by es for these two residents. otified the facility residents // family as to this process. n responsible for eptable plan of correction. hall be responsible for /e actions to include an rrection. on was verified by: dent #167 and Resident #19 he ADON and the Staff hator using the Side Rail ht Screens and the side rails h residents. observed on 10/6/2017 at ut side rails. he reassessments for every using the Side Rail as reviewed by the survey assessed as a safety nted as removed. esidents who were assessed	F	32:	3		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/11/2017 APPROVED D: 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345175 B. WING					C 06/2017			
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SMITHFIE	LD MANOR NURSING A	ND REHAB			2 BERKSHIRE ROAD MITHFIELD, NC 27577			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR			D PROVIDER'S PLAN OF CORRECTION (C) FIX (EACH CORRECTIVE ACTION SHOULD BE COMP G CROSS-REFERENCED TO THE APPROPRIATE D. DEFICIENCY)				
F 323	Continued From page safety/entrapment.	2 44	F	323				

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