STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to honor choices for bedtime for 1 of 3 residents (resident #43), reviewed for choices. The findings included: Resident #43 was re-admitted to the facility on 1/2/2014 with diagnoses including Coronary Artery Disease and pacemaker. The annual comprehensive Minimum Data Set (MDS) assessment dated 12/30/2014, revealed that deciding her own bedtime was very important to her. The most recent quarterly Minimum Data Set (MDS) assessment dated 9/17/2015, revealed her cognition to be intact. She was independent with most Activities of Daily Living and was always continent with bowel and bladder. An interview was conducted with the resident on 12/14/2015 at 11:44 AM, who stated she had no choice on bedtime, because she had to wait up for her medicines. She indicated the previous nurse had always brought her medicines in at 7:30 PM, so she could get to sleep at 8:00 PM, her desired bedtime, but the new nurse wouldn't bring in her medicines until 9:00 PM. On 12/15/2015 at 4:55 PM, an interview was	F 242	Request for bedtime medications to be administered at 7:30pm for resident #43 to be honored and initiated no later than 1-14-16. Bedtime medication times shall by care planned accordingly to reflect resident #43's choice and reassessed quarterly and as needed. Nurses #2 and #3 to be provided written counseling by Staff Development Coordinator no later than 1-14-16, related to facility policy, "Quality of Life- Self Determination and Participation" and expectations in regards to communication of residents' desires for choices to Nursing Administration/Supervisor. Facility wide in-servicing to be completed by Staff Development Coordinator no later 1-14-16, in regards to residents rights, with concentration and focus on, but not limited to, choices about aspects of life in the facility that are significant to the resident. Facility wide audit entitled "Choice Audit" to be completed no later that 1-14-16 by the Quality Assurance Coordinator or his designee to canvas all current alert and oriented residents to	1/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 conducted with the resident, who stated she did not feel good about going to sleep until she had taken her evening medicines. She indicated she had told the evening nurse she wanted her medicines at 7:30 PM. On 12/16/2015 at 11:35 AM an interview was conducted with the nursing assistant (NA #3), who stated the resident was alert and oriented. She indicated the resident was completely independent and could make her own decisions and choices. On 12/16/2015 at 5:23 PM an interview was conducted with the evening nurse (Nurse #2), who indicated she worked on this hall only as needed. She stated resident #43 came to her every time she worked here and told her what time she wanted her evening medicines, which were scheduled at 9:00 PM. She indicated the resident went to bed after she received her medicines. The nurse stated she had not communicated that request to anyone, because she was able to get her medicines to her as requested, and had not thought about other nurses working on this hall. An interview was conducted with the Social Worker (SW #2), on 12/17/2015 at 9:15 AM. The SW stated that the resident was very expressive about her likes and dislikes, but had not heard about a bedtime preference. On 12/17/2015 at 10:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents' choices were honored. He indicated that if a resident wanted their medicines at a certain time each day, that nurse should communicate to the nursing supervisor, and the nursing supervisor should call the physician. The DON stated his staff knew to go up the chain of command to honor resident choices.	F 242	include, but not limited to choices about aspects of life such as heath care interest, assessments, plan of care and interacting with members of the community both in and outside of the facility. Any residents voicing concerns shall be referred to nursing for care plan adjustment to reflect said choice. Surveys Entitled "Choice Survey" to be completed by the Quality Assurance Coordinator or his designee weekly X 1 month, monthly X 1 quarter and quarterly thereafter with the first survey to be completed no later than 1-14-16. Surveys are to include questioning of residents, family members and staff members regarding satisfaction of residents choice about aspects of life in the facility that are significant to the resident. Resident #43 shall be included in first completed survey. Residents Rights with concentration and focus on, but not limited to choice, shall be discussed and communicated to residents monthly by the Social Worker during monthly Resident Council Meetings. Any residents voicing concerns shall be referred to nursing for care plan adjustment to reflect said choice. Choice surveys conducted by the Quality Assurance Coordinator and Resident Council Meeting minutes conducted by the Social Worker shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates to maintaining residents rights specific to choice about aspects of life in the facility that are significant to the resident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 2 On 12/17/2015 at 10:29 AM, a phone interview was conducted with the evening nurse (Nurse #3). The nurse stated the resident asked her for medications at 7:30 PM for the first 2 weeks that she began working on that hall. The nurse indicated she told the resident every time she could not give her medicines until 9 PM. She stated it took 2 weeks, but the resident had finally settled down. She stated the resident will come out of her room and look for the snack cart at 8:00 PM or 8:30 PM, and will ask for her medicines if she has not gotten them yet. She stated she had asked the supervisor about this resident when she first started, but the supervisor had told her the resident had always wanted her medicines early. The nurse had not communicated the resident's request further because it had not occurred to her the times could be changed.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		2/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code active diagnoses for 3 of 21 sampled residents (Residents #85, #122 and #169) whose Minimum Data Set (MDS) was reviewed. Findings included: 1. Resident #122 was admitted to the facility on 11/6/15. The undated electronic medical record diagnoses sheet included coronary artery disease, non -pressure chronic ulcer of the left lower leg, , non-pressure chronic ulcer of the right lower leg, cellulitis of the left lower limb and right lower limb, pressure ulcer of the heel-Stage III, diabetes, hypertension, chronic kidney disease, anemia, and generalized edema. The Medication Administration Record (MAR) and hospital discharge summary, dated 11/6/15 also included the diagnoses of peripheral vascular disease (PVD). The care plan, initiated on 12/8/15 identified a pressure area on Resident #122 ' s right heel, several venous ulcers to the bilateral lower extremities and a risk of pressure areas due to impaired bed mobility, incontinence, history of	F 278	Resident # 122 shall have Minimum Data Set (MDS) assessment dated 12-8-15 modified by Resident Care Coordinator (RCC) to reflect diagnoses of anemia diabetes and peripheral vascular disease (PVD) under section I of the MDS assessment to be completed no later than 1-14-16. Resident # 169 shall have MDS assessment dated 12-2-15 modified by the RCC to reflect the diagnoses of hypertension, dementia and anxiety under section I of the MDS assessment to be completed no later than 1-14-16. Resident # 85 noted as discharged from the facility. The RCC shall be provided counseling by the Staff Development Coordinator no later than 1-14-16 to include, but not limited to MDS assessment accuracy and Section I of the Resident Assessment Instrument manual. In-servicing of all MDS nurses to include but not limited to MDS accuracy and Section I of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4 PVD with stents in bilateral lower extremities. Review of the Quarterly MDS, dated 12/8/15 revealed anemia, diabetes and PVD were not included in the active diagnoses. The Resident Care Coordinator (RCC) was interviewed on 12/16/15 at 4:03 PM. The RCC stated she was responsible for completing the MDS. She stated information was gathered from nurse's notes, skin assessments, staff interviews and physician progress notes to complete the assessment. Decisions to add active diagnoses were determined by the diagnoses on hospital discharge summaries or those added or addressed by the facility physician. She stated anemia, diabetes, and PVD should have been included in active diagnosis, if the diagnoses were approved by a physician. The RCC reviewed the quarterly MDS for Resident #122 and acknowledged active diagnoses should have included PVD, anemia and diabetes. She added the omission would be considered an MDS inaccuracy. 2. Resident #169 was readmitted to the facility on 9/7/15 with diagnoses that included femur fracture, hypertension, and diabetes, dementia without behaviors, anxiety and hypothyroidism. The MDS, a quarterly dated 12/2/15, indicated active diagnoses did not include hypertension, anxiety or dementia. During an interview with the Resident Care Coordinator (RCC) on 12/16/15 at 4:03 PM, she stated she used information from nurse's notes and physician's progress notes to code active diagnoses on the MDS. Decisions to add active diagnoses are determined by the diagnoses on hospital discharge summaries or those added or addressed by the facility physician. The RCC reviewed the quarterly MDS for Resident #169 and stated hypertension, dementia and anxiety	F 278	Resident Assessment Instrument Manual and facility policy entitled "Resident Assessment Instrument" to be completed by Staff Development Coordinator no later than 1-14-16. Audit entitled "MDS Assessment Accuracy" shall be completed by the Quality Assurance Coordinator or his designee no later than 1-14-16 to ensure accuracy and completion of Section I of all current resident's MDS assessments. Any incomplete or inaccurate assessments shall be reported to the RCC for MDS assessment modification. Further "MDS Assessment Accuracy" audits shall include 10% of current resident census and be completed weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Audits entitled "MDS Assessment Accuracy" shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates to MDS assessment accuracy. Evaluation of MDS Assessment accuracy and quality assurance of such, shall be completed by contracted quality improvement organization as to provide expert evaluation of current practices and ongoing sustainment of effective MDS accuracy for current residents. Evaluation and education of such, to be completed no later than 2-2-16 through 2-4-16 (contract date) and shall be conducted quarterly for routine assessment of regulatory compliance as it relates to MDS assessment accuracy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5	F 278		

should have been included in active diagnosis. She added the omission of those diagnoses would be considered an MDS inaccuracy.

3. Resident # 85 was re-admitted to the facility on 11/5/2015 with diagnoses to include congestive heart failure and sepsis.
The physician orders dated 7/1/2015 through 7/31/2015 included diagnoses for metabolic encephalopathy, atrial fibrillation, hypertension, anemia, acute renal failure, congestive heart failure and sepsis.
A quarterly Minimum Data Set (MDS) assessment, dated 7/17/2015 had no diagnoses included, as the section was left blank.
The physician orders dated 10/1/2015 through 10/31/2015 included diagnoses for metabolic encephalopathy, atrial fibrillation, hypertension, anemia, acute renal failure, congestive heart failure and sepsis.
The most recent quarterly Minimum Data Set (MDS) assessment, dated 10/13/2015 had no diagnoses listed, as the section was left blank.
On 12/16/2015 at 4:02 PM, an interview was conducted with the MDS coordinator. The MDS coordinator stated she completed the MDS assessment by gathering information which included reviewing the resident's chart. She indicated if no diagnoses were listed on the MDS, they should have been. She stated she was responsible for including the diagnoses on the MDS, and the 10/13/2015 and 7/17/2015 MDS assessments were inaccurate, and she was not sure why the diagnoses were not included in the assessments.
On 12/17/2015 at 1:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that perhaps the MDS diagnoses were included on the assessment and it had just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 not been transmitted correctly.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to care plan the use of Coumadin (Resident #169), the refusal to use a splint (Resident #51), significant weight loss (Resident #245), and psychotropic medication (Resident #119) for 4 of 21 care plans reviewed. Findings included: 1. Resident #169 was readmitted on 9/7/15 with diagnoses that included femur fracture and atrial	F 279	Resident # 169 shall have care plan completed for Coumadin usage with measurable goals and interventions specific for the prevention of the side effects of Coumadin by the minimum data set (MDS) department to be completed no later than 1-14-16. Facility wide report compiled from contracted pharmacy services to determine facility wide Coumadin usage. All residents with	2/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 fibrillation. The MDS, a quarterly dated 12/2/15, indicated the resident was moderately cognitively impaired. Active diagnoses included atrial fibrillation. The resident was identified as receiving Coumadin (an anticoagulant). The most current physician's orders, dated December 2015 indicated Resident #169 received Coumadin 3.5 milligrams daily. Review of the 12/1/15 physician's telephone orders revealed a blood test was done on 12/7/15 to check the effectiveness of the Coumadin. The blood test was repeated on 12/14/15 and was found to be in a therapeutic level. Review of the care plan for Resident #169, with a 12/3/15 revision date, indicated Coumadin was included under the identified problem of at risk for skin decline. The goals failed to include any that were specific for identifying Coumadin side effects. Review of interventions failed to direct staff to observe for signs and symptoms of bruising or bleeding and failed to include interventions that would decrease the chance of bruising or bleeding. During an interview with the Resident Care Coordinator (RCC) on 12/16/15 at 4:03 PM, she stated care plan decisions were based on the fact a medication posed a problem or a potential problem for the resident or any concern that may be improved. Typically, she stated, the use of Coumadin was included in care plans for falls. The RCC reviewed the care plan for Resident #169 and acknowledged there was no inclusion for Coumadin under the fall care plan. She further reviewed the care plan and acknowledged there was no care plan for Coumadin with measurable goals and interventions specific for prevention of the side effects of Coumadin. The Director of Nursing was interviewed on	F 279	physician orders for Coumadin shall have care plan completed for Coumadin usage with measureable goals and interventions specific for the prevention of side effects of Coumadin by the MDS department to be completed no later than 1-14-16. Resident # 51 shall have care plan completed for refusal to wear a splint in her contracted left hand by the MDS department to be completed no later than 1-14-16. Facility wide audit entitled "Choice Audit" to be completed no later than 1-14-16 by the Quality Assurance Coordinator or his designee to canvas all current alert and oriented residents to include, but not limited to choices, as to ascertain any desired refusal of splints. Any recognized refusals shall be referred to nursing for care plan adjustment to reflect said choice. Resident # 245 shall have care plan completed for weight loss by the Dietary Manager to be completed no later than 1-14-16. All current interventions shall be reviewed by primary medical doctor and dietician for review and approval no later than 1-14-16. All current resident weights shall be obtained by facility weight team and compared to most recently obtained weights by Dietary Manager as to ascertain any recognized weight loss and the need for care planning of such. Any recognized residents shall have care plan for weight loss completed by Dietary Manager no later than 1-14-16. The Quality Assurance Coordinator shall be included in future Interdisciplinary Nutrition Committee meetings to review and ensure all residents with identified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 12/17/15 at 11:08 AM. He stated he would have expected for the use of Coumadin to be care planned. 2. Resident #51 was readmitted on 10/5/15 with diagnoses that included cerebrovascular accident with left hemiparesis and a contracture of the left hand. Review of the 10/12/15 Significant Change Minimum Data Set, indicated Resident #51 was cognitively intact and had limitation in range of motion on one side in both upper and lower extremities. The care plan, with a revision date of 10/25/15 identified the resident's hemiparesis, but failed to identify the resident's refusal to wear a splint in her contracted left hand. The resident was observed on 12/16/15 at 12:45 PM with no splint or protection in the palm of her contracted left hand. Resident #51 stated had a splint that she was able to put the splint on and take it off as she wished. She added she wore it at times and at times she did not. The resident denied poor fit or pain associated with the splint. The Rehabilitation Manager (RM) was interviewed on 12/16/15 at 3:00 PM. The RM reported Resident #51 was last assessed in October 2015 and found to be alert and oriented. The manager presented a note, documented by the therapist that indicated Resident #51 was not interested in wearing the left hand splint for extended lengths of time. The Resident Care Coordinator (RCC) was interviewed on 12/16/15 at 4:03 PM. The RCC stated typically refusal of care/treatment was care planned. She added refusing to wear a splint when a contracture was present would be care planned. She stated this would be the responsibility of both nursing and the Social	F 279	weight loss have a corresponding care plan completed. Resident # 119 shall have care plan completed for target behaviors and non-pharmacological interventions by Social Worker #1 no later than 1-14-16. Facility wide report from contracted pharmacy services obtained by Director of Nursing for all residents prescribed anti-psychotic medications. All residents noted to be prescribed anti-psychotic medications shall have target behaviors and non-pharmacological interventions care planned by the Social Worker to be completed no later than 1-14-16. Form entitled "Behavior/Interventions Monthly Flow Record" shall be initiated no later than 1-14-16 for all residents prescribed anti-psychotic medications and to be completed by unit nurses each shift as to monitor said residents target behaviors and non-pharmacological interventions, to include side effects. In-servicing shall be provided by Staff Development Coordinator to social workers and nursing staff no later than 1-14-16 to include, but not limited to documentation and care planning of target behaviors and non-pharmacological interventions for residents prescribed anti-psychotic medications. Audit entitled "Anti-psychotic Medication Audit" shall be completed by the Quality Assurance Coordinator or his designee no later than 1-14-16, to include, but not limited to all current residents prescribed anti-psychotic mediations, identification of target behaviors and non-pharmacological interventions with completed care planning of such. Audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 Worker as a negative behavior. She acknowledged there was no care plan for Resident #51's refusal to wear her splint, but could not give a reason for the omission. The Director of Nursing was interviewed on 12/17/15 at 11:08 AM. He stated he would have expected the refusal to wear a splint to be care planned. 3. Resident #245 was admitted on 10/13/15 with diagnoses that included metabolic encephalopathy, hypokalemia, unspecified fluid overload, generalized muscle weakness, dementia and hypertension. His admission weight was recorded as 194.6 pounds. Review of the Admission Minimum Data Set (MDS), dated 10/20/15 indicated Resident #245 was moderately cognitively impaired. He required supervision with eating and his weight was coded as 195 pounds with no significant loss or gain. The 10/20/15 Care Area Assessment indicated the resident triggered in the area of nutrition, but a decision was made not to care plan nutrition. On 10/21/15 at 1:17 PM, the resident's weight was coded as 187 pound which reflected a 7 pound weight loss in 8 days. Review of Resident #245's care plan with an onset of 10/23/15 did not address actual or potential weight loss. The care plan was reviewed on 10/27/15 and continued with no nutritional plan. An interview was held with the Resident Care Coordinator (RCC) on 12/16/15 at 4:03 PM. She stated significant weight loss was care planned when a resident lost 5% of their weight in 30 days or 10% in 180 days. The RCC added the Dietary Manager (DM) was responsible for care planning significant weight loss; adding the expectation was to care plan the significant	F 279	shall be completed weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Audits entitled "Anti-psychotic Medication Audit" shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance of identification, documentation and care planning of target behaviors and non-pharmacological interventions for current residents prescribed anti-psychotic medications. In-servicing entitled "Care Planning in Long Term Care" and "Care Planning Guidance" shall be provided through contracted educational organization by Staff Development Coordinator to all disciplines of the care planning staff. Audits entitled "Care Planning" shall be completed by the Quality Assurance Coordinator or his designee to include, but not limited to, care completion for Coumadin use, refusal of splints, weight loss, and psychotropic medication use with first audit to be completed no later than 1-14-16 and to continue weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Audits entitled "Care Planning" shall be incorporated into the Quarterly Quality Assurance Committee to ensure regulatory compliance as it relates to multidisciplinary comprehensive care planning. Evaluation of care planning and quality assurance of such shall be conducted by contracted quality improvement organization as to provide expert evaluation of current practices and ongoing sustainment of effective care planning for current residents. Evaluation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 weight loss as soon as the weight loss was recognized. Review of the care plan for Resident #245 revealed no nutritional care plan. The DM was interviewed on 12/17/15 at 12:15 PM. She defined significant weight loss as 5% weight loss in 30 days or 10% in 180 days. The DM added weight loss was reviewed weekly during the Nutrition at Risk meeting that she attended along with the Director of Nursing and the Staff Development Coordinator. The DM reviewed the weights for Resident #245 and acknowledged his significant weight loss of 8 pounds in 8 days. She stated she and the Registered Dietician were responsible for care planning nutrition and weight loss, but added she had been unaware of Resident #245's significant weight loss. The DM added while multiple nutritional interventions had been placed for this resident, she had failed to care plan nutrition to alert all staff to the interventions. The DM reported on 12/17/15 at 2:20 that Resident #245's current weight was 165 pounds which reflected a total loss of 30 pounds since his 10/13/15 admission. The Director of Nursing was interviewed on 12/17/15 at 11:08 AM. He stated he would have expected the resident's significant weight loss to be care planned. Facility failed to develop comprehensive care plan for refusing a splint, for coumadin use, depression, and DM for 4 of 21 residents whose care plan were reviewed. (#51, 58, 169, 119). 12/16/2015 2:15:48 PM propelling self in hall in w/c 12/16/2015 2:45:22 PM Sitting up in room, alert, "waiting for my daughter"	F 279	and education of such, to be completed no later than 2-2-16 through 2-4-16 (contract date) and to be continued quarterly for routine assessment of regulatory compliance as it relates to multidisciplinary comprehensive care planning.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11	F 279		

Medication
Zoloft 50mg qam

Insulin

? Diuretic

GDR qmonth

adm 4/13/15, most recent quarterly assesment 10/7/15, cognitively intact (15), no mood, or rejection of care. Requires extensive assistance with bed mobility, transfers with 2 person assist, extensive assistance with dressing toileting and personal hygiene with 1 person assist. Set up only with eating. REsident is able to propel self in w/c.Always incontinent of bowel and bladder, not in a toileting program.

Active DX: HTN, DM, hyperlipidemia, CVA, depression,

Medications- Received injections 7/7 days, antidepressant 7/7 days, diuretic 7/7 days.

Receiving PT/OT in look back

Care plans include

Dependent for all basic care needs. Rt. sided hemiplegia d/t recent CVA. Diabetic on insulin. Diabetic monitoring per md orders. Monitor for s/sx of hyper/hypo glycemia. revised/cont 10/7/15.

12/16/2015 4:50:02 PM Theresa Hardison, RN MDS/Resident Coordinator
REviewed and stated would you expect there to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 12	F 279		

be target behaviors identified for a resident receiving Zoloft with interventions? Yes.

Are there any specific interventions related to her diabetes besides monitor for s/sx of hyper/hypoglycemia? No,
states DM is addressed under care plan for skin, are there any specific interventions addressing her DM? No

REsident: Has staff talked to you about the medicines you're taking and why you're taking them?yes, yes I take blood thinner and water pill. I don;t know what the other one are. THey did talk to me about meds for depressing

Did they discuss the goals for the meds?

Were you provided with information about risks and benefits?yes

Do you think the medication has helped? Noticed any side effects?yes, not noticed any side effects

Staff:
12/17/2015 10:09:27 AM Sue Wilson, lpn, Have only cared for her twice, she wouldnt take breathing treatment this morning, she said it makes her nervous and jittery,
What kind of mood/behaviors does res exhibit?None noted

How do you know what kind of care/interventions she needs? MAR
To whom do you report behaviors/changes?report to supervisor

Are any non-pharm interventions utilized?no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13 Has res mood changed/improved or declined?I have not observed any in the two times I've had her. 4. Resident #119 was admitted 8/26/15 with diagnoses which included mood (affective) disorder, insomnia, anxiety, depression and dementia. Her most recent Minimum Data Set a quarterly assessment completed on 11/20/15 revealed moderately impaired cognition with moods present, verbal behaviors and rejection of care. The resident ' s care plan dated 9/4/15 specified the resident was at risk for falls due to falls, received psychotropic medications, and had diagnoses of Parkinson ' s disease and dementia. Goals were " will not experience side effects of psychotropic medication " . Interventions listed " monitor for side effects of psychotropic medication usage (increased lethargy, decreased appetite) and " monthly and PRN medication review by physician " . An interview was conducted with Social Worker #1 (SW) on 12/16/15 at 5:23 PM. She stated that she was responsible for care planning psychotropic medications on Resident #119. She stated that she would expect behaviors for depression, anxiety and the use of psychotropic medications to be addressed on the care plan and they were not.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 14 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to keep nails clean for 2 of 3 (Residents #74 and #55) dependent residents reviewed for needing extensive assistance with activities of daily living (ADLs). The findings included: 1) Resident #74 was readmitted to the facility on 5/21/15 with diagnoses which included hypothyroidism, unspecified convulsions and glaucoma. The significant change Minimum Data Set dated 9/8/15 revealed the resident was severely cognitively impaired. She was totally dependent for bathing and required extensive assistance with dressing and personal hygiene. The Care Plan revealed Resident #74 required assistance with ADLs. On 9/10/15 the care plan was updated and revealed she had a "recent decline in ability to participate in personal hygiene and ADL routines." The interventions included assist resident with ADLs and encourage resident to participate as able. An observation on 12/14/15 at 12:43 PM revealed Resident #74 had black debris under her fingernails on both hands. An observation on 12/15/15 at 10:20 AM revealed her fingernails continued to have black debris buildup under her fingernails on both hands. On 12/16/15 at 9:19 AM the resident was observed wearing the same shirt as she had on the previous day and her nails remained dirty. On 12/16/15 at 11:12 AM the resident stated she	F 312	Residents #74 and #55 noted to have current, appropriate nail care provided. Nursing Assistant #'s 1,2,5,6 and all other Nursing Assistants responsible for nail care for residents #74 and #55 during the dates of 12-14-15 through 12-17-15 shall be provided written counseling by Staff Development Coordinator no later than 1-14-16 to include, but not limited to facility policy entitled "Care of Fingernails/Toenails." Facility wide nursing in-services to be completed by staff Development Coordinator no later than 1-14-16 to include, but not limited to facility policy entitled "Care of Fingernails/Toenails." Facility policy entitled "Care of Fingernails/Toenails" to be included with new hire orientation for nursing staff and included in Nursing Assistants annual skills lab. Facility Wide Audit of all residents entitled "Facility Nail Care Audit" to be completed by the Quality Assurance Coordinator or his designee no later than 1-14-16 to ensure appropriate nail care for all current residents has been completed. Audit entitled "Resident ADL Audit" focusing on, but not limited to nail care and activities of daily living to be completed by the Quality Assurance Coordinator or his designee no later that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 15 had just received her bath but complained that it was not a "good" bath. An observation of her fingernails revealed they remained dirty. She was not wearing the same shirt as the 9:19 AM observation. On 12/16/15 at 3:29 PM during an interview with Nursing Assistant (NA) #1 she stated she had given Resident #74 a full bath this morning and nail care was considered part of the resident's bath. An observation of the resident's fingernails was conducted at this time. NA #1 stated she did not complete nail care because she did not have time. She stated the resident's nails needed trimming and were dirty. On 12/17/15 at 10:18 AM NA #2 stated she gave Resident #74 a bath and washed the resident's hands including under the fingernails. On 12/17/15 at 10:20 AM Nurse #1 stated she worked with Resident #74 yesterday and at 8:30 PM she observed the resident's nails had been cleaned but she did not know who did it. On 12/17/15 at 4:00 PM the Director of Nursing reported he expected nail care to be completed as part of the resident's daily bath. 2.) Resident #55 was admitted 8/13/10 with diagnoses which included dementia and anxiety. The most recent quarterly assessment dated 11/17/15 revealed the resident was severely cognitively impaired and was totally dependent on staff for personal hygiene. The Care Plan, updated 11/17/15, revealed Resident #55 had a self-care deficit with grooming related to impaired physical mobility and cognitive decline. On 12/14/15 at 12:27 PM, resident #55 was observed sitting in her Geri-chair in her room. There was a dark substance noted under all fingernails on both hands.	F 312	1-14-16 and to continue weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Audit findings shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates to facility activities of daily living with concentration on nail care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 16 On 12/16/15 at 8:43 AM, resident #55 was observed lying in bed asleep. The left hand was observed to have a dark substance under the fingernails. On 12/16/15 at 12:47 PM, the resident was observed sitting up in her Geri-chair, fingernails continued to have black substance underneath. On 12/16/15 at 2:44 PM, the resident was observed sitting up in Geri-chair, continued to have dark substance under fingernails. An interview was conducted on 12/16/15 at 2:46 PM with Nursing Assistant #5 (NA #5). She stated that resident #55 gets her bath on day shift. She reported that she does nail care before each meal and as needed. NA # 5 observed resident #55's nails and stated that they needed cleaning but "that's not as bad as I have seen them". NA #5 indicated she would come clean them as soon as she finished charting. On 12/17/15 at 9:19 AM, resident was observed lying in bed with sheet over face, right hand exposed. Fingernails had dark substance underneath. On 12/17/15 at 10:45 AM, an interview was conducted with NA #6. She stated that she had just finished resident #55's bath. She stated that she had washed her hands and nails. She reported that the NA's were responsible for cleaning fingernails and she did that once a week. NA #6 observed resident's nails and stated that was normal for Resident #55 but noticed she missed a spot and used a washcloth to clean the outside of the nail. On 12/17/15 at 11:07 AM, an interview was conducted with Nurse #1. She reported that all staff are responsible for nail care as care planned under daily care. She stated that nail care would be done as needed and with bathing.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 17	F 322		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to check placement and flush prior to the administration of medicine via gastric tube for 1 of 9 residents (resident # 161) observed during medication pass. The findings included: A facility policy titled "Administering Medication through an Enteral Tube" was revised March 2015. Steps in the procedure included: "#18. Confirm placement of feeding tube." "#21. When correct tube placement and acceptable gastric residual volume have been verified, flush tubing	F 322	Medication Error Report to be completed for Resident #161 by Director of Clinical Services no later than 1-14-16. Nurse #3 to be provided written counseling by Staff Development Coordinator no later than 1-14-16 to include, but not limited to, facility policy entitled "Administering Medication through an Enteral Tube." Facility Wide nursing in-servicing to be completed by Staff Development Coordinator no later than 1-14-16 to include, but not limited to, facility policy	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 18 with 15-30 mL (millileters) warm sterile water." Resident #161 was admitted to the facility on 3/19/2013 with diagnoses to include hypotension, gastric (G) tube placement and malnutrition. Physician orders dated 12/1/2015 included an order for midorine (a medication for hypotension) 2.5 milligrams (mg) via gastric (G) tube three times a day (TID). On 12/14/2015 at 5:04 PM, during an observation of medication administration, the nurse (nurse #3) entered the resident's room with the midorine medication and readied the supplies. The nurse donned gloves, attached the syringe to the G tube and poured the medication, that had been crushed and mixed with water, down the G tube. She flushed the tube with 1 and ½ cups of water after the medication. She then put the supplies away, took off her gloves and washed her hands. In an interview with the nurse immediately following, the nurse stated she forgot to check placement of the G tube before giving the medication. She stated she usually checked the placement with a syringe of air and a stethoscope. She was uncertain about flushing the tube before the medication, and stated the resident's G tube always flushed very well, she has never had problems with it. On 12/17/2015 at 9:48 AM an interview was conducted with the Director of Nursing (DON). The DON stated he expected the nurse to follow the facility policy and procedure for G tube medication administration. He stated G tube medication administration was covered in new hire orientation and in an annual clinical skills lab.	F 322	entitled "Administering Medication through an Enteral Tube." Said policy to be amended by Director of Nursing to strike "sterile" from #18 prior to in-servicing of policy. Facility policy entitled "Administering Medication through an Enteral Tube" to be included in new hire orientation for all nurses and included in required annual "Nursing Skills Lab." Audits entitled "Medication Pass Audit" focusing on, but not limited to administering medication through an enteral tube shall be completed by the Quality Assurance Coordinator or his designee to ensure nursing staff compliance with policy entitled, "Administering Medication through an Enteral Tube." First Audit to be completed by 1-14-16 and continued weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Contracted Pharmacy Consultant shall complete monthly audits entitled " Medication Administration Observation Report" to ensure compliance with policy entitled "Administering Medication through an Enteral Tube" with first audit to be completed no later than 1-14-16. Audit findings shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates to facility policy entitled "Administering Medication through an Enteral Tube."	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility failed to identify target behaviors and non-pharmacological interventions for 1 of 4 sampled residents (Resident #122) receiving an antipsychotic medication. Findings included: Resident #122 was admitted on 11/6/15 with diagnoses that included depression. On 11/23/15, Nurse #4 documented Resident #122 was picking at the scabs on her legs to "get the bugs off." An 11/23/15 Psychiatric progress note indicated	F 329	Resident # 122 shall have care plan completed for target behaviors and non-pharmacological interventions by Social Worker #1 no later than 1-14-16. Facility wide report from contracted pharmacy services obtained by Director of Nursing for all residents prescribed anti-psychotic medications. All residents noted to be prescribed anti-psychotics medications shall have target behaviors and non-pharmacological interventions care planned by the Social Worker to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 20 the follow up evaluation was due to staff request. Documented was a recent increase in tearfulness, anxiety with tactile hallucinations and delusional thoughts. The physician documented the resident thought the scabs on her lefts were bugs. Further documentation indicated the resident had as needed Xanax for acute episodes of anxiety and had required the Xanax 7 times so far during the month. During this visit, the resident's Seroquel (an antipsychotic medication) was increased to include a noon dose. Review of the December 2015 physician's orders included Seroquel 12.5 milligrams (mg) every morning and noon and 25 mg at bedtime for unspecified psychosis. The orders also included Xanax (an antianxiety medication) 0.25 mg daily as needed. On 12/7/15, the psychiatric follow up note indicated the increase in Seroquel had helped Resident #122. Xanax had been used four times during the month for acute anxiety. A Nursing Quarterly Assessment, dated 12/8/15, documented the use of Seroquel and Xanax, but did not identify target behaviors or any non-pharmacological interventions. On 12/8/15, the Social Worker documented a quarterly assessment. There were no delusions, hallucinations or anxiety identified. The Quarterly Minimum Data Set (MDS), dated 12/8/15 indicated Resident #122 was cognitively intact. The MDS did not identify delusions or hallucinations during the assessment period. Review of the care plan for Resident #122, reviewed on 12/8/15, included the use of psychoactive medications under the fall care plan. Review of goals indicated the resident would have no adverse side effects from the use of the medications. Interventions did not include direction for the prevention of side effects and did	F 329	completed no later than 1-14-16. Form entitled "Behavior/Interventions Monthly Flow Record" shall be initiated no later than 1-14-16 for all residents prescribed anti-psychotic medications and to be completed by unit nurses each shift as to monitor said residents target behaviors and non-pharmacological interventions, to include side effects. In-servicing shall be provided by Staff Development Coordinator to social workers and nursing staff no later than 1-14-16 to include, but not limited to documentation and care planning of target behaviors and non-pharmacological interventions for residents prescribed anti-psychotic medications. Audit entitled "Anti-psychotic Medication Audit" shall be completed by the Quality Assurance Coordinator or his designee no later than 1-14-16, to include, but no limited to all current residents prescribed anti-psychotic mediations, identification of target behaviors and non-pharmacological interventions with completed care planning of such. Audits shall be completed weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Audits entitled "Anti-psychotic Medication Audit" shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance of identification, documentation and care planning of target behaviors and non-pharmacological interventions for current residents prescribe anti-psychotic medications. Resident # 119 shall medication error report completed by Director of Clinical Services no later than 1-14-16. Nurse # 7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 21 not include non-pharmacological interventions to be used and documented prior to the use of the as needed Xanax. An interview was held with Resident #122 on 12/16/15 at 10:10 AM. The resident stated she had received something for her nerves that morning because she was so depressed all she could do was cry. She added people tried to make her feel crazy when she stated bugs were biting her; adding it was not the nurses and nursing assistants (NAs), but her family and "other workers". The resident stated she had the bugs biting her for a long time. Nurse #4 was interviewed on 12/16/15 at 11:20 AM. Nurse #4 stated Resident #4 was followed by psychiatric services because she had a feeling bugs were biting her. She stated when the resident had concerns of bugs biting, she assessed Resident #122, but had found nothing. The usual complaints of bugs biting was confined to the extremities and not to the trunk. During an interview with the Resident Care Coordinator (RCC) on 12/16/15 at 4:03 PM, she stated information for the MDS and care plans was obtained from nurse's notes, interviews with the resident and family members, review of physician's progress notes and psychiatric progress notes. The RCC defined target behaviors as behaviors that were displayed by a resident, such as wandering, crying, sad, or not wanting to participate in activities. The SW held the responsibility of care planning psychotropic medications. The RCC added she was unaware non-pharmacological interventions were needed and needed to be documented for the use of psychotropic medications. The nurse reviewed the care plan and acknowledged there was no specific target behaviors for Resident #122's Seroquel on the care plan and her as needed	F 329	shall be provided counseling by Staff Development Coordinator no later than 1-14-16 to include, but not limited to, accuracy of mediation administration monthly review. Contracted Pharmacy Consultant shall review all currents medication administration records no later than 1-14-16 as to ensure accuracy of transcription of all physician orders. Staff Development Coordinator shall provide in-servicing to nursing staff no later than 1-14-16 to include, but not limited to, monthly medication administration record review on the first day of every month for all shifts as to ensure accuracy of transcription of all physician orders. Audits entitled "Medication Administration Record Review" shall be completed by the Quality Assurance Coordinator or his designee monthly as to ensure accuracy of physician order transcription and completion of monthly medication administration record review by unit nurse with first audit to be completed no later than 1-14-16. Audits shall be incorporated into the Quarterly Quality Assurance Committee as to ensure ongoing compliance as it relates to mediation administration records accuracy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22	F 329		

Xanax was not mentioned.
An interview was held with the Social Worker (SW) #1 on 12/16/15 at 5:12 PM. The SW stated target behaviors were those behaviors exhibited by residents that make the use of psychotropic medications necessary. She added she was not aware target behaviors should be care planned with measurable goals and interventions and was unaware non-pharmacological interventions were needed. She stated she was unaware of Resident #122's target behaviors for the use of the Seroquel or the Xanax. The SW reviewed the care plan for Resident #122 and acknowledged target behaviors, measurable goals, interventions and non-pharmacological interventions had not been identified and care planned for the resident. She stated if nurses knew about the behaviors, there should be communication with her. In review of the resident's medical record, the SW stated she had not seen documentation to substantiate Resident #122 thinking bugs were biting.
The Director of Nursing was interviewed on 12/17/15 at 10:42 AM. He stated target behaviors were problematic issues for a resident and were listed in the electronic medical record. The DON added that all behaviors and not just target behaviors should be care planned along with non-pharmacological interventions if that was what the regulation required.
Resident #119 was admitted to the facility 8/26/15 with cumulative diagnoses which included hyperlipidemia and dementia.
The monthly physician orders for October 2015 included Aricept 5 milligrams (mg) by mouth (PO) at bedtime and atorvastatin 10 mg PO at bedtime. A physician order dated 10/27/15 included to discontinue the Aricept and atorvastatin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23 A review of the October Medication Administration Record (MAR) revealed Aricept and atorvastatin were crossed through and "D/Cd (discontinued) 10/27" was written through the dates for the remainder of the month. A review of the November MAR revealed that donepezil (Aricept) and atorvastatin (Lipitor) were listed as active medications and were offered or administered the entire month. A review of the December MAR revealed that Lipitor was written in with a note stating "from prev. MAR." In an interview on 12/17/15 at 9:11 AM, Nurse #5 stated that MARs were received a few days before the end of the month and checked by the front office and go through several checks. She explained that on the first day of the month, nurses were supposed to have both the previous month and new month's MAR on the medication cart to check for accuracy. She stated, "I don't know what happened there." An interview was conducted on 12/17/15 at 9:55 AM with Nurse #6. She stated that the new MARs come out around the 26th of the month. She stated that new orders should be written on both sets of MARs and the medications should have been discontinued by the unit nurse at the time it was written. She stated if that was missed, it should have been picked up by the person that does chart checks. She stated that nurse #7 was the person responsible for doing the monthly chart checks. The December MARs were reviewed by nurse #6 and she stated that Aricept and atorvastatin were not on there. An interview was conducted with the Director of Nursing (DON) on 12/17/15 at 11:00 AM. He stated that the facility employed nurses to come in and review charts and MARs for accuracy. He stated that he might have seen this type of omission once or twice a year.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 A telephone interview was conducted with Nurse #7 on 12/17/15 at 11:20 AM. She stated that she was the person responsible for checking the MAR on resident #119 but she could not immediately recall checking the November MAR because she checks so many. She stated that the floor nurses were supposed to check them on the first day of the month as well by having the previous month and new month on the medication cart. She stated that it is the responsibility of each shift's nurse to check the medication ordered for their shift after she checks them. She stated it was a human error. A voicemail message was left on 12/17/15 at 11:39 AM for Nurse #8 who gave the first dose of Atorvastatin and Aricept on 11/1/15. There was no returned call.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain a medication error rate less than 5%. There were 2 errors out of 25 opportunities for error, resulting in an 8% error rate. The findings included: #1. Resident #161 was admitted to the facility on 3/19/2013 with diagnoses to include hypotension, gastric tube placement, and malnutrition. Physician orders dated 12/1/2015 through 12/31/2015 included an order for midorine (a	F 332	Medication Error Form shall be completed no later than 1-14-16 by Director of Clinical Services for Resident # 161 and Resident # 164. Nurse # 3 to be provided written counseling by Staff Development Coordinator no later than 1-14-16 to include, but not limited to, facility policies entitled "Administering Medication through and Enteral Tube," "Documentation of Medication Administration" and "Medication	1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 25 medication for hypotension) 2.5 milligrams (mg) via gastric (G) tube three times a day (TID). On 12/14/2015 at 5:04 PM, during an observation of medication administration, the nurse (nurse #3) entered the resident's room with the midorine medication and readied the supplies. The nurse donned gloves, attached the syringe to the G tube and poured the medication, that had been crushed and mixed with water, down the G tube. She flushed the tube with 1 and ½ cups of water after the medication. She then put the supplies away, took off her gloves and washed her hands. In an interview with the nurse immediately following, the nurse stated she forgot to check placement of the G tube before giving the medication. She was uncertain about flushing the tube before the medication, and stated the resident's G tube had always flushed very well, and she had never had problems with it. On 12/17/2015 at 9:48 AM an interview was conducted with the Director of Nursing (DON). The DON stated he expected the nurse to follow the facility policy and procedure for G tube medication administration. He stated G tube medication administration was covered in new hire orientation and in an annual clinical skills lab. #2. Resident #164 was re-admitted to the facility on 7/27/2014 with a history of right hip fracture and chronic pain. Physician orders dated 12/1/2015 through 12/31/2015 included an order for oxycodone 5 milligrams (mg) ½ tablet (2.5mg) twice per day at 8:00 AM and 4:00PM. On 12/14/2015 at 5:12 PM, during an observation of medication administration, the nurse (nurse #3), removed the oxycodone from her cart and put it in a medicine cup. The nurse entered the resident's room and administered the medication to the resident at 5:15 PM.	F 332	Administration" with concentration on medication times. Facility policies entitled "Administering Medication through an Enteral Tube," "Documentation of Medication Administration" and Medication Administration" to be included in new hire orientation for all nurses and included in required annual "Nursing Skills Lab." Facility Wide nursing in-servicing to be completed by the Staff Development Coordinator no later than 1-14-16 to include, but not limited to, facility policies entitled "Administering Medication through an Enteral Tube," "Documentation of Medication Administration" and "Medication Administration" with concentration on medication times. Audits entitled "Medication Pass Audit" focusing on, but not limited to medication administration through an enteral tube and documentation of mediation administration shall be completed by the Quality Assurance Coordinator or his designee no later than 1-14-16 and to continue weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Contracted pharmacy consultant shall complete monthly audits entitled "Medication Administration Observation Report" to ensure compliance with policies entitled "Administering Medication through an Enteral Tube," "Documentation of Medication Administration" and "Medication Administration" with first audit to be completed no later than 1-14-16. Audit finding shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates to medication errors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 26 On 12/17/2015 at 9:48 AM an interview was conducted with the Director of Nursing (DON). The DON stated his expectation for a 4:00PM medication pass time, would be between the hours of 3:00 PM and 5:00 PM. He indicated that if the medication was not passed on time, he expected the nurse to report to the supervisor and the physician to be notified. On 12/17/2015 at 12:29 PM an interview was conducted with the nurse. The nurse stated her general time frame to give medications was 1 hour before to 1 hour after the order time. She indicated if she couldn't give the medication in that time frame, she would report to the supervisor, so the doctor could be called for a time change order. She stated she did not notify the supervisor for the observed medication pass for resident #164.	F 332		
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 368	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews the facility failed to provide three meals daily for 1 of 1 sampled resident (Resident #6) who did not receive a breakfast meal or a meal replacement on days she was sent to the hemodialysis (HD) clinic. The findings included: Resident #6 was readmitted to the facility on 9/6/13. Her diagnoses included end stage renal disease, hemodialysis (HD) and diabetes. The quarterly Minimum Data Set (MDS) dated 11/4/15 revealed she was moderately cognitively impaired and required extensive assistance with eating. A review of the Physician's orders revealed she had hemodialysis on Monday, Wednesday and Friday of each week and a diet of Mechanical Soft. A review of the "Dietary Food Cart Delivery Schedule" revealed cart #6 "West Hall (One to One)" which was the cart Resident #6's tray was on, delivered dinner at 5:50 PM, delivered breakfast at 7:50 AM and delivered lunch at 12:50 PM. A review of the Care Plan for Resident #6 updated on 8/12/15 revealed a problem listed as "Monitoring resident for nutritional decline: Receiving HD on M, W, F; PO intake is 91%; Mighty Shakes chocolate BID with meals and is fed at meals. Weight stable." On 12/15/15 at 12:04 PM Nursing Assistant (NA) #4 stated Resident #6 goes to dialysis on Monday, Wednesday and Friday and she had to be ready to go by 5:15 AM because that was when she was scheduled to be picked up by the transport vehicle.	F 368	Resident #6 shall be prepared breakfast by the dietary department to be offered by Nursing Assistant staff prior to all future dialysis appointments earlier than 6 am to begin immediately. All future appointments for residents scheduled for appointments earlier than 6am shall be reported by the Admissions Coordinator or her designee to dietary department on form entitled "Appointment Notification" to begin no later than 1-14-16. All appointments for residents scheduled appointments earlier than 6am shall be communicated by Admissions Coordinator or her designee, to nursing staff through written communication by posting individual resident appointment times on the scheduling white board at each nursing unit, to begin no later than 1-14-16. Nursing and dietary departments shall be provided in-servicing by Staff Development Coordinator to be completed by 1-14-16 to include, but not limited to facility policy entitled "Frequency of Meals." Facility Wide Audit entitled "Early Appointment/Breakfast Audit" to be conducted by the Quality Assurance Coordinator or his designee no later than 1-14-16 to ensure all current residents who are scheduled appointments earlier than 6am have been reported to the dietary department by Scheduling Coordinator or her designee on form entitled "Appointment Notification" and breakfast has been offered by the Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 368	Continued From page 28 On 12/15/15 at 11:20 AM Resident #6 was observed in bed wearing a coat, scarf, toboggan and a blanket was covering her from the chest down. She stated she had just returned from dialysis. She told NA #3 that she was hungry. Resident #6 stated she had no trouble eating and had a good appetite. On 12/16/15 at 11:23 AM Nursing Assistant #3 stated Resident #6 did not receive any food before she went to dialysis so she would get the Resident a cookie if it was before 10:30 AM when she returned from dialysis but if it was too close to lunch she would wait so it would not interfere with the resident eating a good lunch. On 12/17/15 at 12:49 PM the Dietary Manager (DM) stated Resident #6 leaves the facility at 5:30 AM which was before the kitchen was open. She stated they had sent a snack with the resident in the past or the nursing staff would come to the kitchen and get food for her but not at the present time. The DM asked the food service staff and they confirmed that they do not prepare any food for Resident #6 because she left for dialysis prior to the kitchen opening for the day. On 12/17/15 at 4:00 PM the Director of Nursing stated he was not aware Resident #6 was leaving the facility so early that she did not receive an early breakfast and did not receive any food to take with her when she went to hemodialysis.	F 368	Assistant staff. These audits shall be completed weekly X 1 month, monthly X 1 quarter and quarterly thereafter. Audits entitled "Appointment Times" shall be incorporated in the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates facility policy entitled "Frequency of Meals."	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520		1/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 29 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed to correct deficiencies in the areas of choices (F242), accuracy of assessments (F278), comprehensive care plans (F279), and care for activities of daily living (ADLs) (F312) cited during the recertification survey of 1/29/2015. As a result, deficiencies in the areas of choices, assessments, care plans, and ADLs were cited again on the current recertification survey. The findings included: This tag is cross referenced to: F242: Based on observations, record review, and staff and resident interviews, the facility failed to honor choices for bedtime for 1 of 3 residents	F 520	Facility deficiencies including choices(F242), accuracy of assessments(F278), comprehensive care plans(F279) and activities of daily living(ADLs)(F312) shall have accepted plans of correction no later than assigned corrective action date. Plans of correction shall incorporate corrective action to sustain ongoing monitoring of deficiencies for current and future residents that were found to have been affected by the deficient practice or were having potential to be affected by the same deficient practice and to be monitored by the Quarterly Quality Assurance Committee to ensure corrective action is achieved and sustained. This process shall be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 30 reviewed for choices. During the recertification survey of 1/29/2015 the facility was cited for failing to honor resident's choice to have bilateral side rails raised. F278: Based on record review and staff interviews the facility failed to accurately code active diagnoses for 3 of 21 sampled residents whose Minimum Data Set (MDS) was reviewed. During the recertification survey of 1/29/2015 the facility was cited for failing to code an MDS assessment accurately for dialysis, ventilator use, and dental condition. F279: Based on observation, staff and resident interviews and record reviews, the facility failed to care plan the use of Coumadin, the refusal to use a splint, significant weight loss, diabetes and the use of an antidepressant for 4 of 21 care plans reviewed. During the recertification survey of 1/29/2015 the facility was cited for failing to care plan broken natural teeth. F312: Based on observations and interviews the facility failed to keep nails clean for 2 of 3 dependent residents reviewed for needing assistance with ADLs. During the recertification survey of 1/29/2015 the facility was cited for failing to remove facial hair. On 12/17/2015 at 12:19 PM, an interview was conducted with the Quality Assurance Coordinator (QA). The QA Coordinator stated residents' choices were tied to a resident satisfaction survey to ensure compliance was maintained. Residents were given the survey every quarter. The MDS inaccuracies and care plan issues from the last survey were maintained by having the MDS nurse review the dental, dialysis, and ventilator status of residents, and also the care plans for dental every quarter. He stated the MDS nurse auditing herself was	F 520	completed by maintaining said committee to be comprised of, but not limited to Director of Nursing Services, facility Medical Director, facility Administrator, Quality Assurance Coordinator, Staff Development Coordinator, Director of Clinical Services, and facility department managers. The Quarterly Quality Assurance Committee shall meet quarterly and as needed to identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified deficiencies. Facility shall begin membership with the state "Quality Improvement Organization" to be initiated by Director of Nursing no later than 1-14-16 as to begin incorporation of "Quality Assurance and Performance Improvement"(QAPI). Facility shall incorporate Root Cause Analysis(RCA)to be completed via "Fishbone Analysis Tool" no later than 1-14-16. Incorporation of membership with state "Quality Improvement Organization" and RCA to be in-serviced to all facility departments by Staff Development Coordinator no later than 1-14-16. Sustainment of performance shall be monitored by facility Director of Compliance through assessment tools outlined in the Centers for Medicare and Medicaid Services (CMS) handbook entitled "QAPI" and results of these assessment tools shall be incorporated into the Quarterly Quality Assurance Committee to ensure ongoing compliance as it relates to Quality Assurance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	POST OFFICE BOX 1940 SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 31 acceptable because she was the expert on the MDS. ADLs were being maintained in QA by having continued quarterly audits of residents' facial hair. The QA Coordinator indicated the continued monitoring was specific for the deficiencies cited.	F 520		