PRINTED: 10/25/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
				С			
345175			B. WING _	· · · · · · · · · · · · · · · · · · ·	09/28/2023		
NAME OF PROVIDER OR SUPPLIER SMITHFIELD MANOR NURSING AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
E 000	Initial Comments		E 00	00			
F 000	investigation survey through 09/28/23. The compliance with the	certification and complaint was conducted on 9/25/23 ne facility was found in requirement CFR 483.73, dness. Event ID #GAIL11.	F 00	00			
	survey was conducte 09/28/23. Event ID# intakes were investig	complaint investigation ed from 9/25/23 through GAIL11. The following gated NC00194813, 201062, NC00201651, and					
F 698 SS=D	,		F 69	98	10/20/23		
	require dialysis receivith professional state comprehensive persiste residents' goals at This REQUIREMENT by: Based on record revisives system in place to method before and after dialysthere was ongoing count of the collaboration before and collaboration before significant collaboration before and statement of the collaboration before and collaboration before significant collaboration before significant collaboration before significant collaboration before comprehensive persistence of the collaboration significant collaboration before comprehensive persistence of the collaboration significant collaboration s	T is not met as evidenced view and facility staff and ws the facility failed to have a onitor for complications ysis treatments and to ensure ommunication, coordination, tween the nursing home and 1 of 1 residents reviewed for		Resident # 46 shall have the "Hemodialysis Communication" form initiated in order to install a system to monitor for complications before and a dialysis treatments as well as ensure ongoing communication, coordination collaboration between Smithfield Man- and the dialysis center. This form sha completed by the unit nurse before an after each dialysis visit.	and or all be		
ADODATODY	DIRECTOR'S OR BROVINER	SUPPLIER REPRESENTATIVE'S SIGNATUR	 >E	TITLE	(X6) DATE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/12/2023 **Electronically Signed**

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
				С			
		345175	B. WING _		0	9/28/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	•		
				902 BERKSHIRE ROAD			
SMITHFIE	LD MANOR NURSIN	G AND REHAB		SMITHFIELD, NC 27577			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE	
F 698	Continued From p	page 1	F 69	98			
	Resident #46 was	admitted into the facility on		All other current and future d	lialveis		
		eadmission on 8/21/2023 that		residents shall also have the	-		
		diagnosis: coronary artery		"Hemodialysis Communication			
	_	e renal disease requiring		initiated in order to install a s			
	hemodialysis.	o remai and dado requiring		monitor for complications be	-		
				dialysis treatments as well as			
	Resident #46's gu	arterly Minimum Data Set dated		ongoing communication, cod			
		Resident #46 was moderately		collaboration between Smith			
	cognitively impaire	ed and received dialysis.		and the dialysis center. This	form shall be		
		·		completed by the unit nurse			
	Resident #46's co	mprehensive care plan dated		after each dialysis visit.			
	4/29/2021 include	d the problem of resident					
	required dialysis f	or renal disease. Dialysis on		Education shall be complete	d by the Staff		
	Monday/Wedneso	day/Friday, a goal of no		Development Coordinator to	all current		
		ited to hemodialysis.		and future nursing staff throu			
		locument dialysis shunt site		in-servicing and new employ			
		g, monitor for peripheral edema		orientation. Education shall			
		notify Medical Doctor of		not be limited to, monitoring			
		, no blood pressure or blood		complications before and aft	-		
		m due to dialysis shunt		treatments and ongoing com			
	·	to assess shunt site for		coordination and collaboration			
		d thrill daily and as needed, and		Smithfield Manor and the dia			
	ordered.	ation to and from dialysis as		through completion of the "H Communication" form.	emodialysis		
	ordered.			Communication form.			
	A review of the ph	ysician orders date 9/2023		Audits entitled "Hemodialysis	3		
	included an order	for hemodialysis on Monday,		Communication Form Audit"	shall be		
	Wednesday and F	Friday, staff to check thrill/bruit		completed by the Quality Ass	surance		
	every shift. (A thri	ll is a vibration felt over the		Coordinator in order to ascer	rtain		
		l a bruit is a swishing sound		compliance with completion			
		oscope when placed on the		ensure monitoring, communi			
		shunt is a surgically created		coordination and collaboration			
		en vein and artery. It allows		Smithfield Manor and the dia	•		
	direct access to th	ne bloodstream for dialysis.)		These audits shall be comple			
				1 month, monthly X 1 quarte			
		conducted on 9/27/2023 with		quarterly thereafter. These a			
		AM who stated that she was		also be included in the quart			
	। not aware of any ।	protocol for assessments		Assurance Committee meeti	ngs and		

Facility ID: 923459

OLIVIER	O T OTT MEDIO, THE G	WEDIO/ ND CEITHICE				<u> </u>	7. 0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(0
		345175	B. WING			l	28/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				90	02 BERKSHIRE ROAD		
SMITHFIE	LD MANOR NURSING A	ND REHAB		s	MITHFIELD, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 698	Continued From page	<u> </u>	F	698			
		e pre and post dialysis	'	030	begin the next meeting scheduled		
		ated that prior to leaving for			October 17th, 2023.		
		residents return vital signs			October 17 til, 2020.		
		nursing assistant. She					
	_	as no system in place for					
		alysis site for bleeding,					
	ensuring a dressing v	vas in place, thrill/bruit were					
	present or cognition p	oost dialysis. She further					
	revealed that prior to						
	system in place for assessment of the dialysis						
	shunt, current weight, incidents or acute problems						
	since the last dialysis treatment, order or						
		or any laboratory tests to be					
	drawn at the dialysis						
	_	was an order to check and bruit every shift however					
		orrespond to pre and post					
		nd could be checked at any					
	_	Nurse #1 was asked what					
		communication, coordination,					
	· ·	petween the facility and the					
		vealed that there was no					
	routine communication	on, coordination, and/or					
	collaboration between	n the facility and the dialysis					
		at there was no written					
		rbal communication between					
		is clinic unless there was an					
		ed that Resident #46 had					
		Monday, Wednesdays, and					
	-	verified that there was no					
		assessments pre and post Resident #46 nor was there					
	-	cation with the dialysis clinic.					
		ealed that she did not know					
		n forms that were sent with					
	-	#1 had not called report to					
		ior to Resident #46 leaving					
		the dialysis center, nor had					
		nmunication from the dialysis					

	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345175	B. WING _				C 28/2023	
NAME OF PROVIDER OR SUPPLIER SMITHFIELD MANOR NURSING AND REHAB			902	BERKSHIRE ROAD	1 00	20/2020	
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
An interview Nursing 11:30 AM who was carevealed that she had what to look for when returns from dialysis. something had chang nurses would let the law who stated that the communication taken dialysis facility. She fid dialysis facility would issues, if they did not facility then the assur was fine. Nurse #2 sreport given to the diaresident leaving the mindicated that the nur for checking dialysis is in place for an assesse either pre or post dial. An interview with the at 12:17 PM indicated communication form would do so. She furt facility called the nursissues with the dialys that there was no connursing facility and the 9/27/2023 at 1:00 PM.	Assistant #1 on 9/27/2023 at aring for Resident #46 di received no training on Resident #46 goes to or She further stated that if ged with Resident #46 the Nursing Assistants know. Ewed on 9/27/2023 at 11:55 here were no written forms of to or received from the arther revealed that the call and notify them of any hear from the dialysis mption was that everything tated that there was no oral alysis facility prior to the nursing facility. Nurse #2 sing staff was responsible patients thrill/bruit every tated that there is no system sment of dialysis patients ysis treatments. Dialysis Staff on 9/27/2023 di that if a facility wanted a filled out the dialysis facility her stated that the dialysis sing facility if there were any is session but other than munication between the e dialysis center. Director of Nursing on I indicated that there was no	F	598				
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR IS CONTINUED FROM PAGE CENTER UNITS OF THE PAGE CENTER	TORRECTION IDENTIFICATION NUMBER: 345175 ROVIDER OR SUPPLIER LD MANOR NURSING AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	A BUILDII 345175 B. WING ROVIDER OR SUPPLIER LD MANOR NURSING AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 center unless there was an issue. An interview Nursing Assistant #1 on 9/27/2023 at 11:30 AM who was caring for Resident #46 revealed that she had received no training on what to look for when Resident #46 goes to or returns from dialysis. She further stated that if something had changed with Resident #46 the nurses would let the Nursing Assistants know. Nurse #2 was interviewed on 9/27/2023 at 11:55 AM who stated that there were no written forms of communication taken to or received from the dialysis facility. She further revealed that the dialysis facility would call and notify them of any issues, if they did not hear from the dialysis facility then the assumption was that everything was fine. Nurse #2 stated that there was no oral report given to the dialysis facility. Nurse #2 indicated that the nursing facility. Nurse #2 indicated that the nursing staff was responsible for checking dialysis patients thrill/bruit every shift. Nurse #2 also stated that there is no system in place for an assessment of dialysis patients either pre or post dialysis treatments. An interview with the Dialysis Staff on 9/27/2023 at 12:17 PM indicated that if a facility wanted a communication form filled out the dialysis facility would do so. She further stated that the dialysis facility would do so. She further stated that the dialysis facility would do so. She further stated that there were any issues with the dialysis session but other than that there was no communication between the nursing facility and the dialysis center. An interview with the Director of Nursing on 9/27/2023 at 1:00 PM indicated that there was no communication between the nursing facility and	A BUILDING 345175 B. WING STR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 center unless there was an issue. An interview Nursing Assistant #1 on 9/27/2023 at 11:30 AM who was caring for Resident #46 revealed that she had received no training on what to look for when Resident #46 goes to or returns from dialysis. She further stated that if something had changed with Resident #46 the nurses would let the Nursing Assistants know. 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She further revaled that the dialysis facility would call and notify them of any issues, if they did not hear from the dialysis facility would call and notify them of any issues, if they did not hear from the dialysis facility to be to the dialysis facility prior to the essemption was that everything was fine. Nurse #2 stated that there was no oral report given to the dialysis facility prior to the resident leaving the nursing staff was responsible for checking dialysis patients thrill/bruit every shift. Nurse #2 also stated that there is no system in place for an assessment of dialysis patients either pre or post dialysis treatments. An interview with the Dialysis Staff on 9/27/2023 at 12:17 PM indicated that if a facility wanted a communication form filled out the dialysis facility would do so. 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		345175	B. WING			C		
NAME OF PE	ROVIDER OR SUPPLIER	343173		STREET ADDRESS, CITY, STATE, ZIP COD		9/28/2023		
				902 BERKSHIRE ROAD				
SMITHFIE	LD MANOR NURSING A	AND REHAB		SMITHFIELD, NC 27577				
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F 698	that the nursing facil communication with the dialysis residents remember nor a pro- complete pre and po- acknowledged there check the thrill/bruit times that it did not of	eatment. He further revealed ity had never had any type of the dialysis facility for any of s as far back as he could	F 69	98				
	that vital signs were assistants pre and p system of pre and po between the nursing center would ensure reduce hospital read	taken by the nursing ost dialysis. He stated that a ost dialysis communication facility and the dialysis that the continuity of care,						
	expected there to be any changes in the risigns and/or change communicated to the dialysis session and communication back regarding the amount vital signs, and any regarding the reside treatment when the stated that the dialys of medication change anything else pertine further stated that the aware of any contreatment, new order removed during treatolerated the treatment of the stated that the saware of t	AM revealed that she communication regarding resident's conditions, vital s in orders to be edialysis facility prior to a for the facility to receive a from the dialysis facility and of fluid removed, weights, bother pertinent information						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
345175 B. WI			B. WING _			C 09/28/2023		
NAME OF PROVIDER OR SUPPLIER SMITHFIELD MANOR NURSING AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COD 902 BERKSHIRE ROAD SMITHFIELD, NC 27577)E	03/20	<i></i>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ORRECTION N SHOULD BE E APPROPRIA	(X5) COMPLETION DATE			
F 698	, ,	e 5 Irsing facility and the dialysis	F 6	98				