	-	ND HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		E SURVEY PLETED
		345175	B. WING _	B. WING			C / 19/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	10/2024
				9	02 BERKSHIRE ROAD		
SMITHFIE	LD MANOR NURSING A	ND REHAB		S	SMITHFIELD, NC 27577		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS	3	F	000			
		ation survey was conducted					
		4/19/24. The following					
	intakes were investig NC00215827 and NC						
		C00216049 resulted in					
	immediate jeopardy.						
	3 of the 6 complaint a deficiency.	allegations resulted in					
	denciency.						
	Immediate Jeopardy	was identified at:					
	CFR 483.12 at tag F((J)	600 at a scope and severity					
	CFR 483.25 at tag F6 (J)	689 at a scope and severity					
	The tags F600 and F Quality of Care.	689 constituted Substandard					
	removed on 4/19/24.	began on 3/04/24 and was A partial extended survey					
F 600	was conducted. Free from Abuse and	Neglect	F	600			5/9/24
SS=J	CFR(s): 483.12(a)(1)			000			5/5/24
	§483.12 Freedom fro Exploitation	om Abuse, Neglect, and					
		right to be free from abuse,					
		ation of resident property,					
	-	efined in this subpart. This					
	includes but is not lin						
		, involuntary seclusion and nical restraint not required to					
	treat the resident's m	-					
	§483.12(a) The facili	ty must-					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	 E		TITLE		(X6) DATE
	cally Signed	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					05/07/2024

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.

		ID HUMAN SERVICES MEDICAID SERVICES	-		FORM AF OMB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345175	B. WING		C 04/19/2	2024
NAME OF PF	ROVIDER OR SUPPLIER	·	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		9	02 BERKSHIRE ROAD			
SMITHFIEI	SMITHFIELD MANOR NURSING AND REHAB		5	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETIO DATE
F 600	Continued From page	91	F 600			
	physical abuse, corpo involuntary seclusion This REQUIREMENT by: Based on observatio interviews with staff, I Examiner and Physic protect a resident's rig for 1 of 3 sampled res (Resident #1). On 3/4 #1 disregarded Resid and plan of care for th person assistance wit (ADL) care and provide without assistance. In resident positioned of at waist height and the washcloth. Resident is face down on the tile transferred to the em Computerized Tomog closed fracture of the the thigh bone just ab skin tear to the left ell blood thinning medical medical comorbidities	is not met as evidenced n, record review and Nurse Practitioner, Medical ian, the facility failed to ght to be free from neglect sidents reviewed for neglect 4/24, Nursing Assistant (NA) lent #1's physician orders he assessed need of 2 th Activities of Daily Living ded care to the resident During care, NA # left the n his right side with the bed rrned his back to get a #1 rolled off the bed, landing floor. Resident #1 was ergency room where a rraphy (CT) scan revealed a left distal femur (a break of bove the knee) and a small bow. Resident #1 was on a ation and he had multiple s making him vulnerable and The death certificate dated use of death as		Resident # 1 noted as discharger All residents receiving ADL care v concentration on residents with or and care plans for 2 person assis ADLs (Activities of Daily Living) ic as residents having the potential affected by injury during ADL care Residents with orders and care pl person assist with ADLs were ide through audit entitled "2 person A order Audit" completed by Directo Nursing 4/17/2024. Audit was cor by reviewing all active residents' of orders and care plans to ascertain residents at risk for injury during A with concentration on 2 person Al orders. Results of audit identifyin residents with 2 person assist witt care was reviewed by facility Qua Assurance Committee (Physician services, Administrator, Director of Nursing, Quality Assurance Coord Rehab Manager, Staff Developme Coordinator, Social Worker, Environmental Services Director) 4/18/2024 and results ensured to	vith rders t with lentified to be e. lans for 2 ntified .DL care or of npleted current n all ADL care g h ADL care g h ADL lity of dinator, ent	
	neglected to provide	ervices required to provide		communicated clearly in facility so to all nursing staff (Nurses and No 1). Software communication note populate in ADL documentation g	urse Aide d to	
	removed on 4/19/24 v implemented an acce			nurses and nurse aides and is po through the ADL care plan once a orders are received and are docu	pulated ny	

Facility ID: 923459

If continuation sheet Page 2 of 20

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		(X3) DATE SURVE	<u>8-03</u> v
	CORRECTION	IDENTIFICATION NUMBER:		G		COMPLETED	
		345175	B. WING			C 04/19/202	24
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE		
				902 BERKSHIRE	ROAD		
	LD MANOR NURSING A			SMITHFIELD, N	IC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE B-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMP	X5) PLETIC ATE
F 600	Continued From page	e 2	F 6	00			
		a lower level and severity of			nning nurse. Current care pla	an	
		e potential for more than			unication was validated by		
		not immediate jeopardy) to			surance Committee by 4/18/2	4.	
		stems put in place were			1 had injury reported via Initia		
	effective.				Report by Director of Nursing	to	
					e Personnel Investigation		
					and Investigation Report		
	The findings included	1:			by Director of Nursing to		
	This tax is succe usfe	non-no-d to .			e Personnel Investigation		
	This tag is cross-refe	renced to:			instructed by NCDHHS. Nursing also notified injury to		
	F689 [.] Based on obse	ervation, record review, staff,			ective Services on 4/18/24 as	,	
	Nurse Practitioner, M				by NCDHHS. Audits entitled "	2	
		the facility failed to provide			L Care Audit" to include	-	
	-	ing (ADL) care safely to a			orders, care planning and staf	ff	
		or 1 of 3 residents reviewed			n were completed by Quality		
	for supervision to pre	vent accidents (Resident		Assurance	Coordinator on 4/18/2024 an	ld	
		ng Assistant (NA #1) began			nue to be completed monthly 2	X	
		sident #1 when he left the			nd quarterly thereafter to		
		n his right side with the bed		-	joing compliance with		
	-	Irned his back to get a			ns with 2 person ADL care		
		#1 rolled off the bed, landing			esults of these audits shall be		
		floor. Resident #1 was ergency room where a			uarterly by the Quality Committee beginning with the		
		graphy (CT) scan revealed a			uled Quarterly Quality	C	
		e left distal femur (a break of			Committee meeting May 14th	h.	
		pove the knee) and a small		2024.		<i>,</i>	
		bow. Resident #1 was on a			Assurance Committee noted	d	
	•	ation and he had multiple			n 4/18/24 new "2 Person assis		
		s making him vulnerable and			are Icon" to be placed at foot	of	
		The death certificate dated		-	/ "Residents at Risk" as to		
	3/31/24 listed the cau				ocess, in order to more clearly		
	complications of a lef	t temur tracture.		-	esidents at Risk" with 2 perso	n	
	Review of the Initial A	Illegation Report dated			ordered. Quality Assurance		
		Allegation Report dated facility's Director of Nursing			ensured accuracy of audit, as nmunication through facility	D	
	(DON)	racinty 5 Director of Nurshig			nd new icon and all nursing		
		sident #1's allegation of			ed education by Staff		
		the State Survey Agency.			ent Coordinator or their		

Facility ID: 923459

If continuation sheet Page 3 of 20

STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · · ·	10. 0938-039 TE SURVEY MPLETED
		345175	B. WING		0	C 4/19/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
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 (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 3	F 60	00		
	 Continued From page 3 The alleged incident occurred on 3/04/24 at 2:50 PM. The resident received a bath and the aide turned away from the bed to retrieve cloth and resident rolled from bed resulting in fall. The Investigation Report dated 4/19/24 completed by the DON for the neglect allegation related to Resident #1 documented the accused staff member (NA #1) was noted to be aware of 2 person ADL care requirement, however, the NA felt he could provide care independently because he had worked with the resident for over a year. A fall occurred during care as a result of care plan not being followed. The report indicated Resident #1 sustained serious bodily injury and the allegation was substantiated. 			designee, regarding all at risk. Education encor residents receiving ADL instruction on safety wit include gathering suppli ensuring proper position provide safety, awarene and leaving residents in with call light in place. E included current list of a Risk," with 2 person AD their orders and care pla identified in facility softw awareness through new expectations regarding with ADL care. Residen party were contacted by Services Coordinator by	npassed all care and included h ADL care to les and equipment, ning in bed to ess of bed height a safe position ducation also ful "Residents at L care and where an may be vare, care plan / Icon and 2 person assist ts / responsible / Resident	
		d Director of Nursing (DON) ediate Jeopardy on 4/17/24		ensure permission to pla avoid any dignity issues acceptance. "2 Person Icon" was placed at foo "Residents at Risk" by 0	ace Icon as to and documented assist with ADL t of bed for all	
	allegation of Immedia	ate Jeopardy removal: hts who have suffered, or serious adverse outcome as		Coordinator by 4/18/202 staff received education for Resident Abuse and policy entitled "Residen	24. Additionally, all on facility policy Neglect to include	
	a result of the noncor			Policy and Procedures" on residents at higher ri	with concentration	
	daily living (ADL) card receiving care, NA#1 independently with R with bed at waist heig that resident had a fa turned from care to re	b have received activities of e by NA #1 on 3-4-24. While noted to be providing care esident # 1 on his right side ght. During care, it is noted Il from the bed while NA#1 etrieve bath cloth. Resident on ADL (activities of daily		ADL care requiring 2 pe to the Administrator / Di any witnessed abuse or residents not meeting fa expectations. Education by 4/19/24 and docume Training Report."	ople and to report rector of Nursing, neglect for these acility was completed	

Facility ID: 923459

If continuation sheet Page 4 of 20

		()(0)			IO. 0938-039	
CORRECTION	· · ·	· /		· · ·	E SURVEY IPLETED	
		A. BUILDING				
	045475				С	
	345175	B. WING			4/19/2024	
ROVIDER OR SUPPLIER				DDE		
_D MANOR NURSING A	ND REHAB					
			SMITHFIELD, NC 27577			
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
Continued From pag	e 4	E 6	00			
•						
-	÷ .					
returning to facility fo	or hospice care. NA #1 noted					
no expected return to	o work date.					
All residents receivin	g ADL care with					
	•					
,	-					
-	-					
•						
•	•					
-						
-	-					
Results of audit ident	tifying residents with 2					
person assist with AI	DL care, shall be reviewed by					
facility Quality Assura	ance Committee (Physician					
	-					
-						
	-					
	5					
,						
	-					
-						
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENC REGULATORY OR Continued From pag remained in facility u drooping noted and w where he was discow leading to sepsis wh and became unrespondent admission at a local returning to facility for to be out of work ind no expected return to All residents receiving concentration on ress plans for 2 person as Daily Living) identifien neglect. Residents w 2 person assist with a through audit entitled Audit" completed by than 4/17/2024. Audit reviewing all active re care plans to ascertar neglect. Entity shall of "Residents at Risk Results of audit iden person assist with Alf facility Quality Assurance C Staff Development C Environmental Servita and results ensured in facility software to Nurse Aide 1). Softw populate in ADL doca and nurse aides and ADL care plan once is documented by care care plan and comm	CORRECTION IDENTIFICATION NUMBER:	CORRECTION IDENTIFICATION NUMBER: A. BUILDIN 345175 B. WING COVIDER OR SUPPLIER	CORRECTION IDENTFICATION NUMBER: A BUILDING 345175 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CC D MANOR NURSING AND REHAB STREET ADDRESS, CITY, STATE, 2P CC SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 4 F 600 remained in facility until new onset of facial drooping noted and was sent to ER 3/18/24 where he was discovered to have renal stones leading to sepsis whereupon resident aspirated and issoin at a local Hospice House instead of returning to facility for hospice care. NA#1 noted to be out of work indefinitely since 3/8/2024 with no expected return to work date. All residents receiving ADL care with concentration on residents with orders and care plans for 2 person assist with ADLs (Activities of Daily Living) identified as "Recipients at Risk" for neglect. Entity shall complete facility wide audit dro regines to assertain all "Recipients at Risk" for neglect. Entity shall completed by reviewing all active residents 'current orders and care plans to ascertain all "Recipients at Risk" for neglect. Entity shall complete facility wide audit dri "Residents Risk" noter than 4/17/2024. Results of audit identifying residents with 2 person assist with ADL care, shall be reviewed by facility Quality Assurance Coordinator, Social Worker, Environmental Services Director of Nursing, Quality Assurance Coordinator, Social Worker, Environmental Services Director of Nursing, Quality Assurance Coordinator, Social Worker, Environmental Services Director of Nursing, Quality Assurance Coordinator, Social Worker, Environmental Services Director of N	CORRECTION IDENTIFICATION NUMBER: A BUILDING Continued 345175 B. WING STREET ADDRESS, CITY, STATE, 2P CODE 00 STREET ADDRESS, CITY, STATE, 2P CODE 01 STREET ADDRESS, CITY, STATE, 2P CODE 02 BERKSHIBE ROAD 03 BUIMARY STATEMENT OF DEFICIENCIES 04 DMANOR NURSING AND REHAB 05 DMERCINCH STATEMENT OF DEFICIENCIES 04 PREVIDER'S PLAN OF CORRECTION 05 RECENTRY TARE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION PREFIX 7 RESULATORY OR LSC IDENTIFYING INFORMATION 7 Continued From page 4 7 F6 600 7 RESULT ON TO SECONDE STATE 2 DEAD 2 DEAD <	

Facility ID: 923459

If continuation sheet Page 5 of 20

			()(0)		(A) E		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY PLETED	
			A. BUILDING				
		245475	B. WING			С	
		345175	B. WING			/19/2024	
NAME OF PI	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 Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	e 5	F 60	20			
1 000				0			
		ve neglect reported via Initial Director of Nursing to Health					
	Care Personnel Inves						
		hall also notify neglect to					
		ces on 4/18/24. Audits					
		DL Care Audit" to include					
	physician orders, car						
	observation shall be						
	Assurance Coordinat						
		e entity will take to alter the					
		ilure to prevent a serious					
		m occurring, and when the					
	action will be comple	te:					
	The Quality Assurance	ce Committee shall also					
		assist with ADL Care Icon"					
	•	of bed for any "Residents at					
	•	process, in order to more					
		dents at Risk" with 2 person					
		Once Committee has ensured					
		well as communication					
		are and new icon, all nursing					
	staff shall receive ed						
	•	nator or their designee,					
	regarding all resident						
		bass all residents receiving					
		instruction on safety with					
		gathering supplies and					
		proper positioning in bed to					
		eness of bed height and					
		a safe position with call light					
		shall also include current list					
		lisk," with 2 person ADL care					
		rs and care plan, may be					
		oftware, care plan awareness d expectations regarding 2					
	person assist with AE						
	person assist with AL		1			1	

Facility ID: 923459

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ATEMENT C	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		COMPLETED
		345175			C 04/19/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
SMITHFIELD MANOR NURSING AND 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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 600	Continued From page	e 6	F 60	00	
		bordinator by 4/18/2024 to			
		place Icon as to avoid any			
	•	cumented acceptance.			
	-	shall receive education on			
		dent Abuse and Neglect to			
		"Resident Abuse Prohibition			
		es" with concentration on sk for falls during ADL care			
	requiring 2 people an	9			
	Administrator / Direct				
		neglect of care for these			
		facility expectations.			
		ompleted and all efforts to			
		aff present 4/18/2024. Any			
	•	3/2024 shall have attempts			
		ucation by phone no later nessages left for any not			
		facility as soon as possible			
	for education, as to p				
		om occurring. Education			
	shall be documented	on "In-service Training			
		opment Coordinator shall			
		isor of any nursing staff on			
		ve not received in-servicing			
	so that education ma	rsing staff that may enter			
		"2 Person assist with ADL			
	Icon" shall be placed				
	"Residents at Risk" b				
	Coordinator by 4/18/2	2024. Audits entitled "2			
		dit" shall be completed by			
	Quality Assurance Co				
	monitoring for compli				
	neglect.	ire prevention on possible			
	-	eopardy Removal Date:			
	4/19/24				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345175	B. WING			C 04/19/2024	
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 / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600 F 689 SS=J	removal plan was cor validation included sta and record review. Ins staff interviews verifie completed on the Abu Procedure with a com- higher risk for falls du their understanding of of providing residents assistance. Additiona education they had the questions on resident Evidence of audits we Neglect and identifyin Resident interviews w issues identified. Obs revealed staff provide to meet the resident's immediate jeopardy re validated. Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation Nurse Practitioner, M- Physician interviews, Activities of Daily Livin	ducted on 4/19/24. The aff interviews, observation, service sign in sheets and d in-services were ise and Neglect Policy and centration on residents at ring ADL care. Staff verified in eglect and the importance with their assessed level of ly, staff revealed during e opportunity to ask Abuse and Neglect. ere reviewed for Abuse and g "Residents at Risk". rere conducted with no ervation of ADL care d the necessary assistance assessed needs. The emoval date of 4/19/24 was ards/Supervision/Devices 2)		600	Resident # 1 noted as discharged. All residents receiving ADL care with concentration on residents with orders and care plans for 2 person assist with ADLs (Activities of Daily Living) identifie	ed	5/9/24

Facility ID: 923459

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/22/202 / APPROVE). 0938-039
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345175	B. WING				C 19/2024
NAME OF PROVID	ER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SMITHFIELD MANOR NURSING AND 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
for #1) pro res at v was fac trar Color the skin blo me at h 3/3 cor Imr failu imr who cre ren at a the not sys The Res 10/ atri cau fac	On 3/4/24 Nursin viding care to Res ident positioned or vaist height and tu shcloth. Resident a e down on the tile asferred to the emo- mputerized Tomog sed fracture of the thigh bone just ab n tear to the left ell od thinning medica dical comorbidities he tar to the left ell od thinning medica dical comorbidities high risk for injury. 1/24 listed the cau nplications of a left nediate jeopardy b ed to provide care nediate jeopardy b en the facility imple dible allegation of noval. The facility nover level and s potential for more immediate jeopart tems put in place e findings included sident #1 was adm 24/22 with diagnos al fibrillation (a typ uses the heart to bure, diabetes melli ease (a condition i	vent accidents (Resident ig Assistant (NA #1) began ident #1 when he left the h his right side with the bed rned his back to get a #1 rolled off the bed, landing floor. Resident #1 was ergency room where a raphy (CT) scan revealed a left distal femur (a break of ove the knee) and a small bow. Resident #1 was on a ation and he had multiple a making him vulnerable and The death certificate dated se of death as t femur fracture. regan on 3/4/24 when NA #1 safely to Resident #1. The vas removed on 4/19/24 emented an acceptable immediate jeopardy remains out of compliance everity of "D" (no harm with than minimal harm that is dy) to ensure monitoring were effective.	F	689	as residents having the potential to b affected by accidents during ADL car Residents with orders and care plans person assist with ADLs were identifit through audit entitled "2 person ADL order Audit" completed by Director of Nursing 4/17/2024. Audit was complet by reviewing all active residents' curr orders and care plans to ascertain all residents at risk for accidents during, care with concentration on 2 person A care orders. Results of audit identify residents with 2 person assist with AL care was reviewed by facility Quality Assurance Committee (Physician services, Administrator, Director of Nursing, Quality Assurance Coordina Rehab Manager, Staff Development Coordinator, Social Worker, Environmental Services Director) on 4/18/2024 and results ensured to be communicated clearly in facility softw to all nursing staff (Nurses and Nurse 1). Software communication noted to populate in ADL documentation grid f nurses and nurse aides and is popula through the ADL care plan once any orders are received and is document care planning nurse. Current care pla and communication was validated by Quality Assurance Committee by 4/14 Resident #1 had injury reported via Ir Allegation Report by Director of Nurs Health Care Personnel Investigation 4/18/2024 and Investigation Report completed by Director of Nursing to Health Care Personnel Investigation 4/18/2024 as instructed by NCDHHS.	e. for 2 ed care eted ent ADL ADL ing DL tor, tor, are e Aide for all ated ed by in 8/24. hitial	

Event ID: 25R411

Facility ID: 923459

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/22/2024 MAPPROVED). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345175	B. WING				C 19/2024
NAME OF PF	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				90	2 BERKSHIRE ROAD		
SIVILIALIE	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	Continued From page	e 9	F	689			
	Resident #1's quarter 12/19/23 revealed he was assessed as dep incontinence care and not coded for any fall assessment. The MD weight as 325 pounds receiving an anticoag A review of the active 2024 included the foll - Two person assist we date 11/01/22). - Eliquis (anticoagular Resident #1's care pl reviewed on 12/20/23 falls related to impair comorbidities, and co Interventions initiated people assisting with An interview was con 4/16/24 at 2:29 PM. S was a two person assist man, and she always provide his care. NA check in the FYI (for the computer to see we An interview on 4/17/ conducted with NA #3 was a 2 person assist	Aly Minimum Data Set dated was cognitively intact. He bendent with bed mobility, d bathing. Resident #1 was s since the prior PS indicated the resident's s and he was coded for julant. Physician orders for March lowing orders: with ADL care (order start nt) 5 milligrams twice daily an initiated on 10/24/22 and B revealed he was at risk for ed mobility, multiple ontinuous oxygen (02). I on 11/01/22 included two care. ducted with NA #2 on She indicated Resident #1 sist as he was a heavy-set had another NA to help her #2 revealed she would your information) section of what care a resident needed. 24 at 1:09 PM was 3. She revealed Resident #1 t with ADL care. NA #3 in the computer to see what			Adult Protective Services on 4/18/24 a instructed by NCDHHS. Audits entitled Person ADL Care Audit" to include physician orders, care planning and stobservation were completed by Qualit Assurance Coordinator on 4/18/2024 shall continue to be completed monthel 1 quarter and quarterly thereafter to ensure ongoing compliance with expectations with 2 person ADL care orders. Results of these audits shall thereviewed quarterly by the Quality Assurance Committee beginning with next scheduled Quarterly Quality Assurance Committee meeting May 1 2024. The Quality Assurance Committee meeting May 1 2024. The Quality Assurance Committee meeting May 1 2024. The Quality Assurance Committee not to adopt on 4/18/24 new "2 Person as with ADL Care Icon" to be placed at for bed for any "Residents at Risk" as to improve process, in order to more cleatidentify "Residents at Risk" with 2 person ADL care ordered. Quality Assurance committee ensured accuracy of audit, well as communication through facility software and new icon and all nursing staff received education by Staff Development Coordinator or their designee, regarding all residents currer at risk. Education encompassed all residents receiving ADL care and incluinstruction on safety with ADL care to include gathering supplies and equipmensuring proper positioning in bed to provide safety, awareness of bed heig and leaving residents in a safe position.	d "2 taff y and y X be the 4th, ted sist ot of arly son as ently uded hent, ht	
	On 4/17/24 at 1:25 P	M the Director of Nursing nt #1 had extension bars on			with call light in place. Education also included current list of all "Residents a Risk," with 2 person ADL care and wh	at	

Facility ID: 923459

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	S FOR MEDICARE &				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345175	B. WING		C 04/19/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SMITHFIELD MANOR NURSING AND 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIN
F 689	his bed that extended the bed frame out 8 inches		F 68	their orders and care plan may	
	fit the bed frame. The Nurse note dated #1 revealed NA# 1 ca Resident #1's room a noted laying on his si with the bed in the hig was turning Resident off the bed onto the fl notified and on asses noted to have blood u locate the source due	t 2:50 PM. Resident #1 was de undressed on the floor gh position. NA #1 stated he #1, and he kept on rolling oor. The Supervisor was sment Resident #1 was upon inspection but could not a to his positioning. The note		identified in facility software, ca awareness through new Icon a expectations regarding 2 perso with ADL care. Residents / resp party were contacted by Reside Services Coordinator by 4/18/2 ensure permission to place Icon avoid any dignity issues and do acceptance. "2 Person assist Icon" was placed at foot of bed "Residents at Risk" by Quality / Coordinator by 4/18/2024. Edu completed by 4/19/24 and docu	nd n assist ponsible ent 024 to n as to poumented with ADL for all Assurance cation was
	EMS (Emergency Me and Medical Doctor n to send Resident #1 t evaluation.	t #1 was on a blood thinner. edical Service) were notified, otified. Order was obtained to (name of hospital) for ident Report initiated on		"In-service Training Report."	
	Manager Nurse was n revealed while care w #1 was turned to face	mpleted on 3/4/24 by Unit reviewed. The report vas being provided Resident e the door, the NA turned his of Resident #1 landed face			
	5:29 PM. NA #1 indic Resident #1 on his rig He indicated he (NA # grab a washcloth. He turned away from the in the room and saw f	ed by phone on 4/16/24 at ated on 3/4/24 he positioned ght side in the middle of bed. #1) turned to the tray table to e indicated while he was bed he looked in the mirror the resident move his leg d face first onto the floor. NA			

	C	FORM APPROVED OMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRU A. BUILDING	RUCTION	(X3) DATE SURVEY COMPLETED
345175 B. WING		C 04/19/2024
NAME OF PROVIDER OR SUPPLIER STREET ADD	DDRESS, CITY, STATE, ZIP CODE	
SMITHFIELD MANOR NURSING AND REHAB	SHIRE ROAD ELD, NC 27577	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F 689 Continued From page 11 F 689 another staff member's assistance on 3/4/24 he indicated there was a lot going on that day, it was close to shift change, he worked with Resident #1 daily, and thought he could provide incontinence care alone. NA #1 indicated Resident #1 was able to assist with his turning and repositioning in bed. A follow up interview with NA #1 was conducted by phone on 4/17/24 at 4:10 PM. He revealed on 3/4/24 the bed was at waist height when the resident rolled onto the floor. NA #1 stated Resident #1 did not hit his head when he fell. In a phone interview on 4/16/24 at 1:12 PM Nurse #1 stated that when she arrived in Resident #1's room on 3/4/24, she found Resident #1 on the floor lying between Bed A and Bed B. He was on his side and she observed some blood but she could not tell where it was coming from, and she wanted to send Resident #1 out for evaluation in case of head injury as he was receiving a blood thinner. She revealed Resident #1 was a larger man and required two persons for assistance with his ADL care. The Unit Manager Nurse was interviewed on 4/17/23 at 9:31 AM. The Unit Manager Nurse revealed when she arrived at Resident #1's room on 3/4/24, the resident was on the floor face down with slight weight on his left side. She indicated NA #1 worked with the resident daily and the resident was a two person assist as he was a heavy man. She reported Resident #1 fell onto the tile floor. The Unit Manager Nurse called 911, the hospital to notify them they had a fall resident and the RP (responsible person). She stated that EMS arrived at the facility within 5 minutes of her call. </td <td></td> <td></td>		

Facility ID: 923459

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345175	B. WING				C / 19/2024
NAME OF P	ROVIDER OR SUPPLIER			5	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	dated 3/4/24 revealed EMS reported an obe but awake, alert, Glas used to objectively de impaired consciousne means you are fully a no problems with thin Computerized Tomog conducted in the ER of extremity and reveale non-displaced fracture meta-epiphysis (round bone) with fracture lim femoral condyle (a br bone) with extension condyle. The resident orthopedics and the fi He was splinted at be facility on 3/5/24. Review of the physicia 3/11/24 documented I the ER on 3/04/24 foll being adjusted in bed bleeding and concern Eliquis. CT scan reve left distal femur. The of determined the fractur resident was splinted showed stable positio cleared to discharge to Review of the nurse r documented the residen atrial fibrillation), 911	ency Room (ER) report a upon arrival at 4:09 PM se, chronically ill-appearing, gow Coma Scale (a scale escribe the extent of ess) of 15 (a score of 15 wake, responsive and have king ability or memory). A raphy (CT) scan was of Resident #1's left lower d a comminuted e of distal femoral ded long end portion of the e extending to the lateral eak in the lower part of a to posterior lateral femoral was assessed by racture was non-operative. dside and returned to the an progress note dated Resident #1 was sent out to lowing a fall from bed while . He was noted with some ed for a head injury as on aled a closed fracture of the orthopedist was consulted, re was nonoperative and the at bedside. Post splint x-ray ning and the resident was to the facility.	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
				(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345175	B. WING				C / 19/2024
NAME OF PF	ROVIDER OR SUPPLIER			s	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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	3/18/24 documented the ER on 3/17/24 for pain. A complete bloo leukocytosis (high wh indicate an infection of Cardiac tests were un proteins leaking into t was discharged back Review of the nurse r AM indicated the resid Practitioner #1 for foll Resident #1 was noted droop, a fixed pupil an Resident #1 was sent and treatment. Review of the Emerge 3/18/24 at 12:44 PM n presented as a preho change in mental stat afebrile, chronically ill lower extremity in a s An EKG (electrocardie fibrillation with prema- is associated with an fibrillation) and a chest venous congestion wi (breathing that is too needs of the Dischar revealed Resident #1 Tele-neurologist for st was ruled out and sug	an progress note dated Resident #1 was sent out to concern of acute chest of count showed no ite blood cell count may or inflammation in the body). The markable, (for heart he blood) and the resident to the facility. The dated 3/18/24 at 11:46 dent was seen by Nurse ow up of chest pain. The to have right sided facial ind acute disorientation. The to the ER for evaluation ency Room report dated revealed Resident #1 spital code stroke due to a tus. The resident was -appearing and had a left plint due to recent fracture. ogram) revealed atrial ture atrial contraction (PVC increased risk of atrial st x-ray revealed pulmonary ith hypoventilatory changes shallow or slow to meet the ture Summary dated 3/29/24 was reviewed by the uspected stroke. The stroke ggested probable acute	F	689			
	Tele-neurologist for su	uspected stroke. The stroke ggested probable acute					

Facility ID: 923459

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COM	E SURVEY PLETED
		345175	B. WING				C / 19/2024
NAME OF P	ROVIDER OR SUPPLIER				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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	encephalopathy occu metabolism cause bra treated with antibiotic (urinary tract infection treatment failure and antibiotic courses) an (occurs when food or airways or lungs inste The Discharge Summ Resident #1's age rela- improvement the fam measures. Resident # hospital on 3/29/24 to Review of Resident # 3/31/24 listed the cau complications of a left An interview was con Examiner (ME) on 4/7 indicated she had rev medical history after s autopsy which reveal- years prior. The Medi a fall or broken bone same and the femur f decline in the body. T #1 was not a young n and determined the c blunt force trauma to The Nurse Practitione on 4/16/24 at 3:24 PM had a history of atrial thinner, and after his Resident #1 out imme injury (individuals taki higher risk of brain blo	rs when problems with your ain dysfunction). He was s for a complicated UTI to that carries a higher risk of typically require longer d aspiration pneumonia liquid is breathed into the ead of being swallowed). hary documented that due to ated debility and poor ily decided on comfort \$1 was discharged from the o an inpatient hospice facility. 1's death certificate dated se of death as t femur fracture. ducted with the Medical 17/24 at 12:39 PM. She iewed Resident #1's she received the body for ed he fractured his ankle 3 cal Examiner indicated after patients were never the racture precipitated a the ME indicated Resident han, had many comorbidities ause of death was due to	F	689	9		

Facility ID: 923459

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345175	B. WING				/19/2024
NAME OF P	ROVIDER OR SUPPLIER			5	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	received a soft cast in facility that same day. Resident #1, was sen of chest pains, where unremarkable for hea blood, and the residen The Nurse Practitione with Resident #1 on 3 the ER for a facial dro stated within a two-we no further falls, had tw his contributing como the fracture could hav A phone interview wa Medical Doctor on 4/1 indicated during Resid 3/18/24, he was diagr tract infection), an act stones, and during the infection that overwhe an acute aspiration ev Resident #1's infectio would have occurred the hospital record hig pneumonia as a contr Doctor indicated he se his fall/fracture and ex The Director of Nursir on 4/17/24 at 5:00 PM were trained to look ir care needs and NA # policies and procedur #1 was care planned computer for a two pe and any residents req	ed with a femur fracture, the ER and returned to the . He indicated on 3/17/24 t to the ER for a complaint a cardiac evaluation was rt proteins leaking into the nt returned to the facility. er revealed he followed up b/18/24 and sent him back to toop and slurred speech. He teck period, Resident #1 had wo hospital visits and with rbidities he did not see how re contributed to his death. s conducted with the 17/24 at 2:47 PM. He dent #1's hospital stay on hosed with an UTI (urinary ute kidney injury, renal at hospital stay he had an elmed his system and had vent. The MD indicated n, UTI, and renal stones regardless of the fall, and ghlighted the aspiration ibuting factor. The Medical aw no connection between	F	689			

Facility ID: 923459

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345175	B. WING			04	U 19/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	5	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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Immediate Jeopardy The facility provided t allegation of Immedia Identify those recipier are likely to suffer, a s a result of the noncor · Resident # 1 noted of Daily Living (ADL) While receiving care, care independently w side with bed at waist noted that resident has NA #1 turned from ca Resident noted to hav of daily living) ordered sent to Emergency R left leg injury. Resided new onset of facial dr to ER 3/18/24 where renal stones leading to resident aspirated an leading to a hospice a House instead of retu-	d DON were notified of on 4/17/24 at 5:51 PM. he following credible te Jeopardy removal: hts who have suffered, or serious adverse outcome as npliance: to have received Activities care by NA #1 on 3-4-24. NA #1 noted to be providing ith Resident #1 on his right height. During care, it is ad a fall from the bed while re to retrieve bath cloth. ve 2 person ADL (activities d. Resident was noted to be boom (ER) and returned with nt remained in facility until ooping noted and was sent he was discovered to have	F	689			
	plans for 2 person as Daily Living) identified accidents and failure	dents with orders and care sist with ADLs (Activities of d as "Recipients at Risk" for					

If continuation sheet Page 17 of 20

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/22/2024 DRM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER/SUPPLIER/CLIA (X2) MULT		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		345175	B. WING				C 04/19/2024
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SMITHFIELD MANOR NURSING AND REHAB				902	2 BERKSHIRE ROAD		
				SN	AITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	entitled "2 person AD completed by Director 4/17/2024. Audit shal all active residents' or to ascertain all "Recip and failure to provide complete facility wide no later than 4/17/202 identifying residents of care, shall be reviewed Assurance Committee Administrator, Director Assurance Coordinat Development Coordin Environmental Service and results ensured to in facility software to Nurse Aide 1). Softw populate in ADL docu and nurse aides and ADL care plan once a is documented by car care plan and commu- by Quality Assurance Specify the action the process or system fai adverse outcome from when the action will b • The Quality Assura adopt new "2 Person to be placed at foot o Risk" as to improve p clearly identify "Resic ADL care ordered. C accuracy of audit, as	I be identified through audit L care order Audit" r of Nursing no later than I be completed by reviewing urrent orders and care plans bients at Risk" for accidents safe care. Entity shall a udit of "Residents at Risk", 24. Results of audit with 2 person assist with ADL ed by facility Quality e (Physician services, or of Nursing, Quality or, Rehab Manager, Staff nator, Social Worker, res Director) on 4/18/2024 o be communicated clearly all nursing staff (Nurses and are communication noted to mentation grid for all nurses is populated through the any orders are received and re planning nurse. Current unication shall be validated Committee by 4/18/24.	F	689			

Facility ID: 923459

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		MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND FLAN OF CORRECTION			A. BUILDING	<u> </u>		
		345175	B. WING			C
		545175	B. WING			19/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	JE	
SMITHFIELD MANOR NURSING AND REHAB				902 BERKSHIRE ROAD		
	1			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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From pag	ie 18	F 68	a		
1 000			1 00	35		
	staff shall receive ed	inator or their designee,				
	regarding all residen					
	0 0	pass all residents receiving				
	-	e instruction on safety with				
		gathering supplies and				
	equipment, ensuring	proper positioning in bed to				
	provide safety, awar	eness of bed height and				
		a safe position with call light				
		shall also include current list				
		Risk," with 2 person ADL care				
		ers and care plan may be				
		oftware, care plan awareness				
	-	d expectations regarding 2				
	person assist with Al					
		all also be contacted by cordinator by 4/18/2024, to				
		o place Icon as to avoid any				
		ocumented acceptance.				
		ompleted and all efforts to				
		aff present 4/18/2024. Any				
		8/2024 shall have attempts				
		ducation by phone no later				
		messages left for any not				
		t facility as soon as possible				
		prevent future serious				
		om occurring. Education				
		on "In-service Training				
		lopment Coordinator shall				
		visor of any nursing staff on				
		ave not received in-servicing				
	so that education ma					
		ursing staff that may enter				
	facility after 4/18/24.	ditionally add lesson plan to				
		o encompass all new hires as				
		st with ADL Icon" shall be				
	⊨won. ∠ i ⊂isun assi		1			
		for all "Residents at Risk" by				

Facility ID: 923459

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HUMAN SERVICES				INTED: 05/22/2024 FORM APPROVED IB NO. 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /) DATE SURVEY COMPLETED
345175	B. WING			C 04/19/2024
	<u> </u>	STREET ADDRESS, CITY, STATE	E, ZIP CODE	04/10/2024
REHAB				
	I			(X5)
JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIATE	COMPLETION DATE
)	F 689			
ardy Removal Date:				
mmediate jeopardy cted on 4/19/24. The interviews, observation, vice sign in sheets and o-services were assist with ADL care. d for facility nursing staff. iding 2-person e revealed no issues. reviewed for 2 person t list of identified sident interviews were is identified. The boal date of 4/19/24 was				
	IDENTIFICATION NUMBER: 345175 REHAB MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION) Ardy Removal Date: ardy Removal Date: Immediate jeopardy cted on 4/19/24. The nterviews, observation, vice sign in sheets and o-services were assist with ADL care. A for facility nursing staff. dig 2-person revealed no issues. reviewed for 2 person tist of identified identified identified) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 345175 B. WING) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345175 B. WING 345175 B. WING STREET ADDRESS, CITY, STATE 902 BERKSHIRE ROAD SMITHFIELD, NC 27577 REHAB ID PROVIDER'S PL (EACH CORRECT) DENTIFYING INFORMATION) PREFIX DENTIFYING INFORMATION) PREFIX TAG PREFIX CROSS-REFERENCE DEF (EACH CORRECT) (EACH CORRECT) CROSS-REFERENCE DEF Immediate jeopardy cted on 4/19/24. The interviews, observation, rice sign in sheets and i-services were assist with ADL care. F 689 If or facility nursing staff. iding 2-person e revealed no issues. revealed no issues. revealed no issues. revealed no issues. revealed no issues. revealed no issues. revealed no issues. F 689	p. pROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) 345175 B. WING (X3) 345175 B. WING 902 BERKSHIRE ROAD SMITHFIELD, NC 27577 REHAB TREET ADDRESS, CITY, STATE, ZIP CODE 902 BERKSHIRE ROAD SMITHFIELD, NC 27577 MENT OF DEFICIENCIES ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Immediate jeopardy cted on 4/19/24. The neterviews, observation, vice sign in sheets and p-services were assist with ADL care. If or facility nursing staff. Iding 2-person revealed no issues. reviewed for 2 person revealed no issues. reviewed for 2 person is ist of identified ident interviews were a identified. The

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet 1 of 2

NO HARM WITH ONLY A PE FOR SNF5 AND NF5 NAME OF PROVIDER OR S SMITHFIELD MANO ID PREFIX TAG F 580 Notif CFR(\$483. (i) A constr (A) A interv (B) A health (C) A adver (D) A (ii) W pertin (iii) T (A) A (ii) T (A) A (B) A health (C) A adver (D) A (ii) W pertin (iii) T (A) A (B) A hits set (iv) T the re repres	R NURSING AND REHAB SUMMARY STATEMENT OF DEFICIENCIES y of Changes (Injury/Decline/Room, etc. s): 483.10(g)(14)(i)-(iv)(15) 10(g)(14) Notification of Changes. Facility must immediately inform the resistent with his or her authority, the resident n accident involving the resident which ention; significant change in the resident's physe, mental, or psychosocial status in either need to alter treatment significantly (that se consequences, or to commence a new decision to transfer or discharge the resist hen making notification under paragrapi ent information specified in §483.15(c)(he facility must also promptly notify the	902 BERKSHIRE SMITHFIELD, N Sident; consult with ent representative(s results in injury an sical, mental, or psy r life-threatening c at is, a need to disc / form of treatment sident from the faci oh (g)(14)(i) of this (2) is available and e resident and the r	n the resident's physician; and notify, s) when there is- nd has the potential for requiring physic sychosocial status (that is, a deteriorat conditions or clinical complications); continue an existing form of treatmen t); or ility as specified in §483.15(c)(1)(ii). s section, the facility must ensure that d provided upon request to the physici resident representative, if any, when t	tion in t due to all ian.							
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this su (iv) T the re repres §483.	change in room or roommate assignmen			(10) 0							
(iv) T the re repres §483.	change in resident rights under Federal	or State law or reg	gulations as specified in paragraph (e))(10) of							
the re repres §483.	he facility must record and periodically	update the address	s (mailing and email) and phone num	ber of							
§483.	sident	1									
-	representative(s).										
-	§483.10(g)(15)										
	Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must										
	disclose in its admission agreement its physical configuration, including the various locations that comprise										
	the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).										
	This REQUIREMENT is not met as evidenced by:										
	Based on record review, staff and family interviews, the facility failed to notify the residents (Resident #1)										
-	Responsible Party (RP) when resident was sent to the hospital for chest pain for 1 of 3 sampled residents										
review	reviewed for notification.										
Findi	Findings included:										
	Resident #1 was admitted to the facility on 10/24/22 with diagnoses that included chronic atrial fibrillation, and heart failure.										
	Review of the quarterly Minimum Data Set dated 12/19/23 revealed Resident #1 was cognitively intact. He was assessed as dependent on 2 or more staff for assistance with bed mobility.										

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	DR MEDICARE & MEDICAID SERVICES			"A" FOR					
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs AND NFs		345175	B. WING	4/19/2024					
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS, C	CITY, STATE, ZIP CODE						
SMITHFIEI	D MANOR NURSING AND REHAB	902 BERKSHIRE SMITHFIELD, N							
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIEN	JCIES							
F 580	Continued From Page 1 Review of Resident#1's face sheet in his medical record listed Resident # 1's son as his responsible person (RP).								
	10:30 AM. On assessment Resident # 1' The Supervisor was notified of the resid	Review of the Nursing progress note dated 3/17/24 documented the resident was complaining of chest pain at 10:30 AM. On assessment Resident # 1's vital signs were taken, skin was noted warm, and dry to the touch. The Supervisor was notified of the residents' cardiac history, (chronic atrial fibrillation) 911 was called and the resident was transported to the hospital ER (emergency room) via stretcher by EMS for evaluation and treatment.							
	An interview on 4/18/24 at 2:30 PM the Unit Manager Nurse revealed she usually called Resident # 1's son with any changes, but she did not call on 3/17/24, as she was getting the resident ready to send out.								
	An interview on 4/18/24 at 3:28 PM the admissions coordinator revealed at one time Resident#1's wife acted as Resident #1's RP. She requested staff to call her son with any ER visits during the night.								
	An interview on 4/17/24 at 1:12 PM Nurse #1 revealed on 3/17/24 Resident #1 complained of chest pain and vital signs revealed a blood pressure of 184/96. She stated she called the physician for the order to send Resident #1 out, called 911 and thought that another nurse or the unit manager would assist her by calling the family. Nurse #1 reported that she did not call the RP on 3/17/24 to notify him Resident #1 was sent to the ER for chest pain.								
	Nurse #3 did not respond to attempts to contact her via telephone for an interview.								
	Review of resident #1's record there was no documentation or evidence in Resident #1's medical record, his RP was notified of his transfer to the ER on 3/17/24.								
	An interview on 4/19/24 at 11:30 AM the Director of Nursing reported the 2 nurses working with Resident #1 on 3/17/24 each thought the other nurse was calling the family to notify that resident was being sent to the ER and neither nurse did.								
31099		Event ID: 25R411		If continuation she					

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