STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	06/14/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		7/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/04/2018

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to change soiled linen for 1 of 1 resident reviewed for a clean and homelike room (Resident #6). The findings included: On 06/11/18 at 3:12 PM the blanket on top of Resident #6's bed was observed with brown colored smears approximately 2 inches wide and 3 inches long. The smears were located on the right top edge of the blanket at the foot of the resident's bed and were visible from the hallway. On 06/12/18 at 8:07 AM Resident #6's bed was observed unmade. The same brown colored smears were observed in the same location on the resident's blanket. At 1:32 PM on 06/12/18 the resident's made bed was observed with the same brown colored smears in the same location on the resident's blanket. The smears were visible from the hallway. An interview with Nursing Assistant (NA) #2 on 06/12/18 at 2:07 PM revealed she made Resident #6's bed today. NA #2 explained she did notice the brown colored smears on the blanket but thought they were stains that were sometimes found on facility blankets. The NA added she did not change the blanket when she made Resident #6's bed today. An interview with the Director of Nursing (DON)	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Plan for correcting the specific deficiency/process that led to the deficiency cited: The blanket remained folded at the foot of the bed the entire time in question. The NA-1 was aware of the linen changing routine (on bath day and whenever soiled) but thought the blanket was stained, not dirty. As soon as staff was made aware by the surveyor that it was dirty, it was removed and replaced with a clean blanket. Nurse managers immediately did a routine check of beds and no other dirty linen was found. Procedure for implementing the acceptable plan of correction: The linen changing policy was reviewed with nursing staff and they were reminded to carefully check linens routinely to ensure soiled linens are removed promptly. Housekeeping/laundry staff were asked to check and remove stained linen prior to folding and placing them in	

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F 584	Continued From page 2 on 06/12/18 at 2:15 PM revealed she expected NAs to change the blankets on residents' beds if they appeared soiled.	F 584	the linen closets. Monitoring Procedure the ensure that the plan of correction is effective and remains corrected: Spot checks will be completed by the Staff Development RN on a weekly basis for 4 weeks, then on a monthly basis for 3 months, and will continue quarterly until the QAPI Committee deems the issue to be resolved and staff are consistently providing residents with clean linens. Title of the Person Responsible for implementing the plan of correction: As stated above, the Staff Development RN is responsible for implementation and completion of the acceptable plan of correction and the QAPI Committee will oversee this implementation to ensure the facility remains in compliance.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow instructions regarding not to crush an extended relief medication for 1 of 7 residents observed receiving medications (Resident #67). The findings included:	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or	7/12/18

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F 760	Continued From page 3 Resident #67 was admitted to the facility 03/06/14 with diagnoses which included mood disorder. A review of Resident #67's medical record revealed a physician's order dated 11/29/17 for Depakote sprinkles (used to treat mood disorder) 125 milligrams (mg) 2 capsules in the morning and at bedtime and 1 125 mg capsule at 2 PM. On 06/13/18 at 8:36 AM, Nurse #3 was observed preparing medications for Resident #67. Medications which included aspirin, baclofen, Lexapro, metoprolol, Zantac, and Senna were placed in a medication cup. Two capsules of Depakote were opened and the contents (small individual sprinkles) were emptied into the cup. All these medications were placed in a pouch. The nurse was observed placing the pouch in a pill crusher and crushing all the medications together. The contents of the pouch were placed in a medication cup with applesauce. During an interview at this time, Nurse #3 stated this was the way she always administered Resident #67's Depakote. Nurse #3 noted the order for the administration of Depakote on the electronic medication administration record also contained the instructions Do Not Crush. Nurse #3 explained she thought that meant not to crush the capsules. Nurse #3 was observed administering the medications as she had prepared them. An interview was conducted via phone with the facility's Pharmacy Consultant (PC) on 06/13/18 at 10:11 AM. The PC explained the Depakote sprinkles were coated so that they were released in the body at different times providing extended coverage. She added crushing the sprinkles would make all the Depakote medication act at once instead of being extended over a period of	F 760	will be corrected by the date indicated. Plan for correcting deficiency/processes that lead to the deficiency as cited: The nurse was immediately re-educated on the proper procedure with Depakote Sprinkles. The resident's physician was immediately notified of this error. Resident's Depakote levels have been stable for many months. Resident has not had a change in Depakote dosage since 2015. Procedure for Implementing the acceptable Plan of Correction: The nurse was immediately re-educated on the proper procedure with Depakote Sprinkles. Licensed Nursing staff were reminded of what can and can't be crushed and reminded to check the DO NOT CRUSH lists posted on each cart. Monitoring Procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and in compliance with regulatory requirements: The nurse who made the error will be shadowed on multiple med passes over the next 3 months by the Staff Development nurse and these will be documented. The pharmacy consultant will also observe medication administration practices during her monthly visits over the next 3 months to ensure compliance with proper medication	

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F 760	Continued From page 4 time. The PC stated she had reviewed Depakote blood levels that were obtained 11/30/17, 03/01/18, and 06/11/18. She added all the levels were within normal limits. The PC further stated the physician should be notified in case changes in the dosage needed to be made. An interview was conducted with the Psych Physician Assistant (PPA) on 06/13/18 at 1:03 PM. The PPA stated she was unaware of Resident #67's Depakote being crushed. She stated due to the sprinkles being coated so the medication was released throughout the day could make a difference in the effectiveness of the Depakote. The PPA did not think any harm was done to the resident at this time but the resident should be monitored. An interview was conducted with the Director of Nursing (DON) on 06/13/18 at 4:30 PM. The DON stated she would be sure the physician was notified of the medication error and the nurse was reeducated. The DON added extended release medications should never be crushed.	F 760	administration procedures. The QAPI Committee will monitor the results and decide when they feel the deficient practice has been resolved and proper administration techniques are consistently followed and whether quarterly reviews need to continue. The title of the person responsible for implementing the plan of correction: As stated above, the Staff Development RN will be responsible for implementing the plan of correction. The QAPI Committee will monitor the results and decide when they feel the deficiency cited has been resolved and proper administration techniques are consistently followed and whether quarterly reviews need to continue.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		7/12/18

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F 812	Continued From page 5 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to clean 1 of 1 kitchen ice machines used to provide ice for residents. The findings included: During the initial tour of the kitchen on 06/11/18 beginning at 8:25 AM, an observation of the ice machine located in the kitchen revealed a pink tinged substance located on the white plastic seal under the ice machine lid. The pink tinged substance was observed to be easily removed by the Director of Operations (DO) with a paper towel. Record review of the 2018 Dietary Services Ice Machine log indicated the ice machine is cleaned monthly with the most recent cleaning on 05/17/17. The log further revealed a deep clean occurs quarterly which included internal cleaning and sanitizing of the ice machine along with a filter change with the most recent cleaning on 03/12/18. During a joint interview with the DO and the Dietary Manager (DM) on 06/14/18 at 10:42 AM, the DO stated the kitchen area was very humid and it had almost been a month since the cleaning had been completed on the ice machine.	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that the alleged deficiency cited has been or will be corrected by the dates indicated. Plan for correcting the specific deficiency/process that led to deficiency cited: These observations were made during the initial kitchen tour on June 11, 2018 and were discussed with the Director of Operations and the Dietary Manager with the contract food management company that morning. The Director of Operations immediately cleaned and wiped the pink tinged substance from the ice machine by using a paper towel, and it was easily removed. Procedure for Implementing the	

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F 812	Continued From page 6 The DO stated the ice machine probably needed to be cleaned every 2 weeks instead of monthly because of the humidity. During an interview with the Administrator on 06/14/18 at 6:40 PM, she stated her expectations were for the ice machine to be cleaned routinely.	F 812	acceptable Plan of Correction: An in-service on Sanitation and Proper Ice Machine cleaning was conducted for all dietary staff by the Director of Operations of the contract food management company. Topic covered included procedure for cleaning the ice machine every 2 weeks instead of monthly because of the humidity. An auditing tool was put into place to monitor compliance of this policy. Monitoring Procedure to ensure the Plan of Correction is effective and the deficiency cited remains corrected/in compliance with regulatory requirements: The Director of Dining and Nutrition Services or their designee will monitor the sanitary practices of the kitchen to include proper cleaning of the ice machine and adherence to department procedures using the Dietary QA Audit Tool. This will be done 2 times per month for 3 months, then monthly thereafter. Reports will be presented to the QAPI Committee to ensure corrective action initiated is appropriate and sufficient to correct the deficiency. Compliance will be monitored and ongoing auditing program reviewed by the QAPI Committee. The Title of the Person Responsible for Implementing the Plan of Correction: The Director of Dining and Nutrition Services will implement the plan of correction with oversight by the QAPI	

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F 812	Continued From page 7	F 812	Committee who ensure continued regulatory compliance. The QAPI Committee will determine if this solution has resolved the deficiency as cited.	