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

PRINTED: 04/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING _____ B. WING _____	C 03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN ST SILER CITY, NC 27344

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F 000	INITIAL COMMENTS 2567 Amended 4/3/2014. Date of IJ beginning for Resident #3 changed from 12/30/2013 to 12/31/2013 when Resident #2 struck Resident #3 in the forehead. Facility added additional information to the credible allegation to address interventions implemented for Resident #3 after incidents with Resident #2.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, staff interviews, and physician interviews the facility failed to prevent resident to resident altercations for one (1) of one (1) residents with aggressive behaviors (Resident #2) exhibited towards two (2) other residents. (Residents #1and #3) which resulted in injury. The immediate jeopardy (IJ) for Resident #1 began on February 2, 2014 when Resident #1 was hit by Resident #2 in a physical altercation. The immediate jeopardy (IJ) for Resident #3 began on December 31, 2013 when Resident #2 punched Resident #3 on forehead with the resident's fist. The Administrator was notified of Immediate Jeopardy on 3/3/14 at 5:30 PM. The	F 323	1. Immediately following the discovery of the incident, Residents in Room 515-1 and 515-2 were assessed by the facility's licensed nursing staff. The residents were immediately separated and one-on-one C.N.A. supervision for each resident was provided until both residents were transported to the local hospital. The resident's physicians were notified and orders were given to transport both residents to the local hospital's emergency room. The responsible parties for each resident were notified as well as the facility's Administrator, Director of Nurses and Assistant Director of Nurses. Under the coordination of the Administrator and Nursing Administration, an investigation of the incident was immediately initiated. A 24-Hour report was transmitted to the Division of Health Services Regulation. The two residents were both transported to the emergency room on 02/02/14. Resident #1's known injuries included bilateral subdural hematoma, facial fractures and lacerations to the face. Resident #1 was hospitalized and then returned to the facility on 02/13/14. Resident #2 was arrested at the hospital and transported to the local jail. As of this date, Resident #2, who was discharged from the facility, has not returned. The facility reviewed the incident, the resulting outcomes and interventions with the facility's Medical Director via telephone on 02/02/14.	3/6/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony Covington | TITLE: Administrator | (X6) DATE: 4/8/14

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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F 323	Continued From page 1 IJ was removed on 3/5/14 at 5:30 PM after an acceptable credible allegation was validated through staff interviews and record reviews. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy (D) for completion of employee training and implement monitoring. The findings included: 1. Resident #1 was admitted to the facility on 7/14/12 with diagnoses of dementia and Alzheimer's Disease. Review of the initial care plan for Resident #1 with a revision date of 1/15/14 indicated the following focus areas: progressive decline in memory/cognition secondary to Dementia, impaired hearing, inappropriate sexual and verbal behaviors, and use of psychoactive medications. Staff was instructed to use interventions for the identified behaviors of monitoring behaviors and remove (the resident) from situation as needed, staff to involve resident in activity such as singing/music, redirect resident ' s thoughts to alternate topic when needed. Review of the quarterly Minimum Data Set (MDS) for Resident #1 dated 2/20/14 revealed he had no physical behaviors toward others, had long and short term memory impairment, was independent with bed mobility, transfers, walking in room and halls. Review of the medications for Resident #1 included Aricept for Dementia, Ativan for anxiety twice a day, and trileptal (mood stabilizer) twice a day. Resident #2 was admitted to the facility on	F 323	2. All residents on the facility's Special Care Dementia Unit were interviewed on 02/02/14 to ascertain whether they had been subjected to any abuse. All facility residents were given a head-to-toe assessment by the Assistant Director of Nurses, the Day RN Supervisor, the MDS Nurse and four LPN Charge Nurses on 02/02/14 for any signs of abuse and none were noted. The Plans of Care for all residents in the facility, with identified behaviors, were reviewed on 02/02/14 by the Director of Nurses, the Assistant Director of Nurses, the Day RN Supervisor and the MDS Coordinator. The Plans of Care and Resident Care Cards were updated as appropriate. On 02/02/14, facility staff were re-inserviced on resident abuse and dealing with behaviors by the Staff Development Coordinator and the Day RN Supervisor. Facility staff, who were unavailable on 02/02/14, were required to be re-inserviced prior to returning to work. Additionally, direct care nursing staff received education on the development of behavioral care plans and reporting observations that require interventions to the Director of Nurses or the Assistant Director of Nurses, on 02/02/14. Education on resident abuse and dealing with behaviors is included as part of the orientation of newly hired facility staff by the Staff Development Coordinator. 3/6/14	

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F 323	Continued From page 2 11/20/13 with diagnoses including dementia secondary to anoxic brain injury from a cardiac arrest. The transfer form (FL2) indicated Resident #2 had dementia, and required a locked unit due to wandering. Upon admission, Resident #2 resided in the locked dementia unit. There were no identified behaviors of physical or verbal abuse on the FL2. Resident #2 was assessed as having short term memory impairment. The " Dementia Functional Assessment Tool " dated 11/22/13 indicated Resident #2 had " Moderately severe cognitive decline (early dementia). On this assessment, Resident #2 was unable to recall most recent events, had purposeless wandering and could not complete a two-stage command. The care plan for Resident #2 dated 12/31/13 addressed a problem of "exhibits behaviors of physical (phys) aggression as evidenced by (AEB) recent resident to resident altercations involving hitting another resident - related to: cognitive impairment." The stated goals included the resident would not strike others, he would have reduced incidents of aggression and angry outbursts and staff would recognize and prevent behaviors that provoke aggressiveness. The approaches included document behaviors/interventions as indicated, remove resident from public area when behavior is disruptive, talk with resident in a low pitch, calm voice to decrease undesired behavior and provide diversional activity and report any change in mood or behavior to nurse immediately. Additionally, an update was added for the same date (12/31/13) for one on one sitter as needed to	F 323	The facility's Director of Nurses, or the Assistant Director Nurses if unavailable, if not in the facility, will be contacted by telephone for any observed behaviors that require assessment and intervention. The interventions for behaviors are reviewed with the Director of Nurses or Assistant Director of Nurses as the behaviors occur, 7-days per week. All observed behaviors are reviewed by the facility's InterDisciplinary Team with recommendations for action made as appropriate including modifications of the resident's Plan of Care, at the facility's Clinical Morning Meeting 5-days per week. Behaviors observed on weekends will be reviewed by the InterDisciplinary Team, utilizing the facility's 24-Hour Report, nurses notes, physician orders if appropriate and the Plan of Care, at the Clinical Morning Meeting on the next business day. On 03/05/14, facility direct care staff were re-inserviced on identifying behaviors on the Behavior Monitoring Sheet, how to complete the Behavior Monitoring Sheet and the use of the *INTERACT* and *Stop and Watch Tools* as a communication tool from CNA's to licensed nurses by the Staff development Coordinator and the Day RN Supervisor. Facility direct care staff, who were unavailable on 03/05/14, were required to be re-inserviced prior to returning to work. Behavior Monitoring Sheet education is included in the orientation of all newly hired licensed nurses by the facility's Staff development Coordinator. The Behavior Monitoring Sheets for all facility residents were audited to ensure that all behaviors were identified by the Director of Nurses, Assistant Director of Nurses, Day RN Supervisor and two charge licensed nurses on 03/05/14.	3/6/14

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F 323	Continued From page 3 monitor. Review of the Minimum Data Set (MDS) a quarterly, dated 1/7/14 revealed Resident #2 had long term memory impairment, behavioral symptoms of physical symptoms directed toward others, independent with bed mobility, transfers, walking in room and halls and eating. Review of Resident #2's nurse' notes dated 2/2/14 at 9:40 AM revealed Resident #2 had a physical altercation with Resident #1. Resident #1 had blood from his nose and mouth with left facial bruise. When asked by the nurse what happened, Resident #1 stated "He (Resident #2) hit me. The resident was assessed for injuries, physician and responsible party notified and sent via EMS (Emergency Medical Services) to the hospital. Per interview with the Administrator on 3/5/14 at 2:40 PM a 24-Hour report was transmitted to the Division of Health Services Regulation. The two residents were both transported to the emergency room on 02/02/14. Resident #1 was hospitalized with bilateral subdural hematoma, facial fractures and lacerations to the face. Resident #2 was arrested at the hospital and transported to the local jail. Interview with Nurse #1 on 3/5/14 at 10:15 AM revealed she was the nurse that worked the first shift on 2/2/14. Nurse #1 explained she was on her med pass, and had been in Resident #1's room to give him medications about ten minutes earlier. There was no indication of a change in his demeanor. Resident #1 was asleep, and she planned to return later to give his medications to him. Aide # 7 called to her from Residents ' #1	F 323	Resident #3's Plan of Care was reviewed, after exhibiting behaviors on 12/27/13, by the facility's Interdisciplinary Team and made the following addition; Resident to be re-directed to activities or TV room. Resident #3's Care Card was updated and the 500 Hall direct care staff provided re-direction to activities. On 12/31/14, Resident #3's Plan of Care was reviewed by the facility's Interdisciplinary Team and made the following addition; Monitor resident closely and re-direct when resident enters other resident's personal space. Resident #3's Care Card was updated and the 500 Hall direct care staff provided re-direction when Resident #3 entered the personal space of other residents. The facility's Interdisciplinary Team also updated the Plan of Care with the following; Conduct a medication review for Resident #3 and the medication review was completed on 1/5/14. On 12/31/14, the facility's Interdisciplinary Team requested a formal meeting with Resident #3's Responsible Party. A meeting was held on 1/10/14 with the facility's Interdisciplinary Team, the Assistant Director of Nurses, the facility's Administrator, Resident #3's attending physician, the Responsible Party and other family members to discuss the results of the medication review, physician recommendations and family suggestions for late afternoon and early evening activities and other interventions. The Responsible Party informed Resident #3's attending physician that she did not want any medication interventions and would prefer to take Resident #3 home if adequate services could be obtained. The Responsible Party offered no suggestions for activities and interventions. The staff scheduling for the Special Care Unit on the 500 Hall was re-aligned starting on 03/04/14 by the Director of Nurses and the Assistant Director of Nurses to provide for one CNA and one Activity person to work split shifts, i.e. 10:00 a.m. to 6:00 p.m., to provide re-direction and intervention for Resident #3 during the late afternoon, when she and other residents on the Special Care Unit on the 500 Hall usually exhibit more wandering behavior.	3/6/14

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F 323	Continued From page 4 and 2 ' s room. Upon entering, Resident #1 was sitting on the side of the bed. He had blood from his nose and mouth. At first, nurse #1 explained she thought it was a nose bleed. Upon speaking with aide #7 and Resident #1, she was informed Resident #2 had hit Resident #1 in the face. Nurse #1 said she informed her supervisor, and assessed Resident #1 further. Resident #2 was lying in bed with the covers pulled up to his head. Resident #2 did not say anything during the questioning of Resident #1. During the interview, Nurse #1 explained Resident #2 responded " yes " when asked if he had hit his roommate. She further explained she asked Resident to see his hands and found blood on the wet cloth when she cleaned his hands. Interview with aide #7 on 3/5/14 at 10:50 AM revealed she was working first shift on 2/2/14. Aide #7 explained it was some time after breakfast, and she saw Resident #2 going into the bathroom in his room. Aide #7 was working in the room next door, making beds. As she went up the hall for linen, she saw Resident #1 sitting on the side of his bed and his nose was bleeding. Aide #7 went into the room and asked Resident #1 what happened. Resident #1 reported his roommate got up and hit him. At that time, Resident #2 was in bed, with the covers pulled up like he was asleep. Aide #7 stated " he wasn ' t asleep " and I asked him what he did. Resident #2 responded " He disrespected me. " When aide #7 was asked to explain if she knew what the resident meant, she stated Resident #2 told her Resident #1 had called him names, like the " N " word. Aide #7 continued to explain she had not heard any noise, or commotion coming from their room prior to the incident. Aide #7 was asked if she had heard Resident #1 call Resident	F 323	3. The facility's Performance Improvement Committee reviewed the incident and the reporting/assessment systems in place, on 02/03/14. The Director of Nurses and/or the Assistant Director of Nurses will audit the Plans of Care of residents with identified behaviors on the appropriate documentation and approaches on the Plans of Care and Resident Care Cards weekly for four weeks, starting on 02/03/14, and report to the Performance Improvement Committee monthly for a minimum of three months. The Director of Nurses and/or the Assistant Director of Nurses will audit the Behavior Monitoring Sheets weekly for four weeks, starting on 03/05/14. The audit reports will be presented quarterly on a continuing basis upon a determination made by the Performance Improvement Committee. 3/6/14	

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F 323	Continued From page 5 #2 names before and she stated "yes" and the social worker was informed. Interview on 3/5/14 at 11:05 AM with the social worker revealed she was not aware of the " name calling " by Resident #1. The social worker explained she had not been told by staff or she would have moved them. The method of communicating between nursing and the social worker included written notes in her box or under her door and by receiving report with the staff at the desk. The social worker further explained the staff had reported the two residents were getting along well. Interview on 3/5/14 at 11:15 AM with aide #7 revealed she had informed the social worker about Resident #1 calling Resident #2 names. She reported the information during a report time at the nurse ' s desk. Aide #7 stated again " It was reported to the social worker. " An interview was conducted with the Social Worker on 3/3/14 at 4:00 PM. The social worker indicated there were no behaviors exhibited by Resident #2. He chose to stay in his room, most of the time. A psychiatric consult was not requested since his behavior was that of wandering. She explained she would do something the first time a resident was physically aggressive, such as request a psych consult. The administrative staff talked about him in the morning meetings. During the interview, the social worker was asked to explain the difference between the previous altercations Resident #2 had with a resident, and the incident on 2/2/14. She replied the incident on 2/2/14 was unprovoked. She further explained nothing was reported that the two residents (#1 and #2) were	F 323		

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F 323	Continued From page 6	F 323		

not getting along, it was unprovoked. Further interview revealed the social worker would spot what are the triggers for residents and explained staff can ' t watch every single second. The social worker stated she " was surprised at what happened. " (Between Residents #2 and #1)

Interview with aide #1 on 3/4/14 at 12:00 PM revealed she worked on the second shift with Resident #1 and #2. Resident #2 was not able to participate in diversional activities; his attention span was too short. During the interview, aide #1 explained Resident #1 had made comments about Resident #2 ' s race.

Interview on 3/4/14 at 2:20 PM with the primary physician (the medical director) revealed he was aware of one resident to resident altercation involving Resident #1. During the interview he was asked if the SBARs (Situation - Background - Assessment - Request) were reviewed on his visits and he stated yes, the chart would be reviewed as well. The nurse practitioner had been informed about some of the incidents. The physician was asked how information was communicated to him by the nurse practitioner and he responded they met each morning through the week. The " on call " is alternated between the nurse practitioner and himself. During the interview, the physician was not aware of any injuries for any resident until the 2/2/14 incident. His expectations for the nursing staff included separating the residents, and he would not expect the Zyprexa to be given to Resident #2. The explanation included, Resident #2 did not remain agitated, calmed down after the incident and would not require medication. He was informed on the day of the incident that Resident #1 was hit by Resident #2. The staff

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F 323	Continued From page 7 was instructed to send both residents to the emergency room. Interview on 3/5/14 at 11:05 AM with the social worker revealed she was not aware of the " name calling " by Resident #1. The social worker explained she had not been told by staff or she would have moved them. The method of communicating between nursing and the social worker included written notes in her box or under her door and by receiving report with the staff at the desk. The social worker further explained the staff had reported the two residents were getting along well. Interview on 3/5/14 at 11:15 AM with aide #7 revealed she had informed the social worker about Resident #1 calling Resident #2 names. She reported the information during a report time at the nurse ' s desk. Aide #7 stated again " It was reported to the social worker. " 2. Resident #2 was admitted to the facility on 11/20/13 with diagnoses including dementia secondary to anoxic brain injury from a cardiac arrest. The transfer form (FL2) indicated Resident #2 had dementia, and required a locked unit due to wandering. Upon admission, Resident #2 resided in the locked dementia unit. There were no identified behaviors of physical or verbal abuse on the FL2. Resident #2 was assessed as having short term memory impairment. The " Dementia Functional Assessment Tool " dated 11/22/13 indicated Resident #2 had " Moderately severe cognitive decline (early dementia). On this assessment,	F 323		

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F 323	Continued From page 8 Resident #2 was unable to recall most recent events, had purposeless wandering and could not complete a two-stage command. The care plan for Resident #2 dated 12/31/13 addressed a problem of "exhibits behaviors of physical (phys) aggression as evidenced by (AEB) recent resident to resident altercations involving hitting another resident - related to: cognitive impairment. " The stated goals included the resident would not strike others, he would have reduced incidents of aggression and angry outbursts and staff would recognize and prevent behaviors that provoke aggressiveness. The approaches included document behaviors/interventions as indicated, remove resident from public area when behavior is disruptive, talk with resident in a low pitch, calm voice to decrease undesired behavior and provide diversional activity and report any change in mood or behavior to nurse immediately. Additionally, an update was added for the same date (12/31/13) for one on one sitter as needed to monitor. Review of the Minimum Data Set (MDS) a quarterly, dated 1/7/14 revealed Resident #2 had long term memory impairment, behavioral symptoms of physical symptoms directed toward others, independent with bed mobility, transfers, walking in room and halls and eating. Resident #3 was admitted to the facility on 1/29/13 with diagnoses of dementia and meningioma (benign brain tumor). Record review for Resident #3 revealed an antianxiety medication had been administered as needed 3 times in December 2013 and 8 times in	F 323		

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F 323	Continued From page 9 January 2014. The original date of this order was 10/17/13. Resident #3 was not on psychotropic medications. Review of Resident #2's nurse's notes dated 12/27/13 at 3:30 PM indicated Resident #2 was observed striking another resident (#3) on her arm with an open hand. Resident #2 was told that was not " nice " and we don ' t allow it. " No incident report was provided by the facility for this incident in the nurse ' s note. An incident report dated 12/27/13 at 4:15 PM indicated Resident #2 was sitting in his wheelchair in the door way to his room. Resident #3 walked up to him and agitated him by her actions of constantly repeating " mama, meme " and " touching him. " Resident #2 "touched the other pt (patient) on the forehead a little roughly with his open hand." Residents were redirected by the aide. Review of Resident #2's "SBAR" (Situation Background Assessment Request form) for communication and progress note for new symptoms, signs and other changes in condition dated 12/27/13 indicated the physician was notified on that date at 4:15 PM. This SBAR was written for Resident #2. The SBAR informed the physician of the second incident. This form included keeping the two residents apart made the condition better, Resident #2 was " becoming combative " and the request was " other " monitor pt (patient). Notes made by the nurse on the back of the form indicated the physician was in the facility, was made aware of the situation and discussed types of dementia with the nurse. The nurse documented no new orders were given by the physician.	F 323		

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Review of Resident #2's nurse's notes dated 12/27/13 at 5:00 PM indicated Resident#2 was observed "touching roughly" another resident (#3) in the face open handed when she went up to him. The nurse informed Resident #2 his behavior was unacceptable and not allowed.

Review of the incident report dated 12/30/13 at 4:45 PM revealed Resident #2 was in his room when Resident #3 entered his room. Resident #2 " pushed [Resident #3] onto the floor. " Resident #3 did not receive any injuries. The incident report indicated the physician was notified on that date. There were no entries made in the nurse ' s notes for this incident. No SBAR was provided by the facility for this incident.

Review of the incident report dated 12/31/13 at 4:20 PM revealed Resident #2 was sitting in a stationary chair in the hallway. He was approached by Resident #3 that " patted resident (#2) on arms, resident (#2) then punched [Resident #3] on forehead with resident ' s fist. Due to cognition resident unable to tell staff why he hit [Resident #3]. " This incident documented Resident #2 as " the aggressor. "

Review of the SBAR for Resident #2 dated 12/31/13 at 5:00 PM revealed Resident #2 had punched female resident on forehead with fist. He had approached " same [Resident #3] each time. " The assessment included " more confused. " The nurse included documentation of the incident on the back of the form. Resident #3 was " observed " to have " small bump on (L) left forehead. " No new orders were given. For " Request " the nurse checked the box for " lab work ...other tests " and to " monitor vital

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F 323	Continued From page 11 signs and observe " for Resident #2. Review of the nurse ' s notes for Resident #2 dated 12/31/13 at 10:00 PM revealed Resident #2 was on " One-on-one sitter @ (at) all times. No further behavior issues noted. The social worker ' s notes for Resident #2, dated 12/30/13 and 12/31/13, indicated she was made aware of incidents that occurred on 12/27/13 and 12/30/13. Staff was to monitor the resident ' s behavior (Resident #2) and the location of Resident #3. The care plan was updated with this approach. Review of the incident reported dated 1/5/14 at 6:30 PM indicated Resident #2 was seated in a straight back chair at the nurses' station. Resident #3 came up to his side and touched his chair. Resident #2 hit Resident #3 on the right side of the head with the back of his hand. No injuries were noted and Resident #2 was identified as the aggressor. There were no entries made in the nurse ' s notes for this incident for Resident #2. Review of the SBAR dated 1/5/14 at 7:00 PM revealed the nurse practitioner was notified of the incident with no injuries. There were no new orders at that time. Review of the Minimum Data Set (MDS) dated 1/7/14 indicated Resident #3 had long and short memory problems, severely impaired decision making abilities, wandering behaviors and verbal/physical behaviors towards others. This MDS assessed the resident as being independent with bed mobility, transfers and walking. The care plan dated 2/21/14 for Resident #3	F 323		

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indicated behaviors of wandering with interventions that included redirecting the resident, provide diversional activity and monitor her whereabouts.

An interview was conducted with the Social Worker on 3/3/14 at 4:00 PM. The social worker indicated there were no behaviors exhibited by Resident #2. He chose to stay in his room, most of the time. A psychiatric consult was not requested since his behavior was that of wandering. She explained she would do something the first time a resident was physically aggressive, such as request a psych consult. The administrative staff talked about him in the morning meetings. There was one resident that was very aggravating to most of the residents back there. (Resident #3) She expected the staff to monitor residents, all staff was to observe Resident#3 when she was pacing. She further explained staff should always know her whereabouts. During the interview, the social worker was asked to explain the difference between the previous altercations Resident #2 had with a resident, and the incident on 2/2/14. She replied the incident on 2/2/14 was unprovoked. Further interview revealed the social worker would spot what are the triggers for residents and explained staff can ' t watch every single second. She did not assess Resident #2 as having patterns of behaviors; the altercations were with just this one Resident (#3).

Interview with aide #1 on 3/4/14 at 12:00 PM revealed she worked on the second shift with Residents #2 and #3. Aide #1 explained she was working when Resident #2 had hit Resident #3 in the face. At the time of the altercation, she saw Resident #3 was in Resident #2 ' s face, but could

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F 323	Continued From page 13 not get to them to intervene before she was hit. Resident #3 was redirected and given diversional activities. Resident #2 was not able to participate in diversional activities; his attention span was too short. Aide #1 reported she did not remember any interventions in place to prevent Resident #3 from going into Resident #2 ' s room. Interview with aide #2 on 3/4/14 at 12:11 PM revealed she was working on second shift when Resident #3 went into Resident #2 ' s room. Aide #2 explained what agitated Resident #2 would be a resident getting in his face or tapping on him/his chair. She further explained he would hit you in these situations. During her shift, she had heard Resident #2 telling a resident to " quit. " She went to Resident #2 ' s room, but was unable to get to them soon enough to prevent the altercation. After the altercation, Resident #3, on her own, left the room. The nurse was informed of the incident and she tried to monitor where Resident #3 was located. Aide #2 was asked how she monitored Resident #3 and she explained every time she went by their rooms, she checked on them. Interview with aide #3 on 3/4/14 at 12:20 PM revealed she had provided 1:1 supervision with Resident #2. Aide #3 was not aware of what behaviors or incidents had occurred while watching him 1:1. She explained she was told he had behavior issues, and she had heard he had pushed Resident #3 down. Interview on 3/4/14 at 2:20 PM with the primary physician (the medical director) revealed he was aware of one incidence between Resident #2 and #3. The physician saw Resident #3 as the problem and a family meeting was held with her	F 323		

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responsible party. He was not aware of all of the incidents between Resident #2 and #3. During the interview he was asked if the SBARs were reviewed on his visits and he stated yes, the chart would be reviewed as well. The nurse practitioner had been informed about some of the incidents. The physician was asked how information was communicated to him by the nurse practioner and he responded they met each morning through the week. The " on call " is alternated between the nurse practitioner and himself. His expectations for the nursing staff included separating the residents, and he would not expect the Zyprexa to be given to Resident #2. The explanation included, Resident #2 did not remain agitated, calmed down after the incident and would not require medication. A psychiatric evaluation was not ordered; due to the facility staff presented the situation as Resident #3 was in Resident #2 ' s space.

Interview with the nurse practitioner on 3/4/14 at 4:05 PM revealed she did not remember the facility informing her of altercations between Resident #2 and #3. The primary physician had asked her about any altercations earlier that day. She stated she recalled one, (incident on 1/5/14), and there were no injuries. Further interview revealed the one incident did not seem to " be a big deal. " She had no further information to provide about either resident.

Interview with the ADON (Assistant Director of Nursing) on 3/5/14 at 4:00 PM revealed Resident #2 had one-on-one sitters for the following dates:

- 12/31/13 second and third shift
- 1/1/14 first, second and third shift
- 1/2/14 first and second shift.

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F 323	Continued From page 15 The nursing administration decided to stop the one-on-one sitters due to no further aggressive physical behaviors were exhibited by Resident #2. Interview with the ADON (Assistant Director of Nursing) on 3/5/14 at 4:00 PM revealed Resident #2 had one-on-one sitters started again on 1/5/14 for second and third shift. Nursing administration decided to end the one-on-one due to no further aggressive physical behaviors were noted during the one-on-one. Interview on 3/5/14 at 2:40 PM with the administrator revealed the facility saw Resident #3 as the instigator in the altercations. He would expect the staff to monitor the resident, redirect her, but he didn ' t know if they could assure she was safe at all times. During the interview he was asked what was done for Resident #2 and he stated he was not the problem, but Resident #3 was in his space. The Administrator was notified of Immediate Jeopardy on 3/3/14 at 5:30 PM. The allegation of compliance was received on 3/5/14 at 1:40 PM. The allegation of compliance was accepted on 3/5/14 at 4:36 PM. The Corrective Plan of Action: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - On February 2, 2014, a resident-to-resident altercation occurred between two residents in Room 515 in the facility ' s Special Care Dementia Unit on the 600 Hall. Following the documented incident, the facility took the following action:	F 323		

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F 323	Continued From page 16 - Immediately following the discovery of the incident, Residents in Room 515-1 (Resident #2) and 515-2 (Resident #1) were assessed by the facility ' s licensed nursing staff. The residents were immediately separated and one-on-one C.N.A. supervision for each resident was provided until both residents were transported to the local hospital. The resident ' s physicians were notified and orders were given to transport both residents to the local hospital ' s emergency room. The responsible parties for each resident were notified as well as the facility ' s Administrator, Director of Nurses and Assistant Director of Nurses. Under the coordination of the Administrator and Nursing Administration, an investigation of the incident was immediately initiated. A 24-Hour report was transmitted to the Division of Health Services Regulation. The two residents were both transported to the emergency room on 02/02/14. Resident #1 ' s known injuries included bilateral subdural hematoma, facial fractures and lacerations to the face. Resident #1 was hospitalized and then returned to the facility on 02/13/14. Resident #2 was arrested at the hospital and transported to the local jail. As of this date, Resident #2, who was discharged from the facility, had not returned. The facility reviewed the incident, the resulting outcomes and interventions with the facility ' s Medical Director via telephone 2/2/14. On February 2, 2014, a resident-to-resident altercation occurred between two residents in Room 515 in the facility ' s Special Care Dementia Unit on the 500 Hall. Following the documented incident, the facility took the following action: 1. Immediately following the discovery of the	F 323		

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F 323	Continued From page 17 incident, Residents in Room 515-1 and 515-2 were assessed by the facility ' s licensed nursing staff. The residents were immediately separated and one-on-one C.N.A. supervision for each resident was provided until both residents were transported to the local hospital. The resident ' s physicians were notified and orders were given to transport both residents to the local hospital ' s emergency room. The responsible parties for each resident were notified as well as the facility ' s Administrator, Director of Nurses and Assistant Director of Nurses. Under the coordination of the Administrator and Nursing Administration, an investigation of the incident was immediately initiated. A 24-Hour report was transmitted to the Division of Health Services Regulation. The two residents were both transported to the emergency room on 02/02/14. Resident #1 ' s known injuries included bilateral subdural hematoma, facial fractures and lacerations to the face. Resident #1 was hospitalized and then returned to the facility on 02/13/14. Resident #2 was arrested at the hospital and transported to the local jail. As of this date, Resident #2, who was discharged from the facility, has not returned. The facility reviewed the incident, the resulting outcomes and interventions with the facility ' s Medical Director via telephone on 02/02/14. 2. All residents on the facility ' s Special Care Dementia Unit were interviewed on 02/02/14 to ascertain whether they had been subjected to any abuse. All facility residents were given a head-to-toe assessment by the Assistant Director of Nurses, the Day RN Supervisor, the MDS Nurse and four LPN Charge Nurses on 02/02/14 for any signs of abuse and none were noted. The Plans of Care for all residents in the facility, with identified behaviors, were reviewed on	F 323		

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F 323	Continued From page 18 02/02/14 by the Director of Nurses, the Assistant Director of Nurses, the Day RN Supervisor and the MDS Coordinator. The Plans of Care and Resident Care Cards were updated as appropriate. On 02/02/14, facility staff were re-inserviced on resident abuse and dealing with behaviors by the Staff Development Coordinator and the Day RN Supervisor. Facility staff, who were unavailable on 02/02/14, were required to be re-inserviced prior to returning to work. Additionally, direct care nursing staff received education on the development of behavioral care plans and reporting observations that require interventions to the Director of Nurses or the Assistant Director of Nurses, on 02/02/14. Education on resident abuse and dealing with behaviors is included as part of the orientation of newly hired facility staff by the Staff Development Coordinator. The facility ' s Director of Nurses, or the Assistant Director Nurses if unavailable, if not in the facility, will be contacted by telephone for any observed behaviors that require assessment and intervention. The interventions for behaviors are reviewed with the Director of Nurses or Assistant Director of Nurses as the behaviors occur, 7-days per week. All observed behaviors are reviewed by the facility ' s InterDisciplinary Team with recommendations for action made as appropriate including modifications of the resident's Plan of Care, at the facility ' s Clinical Morning Meeting 5-days per week. Behaviors observed on weekends will be reviewed by the InterDisciplinary Team, utilizing the facility's 24-Hour Report, nurses notes, physician orders if appropriate and the Plan of Care, at the Clinical Morning Meeting on the next	F 323		

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F 323	Continued From page 19 business day. On 03/05/14, facility direct care staff were re-inserviced on identifying behaviors on the Behavior Monitoring Sheet, how to complete the Behavior Monitoring Sheet and the use of the INTERACT and Stop and Watch Tools as a communication tool from CNA's to licensed nurses by the Staff development Coordinator and the Day RN Supervisor. Facility direct care staff, who were unavailable on 03/05/14, were required to be re-inserviced prior to returning to work. Behavior Monitoring Sheet education is included in the orientation of all newly hired licensed nurses by the facility ' s Staff development Coordinator. The Behavior Monitoring Sheets for all facility residents were audited to ensure that all behaviors were identified by the Director of Nurses, Assistant Director of Nurses, Day RN Supervisor and two charge licensed nurses on 03/05/14. Resident #3's Plan of Care was reviewed, after exhibiting behaviors on 12/27/13, by the facility's Interdisciplinary Team and made the following addition; Resident to be re-directed to activities or TV room. Resident #3's Care Card was updated and the 500 Hall direct care staff provided re-direction to activities. On 12/31/14, Resident #3's Plan of Care was reviewed by the facility ' s Interdisciplinary Team and made the following addition; Monitor resident closely and re-direct when resident enters other resident ' s personal space. Resident #3's Care Card was updated and the 500 Hall direct care staff provided re-direction when Resident #3 entered the personal space of other residents. The facility ' s Interdisciplinary Team also updated the Plan of Care with the	F 323		

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F 323	Continued From page 20 following; Conduct a medication review for Resident #3 and the medication review was completed on 1/5/14. On 12/31/14, the facility's Interdisciplinary Team requested a formal meeting with Resident #3 ' s Responsible Party. A meeting was held on 1/10/14 with the facility ' s Interdisciplinary Team, the Assistant Director of Nurses, the facility's Administrator, Resident #3's attending physician, the Responsible Party and other family members to discuss the results of the medication review, physician recommendations and family suggestions for late afternoon and early evening activities and other interventions. The Responsible Party informed Resident #3 ' s attending physician that she did not want any medication interventions and would prefer to take Resident #3 home if adequate services could be obtained. The Responsible Party offered no suggestions for activities and interventions. The staff scheduling for the Special Care Unit on the 500 Hall was re-aligned starting on 03/04/14 by the Director of Nurses and the Assistant Director of Nurses to provide for one CNA and one Activity person to work split shifts, i.e. 10:00 a.m. to 6:00 p.m., to provide re-direction and intervention for Resident #3 during the late afternoon, when she and other residents on the Special Care Unit on the 500 Hall usually exhibit more wandering behavior. Beginning at 4: 45 PM on 3/5/14, interviews were conducted with staff members in nursing to determine compliance. Interviews revealed staff had been provided the in- services, were able to repeat the reporting procedures, use of the Stop and Watch and steps to take if aggressive behaviors did re-occur. As of 5:15 PM the nurses on all units had been interviewed for compliance with inservices and the aides on the locked unit	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN ST SILER CITY, NC 27344

(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 323	Continued From page 21 had received inservices. Information was reviewed that was used in the inservice training, the signature lists of all staff, chart audits completed by administrative nursing staff members on 2/2/14, and care plans for residents identified as having behaviors which required interventions. Other information reviewed consisted of the head to toes assessments performed on all residents, the Behavior Monitoring flow sheets and Target Behavior flow sheets to identify behaviors and document the interventions used for those behaviors. The 24 hour report was reviewed for information given shift to shift regarding resident ' s behaviors. The QI tool to be used by the DON or ADON to monitor the behavior was reviewed. A resident sample was selected from the list of residents on the locked dementia unit that included Residents # 4, 5 and 7. Record review revealed one of the three the sampled residents (Resident #4) was removed from the facility after an altercation that had occurred after 2/2/14. The care plans for these residents had been updated, the target behaviors were identified and behaviors had been documented.	F 323		