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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 000	INITIAL COMMENTS IDR 10/17/16 resulted in deletion of F 312.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide maintenance services necessary to maintain a safe and comfortable interior on five of five hallways (100,200,300,400 and 500) and failed to maintain a sanitary environment on one of five halls (200 hall). The findings included: On 8/18/16 at 2:55 PM, a tour of the rooms and hallways was conducted. The following was observed in the hallways and in the resident rooms. 100 hall: In the hallway, wallpaper just above the baseboard was taped with clear tape between room 110-111 Room 105 scuffed walls and sheetrock crumbled at the baseboard by the closet; missing baseboard on wall by closet; bathroom door had hole the size of the room door handle; door handle cover on the inside of the door was loose. Room 106--scuffed walls; baseboard and some sheetrock missing near the closet Room 108--bifold closet doors off track Room 112--scuffed walls approximately 12 inches above baseboard near the closet; paint peeled on lower part of door to room (7 areas).	F 253	1. Rooms 105, 106, 112 and 210 will be repaired by 09/16/16 including replacing sheetrock, patching walls and painting the walls by the Maintenance Director/Assistant. Room 105□s bathroom door and door handle will be repaired by 09/16/16 by the Maintenance Director/Assistant. Rooms 108,316 and 412 bifold closet doors were inspected and put back on track by Maintenance Director/Assistant on 08/19/16. Room 205□s commode seat was removed and replaced on 08/19/16 by the Maintenance Director. 2. Center Executive Director (CED) and Admission Director completed commode seat audit on 08/26/16 to identify any commode seats that needed to be replaced. 16 commode seats were identified and replaced by Environmental Services Director on 09/07/16. Environmental Services Director completed sink audit on 08/16/16 to ensure the cleanliness of the sinks. 3 sinks were identified and cleaned	9/16/16

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

Electronically Signed | 09/08/2016

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 253	Continued From page 1 200 hall: Dark area with broken sheetrock just above baseboard in the hallway between rooms 201-202 Wallpaper loose and broken sheetrock in baseboard in the hallway between rooms 203-204 Black and peeling wallpaper and broken sheetrock above baseboard in the hallway between rooms 205-206 Room 205-commode seat was very loose and paint coming off seat Room 210 --paint chipped and peeling on room 210 door frame; black scuffs along the closet door and wall approximately 12 inches above floor. 300 hall: Loose wallpaper and loose baseboard in the hallway between rooms 305-306 Peeling wallpaper just above baseboard in the hallway between rooms 313-314 Dark area and loose baseboard in hallway going into the courtyard between 300 and 400 hall Loose baseboards in bathing room which was located between 300 and 400 hall Room 316--bifold closet doors off track 400 hall: Loose wallpaper in hallway between rooms 410-411 Loose wallpaper and baseboard in hallway between rooms 402 and 403 Room 412--closet door off track. 500 hall: Loose baseboard approximately 12 inches in length on left side of hallway near the courtyard door. On 8/18/16 at 3:10PM, an interview was conducted with the Maintenance Director. He stated he had been at the facility approximately 4 months and maintenance of the buildings was completed through the use of work orders. He	F 253	08/16/16. CED completed door audit on 08/22/16 to identify any doors that may have holes in them or any door knobs that were loose or in need of repair. Areas that were identified were repaired and/or replaced. Wall Door Bumpers will be placed on each resident bathroom door to prevent any future damage by the Maintenance Director/Assistant by 09/16/16. Center Executive Director completed closet door audit on 09/08/16 to identify any bifold closet doors that were off the track or in need of repair. Four closet doors were identified will be repaired or replaced by 09/16/16. Regional Property Manager, Maintenance Director and Maintenance Assistant audited all five halls of the center on 08/31/16 for walls/sheetrock/wallpaper/baseboard that was in need of repair. Areas were identified on all five halls including areas between 110-111, 201-202, 203-204, 205-206, 305-306, 313-314, 300-400, 410-411 and 402-403. All areas identified will be repaired or replaced by 09/16/16 by the Regional Property Manager, Maintenance Director and Maintenance Assistant. 3. Nurse Practice Educator (NPE) will reeducate licensed nurses, certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), dietary, housekeeping and department heads by 09/16/16, concerning completing maintenance work order forms when needs or concerns are identified. Regional Property Manager	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 253	Continued From page 2 indicated he performed " walk throughs " of the building every morning from Monday through Friday. The Maintenance Director stated there were blank work order forms at the main nursing station for 100,200,300, 400 halls and one on 500 hall. Anyone could fill out the form. The Maintenance Director stated it was usually nursing staff who filled out the work order forms. He stated the maintenance staff were painting the doors, door frames and walls and went from one hall to the next. He said by the time they got 500 hall done, they were back on 100 hall. Currently, 300 hall was being painted. He also said the maintenance staff had removed some of the baseboard on 100 hall, repaired the sheetrock and replaced the baseboard-not sure of time that was completed. A walk through of the building was conducted with the Maintenance Director at 3:05PM. All above areas were reviewed and shown to the Maintenance Director. Also, it was noted that the sink in room 205 was " stopped up " with light brown liquid. He stated he had not received any work orders for repair to the bathroom door in room 105 or the closet doors in rooms 108, 316 and 412. He stated they had just painted the walls/ doors on 200 hall 2 weeks ago. The Maintenance Director also stated he was aware that some of the wallpaper and sheetrock was in disrepair. He indicated he was not aware of the closet doors being off-track. On 8/18/16 at 3:30PM, an interview was conducted with the Housekeeping Supervisor. He stated any staff could fill out a work order if they saw something that needed repair. They would fill out the work order and put it in the box. Maintenance checked the box every morning and also, in most instances, in the evening. Also, he stated housekeeping staff told him if there was	F 253	provided re-education to the Maintenance Director and Maintenance Assistant on 09/06/16 to ensure that work orders are completed timely and are prioritized appropriately. Center Executive Director, Maintenance Director, Maintenance Assistant and Environmental Services Director will conduct sink audits, commode seat audits, bifold door audits, walls audits and door audits on all halls weekly times one month and monthly times two months. 4. Maintenance Director will report the findings of the audits to the monthly PI Meeting to ensure compliance and consistency. Center Executive Director, Maintenance Director and Environmental Services Director will complete weekly environmental rounds.	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 253	Continued From page 3	F 253		

anything that needed repair and he would verbally tell the Maintenance Director.
On 8/18/16 at 4:15PM, an interview was conducted with the Administrator. She stated her expectation was for any staff member to complete a work order if they noticed anything that was in disrepair. The Administrator stated they had identified that there was a need for a wall repair and painting schedule and they had just instituted a monthly schedule to ensure that the painting and wall repairs would be completed on each floor each month. She stated the facility had an in-service in May, 2015 regarding work orders and facility staff were educated on their responsibilities of completing a work order and returning the work order forms to maintenance.
A review of the Work Orders in-service dated 5/19/15 was reviewed and noted that all facility staff (nursing, social work, administrative, housekeeping, dietary, laundry) were educated on the location of the work order forms and their responsibility to complete the forms when they saw something in the building that needed repair.
On 8/19/16 at 8:45AM, an interview was conducted with housekeeper #1. She stated she worked on the floor on occasion and stated she had worked on 200 hall yesterday. She said she noted that the sinks in 205 and 206 had " stopped up " but did not fill out a work order because the assistant maintenance director had already completed a slip. Jackie stated that she would complete a work order form if she saw anything that needed to be repaired.
On 8/19/16 at 8:50 AM, an interview was conducted with housekeeper #2. She stated she worked on 100 hall and had been working at the facility for two years. She said she would fill out a work order form that was located at the nursing station if she saw anything that needed repairing.

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 253	Continued From page 4	F 253		

She indicated she had not noticed anything that needed repair and had not noticed the hole in the bathroom door in room 105-she had been off a few days and had come back to work yesterday. She also stated she had not noticed or filled out a work order for the closet doors in room 108.

On 8/19/16 at 9:15AM, an observation of the bathrooms in room 205 and room 206 was conducted. Both sinks in each of the bathrooms was coated with black/ brown material. The bathroom floor in room 206 had brown water under the sink and, at the front of the sink, approximately 6 inches in width. There was an odor in both bathrooms. Nursing staff interviewed indicated the residents in room 206 and the resident in room 205 did not use the bathroom.

On 8/19/16 at 9:17 AM, an observation of both bathrooms was conducted with the Administrator. She stated the sinks must have been "stopped up" and they had used something to unstop the drains. The Administrator stated she expected maintenance to notify housekeeping that the bathrooms and sinks needed to be cleaned after they had unstopped the drains.

On 8/19/16 at 9:20AM, an observation of the bathroom sinks in rooms 205 and 206 and the bathroom floor in 206 was conducted with the Housekeeping Supervisor and the Administrator. He stated housekeeping staff were in the facility until 7:00pm 8/18/16. He was not aware if housekeeping had been notified to clean the bathrooms. He stated he expected maintenance staff to notify housekeeping that the bathroom sinks and the water on the floor in the bathroom in 206 needed to be cleaned.

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 253	Continued From page 5 On 8/19/16 at 9:30PM, an interview was held with housekeeper #3. He stated he worked until 7:00PM yesterday and he was not informed that the bathrooms in rooms 205 and 206 needed to be cleaned.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272		9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 272	Continued From page 6 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to completely assess residents on the comprehensive assessment in the area of pain for 2 of 5 residents (Residents #28 and #44) reviewed for unnecessary medications. The findings included: 1. Resident #28 was admitted to the facility on 1/17/14 with multiple diagnoses including heart failure, depression, and chronic pain. The annual Minimum Data Set (MDS) assessment dated 7/1/16 indicated Resident #28 had significant cognitive impairment. She was assessed as able to make herself understood and able to understand others. Section J, the Health Conditions section, was not fully completed. Question J0200 indicated a pain assessment interview was to be completed with Resident #28. The remaining questions in the resident pain assessment interview, questions J0300 through J0600, were not assessed. The staff assessment for pain, question J0700, indicated it was not assessed. The annual MDS dated 7/1/16 for Resident #28 indicated MDS Nurse #1 completed Section J. An interview was conducted on 8/17/16 at 3:30 PM with MDS Nurse #1. Section J of the 7/1/16	F 272	1. Pain assessments were updated for Resident #28 and Resident #44 on 09/07/16 by the Licensed Nurse. 2. Clinical Reimbursement Coordinators (CRC) completed audit on 08/31/16 of the Pain Assessment (Section J) for the last 90 days (05/01/16-08/31/16) and identified ten pain assessments that were not completed. Pain Assessments were completed by 09/07/16 by the Licensed Nurse. 3. Nurse Practice Educator (NPE) will re-educated licensed nurses, including weekend and prn licensed nurses by 09/16/16, concerning pain assessments being completed accurately and timely. Center Nurse Executive, Clinical Reimbursement Coordinator or Nursing Supervisor will review the Nursing Assessment/User Defined Assessment (UDA) (which includes the Pain Assessment) that are scheduled each week five times/weekly in Clinical Stand-up times one month then weekly times two months. Clinical Reimbursement Coordinator(s) will review Section J of Minimum Data Set for	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 272	Continued From page 7 annual MDS for Resident #28 was reviewed with MDS Nurse #1. She indicated she had completed Section J of the 7/1/16 annual MDS for Resident #28. She revealed it was not a surprise to her that this section was incomplete. MDS Nurse #1 stated that nursing staff was responsible for conducting and documenting in the Electronic Medical Record (EMR) the resident pain assessment interview prior to the assessment reference date (ARD) of the MDS. MDS Nurse #1 indicated she took the documented answers from the EMR and completed the resident pain assessment interview questions on Section J of the MDS. She explained that sometimes nursing staff had not completed the resident pain assessment interview prior to the ARD and therefore, she was unable to complete the resident pain assessment interview questions on the MDS. She revealed this is what must have happened for the 7/1/16 annual MDS for Resident #28. She indicated when this occurred she reported to the nursing supervisor or the Director of Nursing (DON). She stated this had not happened "frequently", but it had happened "occasionally". MDS Nurse #1 reported the facility was working on a monitoring system to double check that the resident pain assessment interview was completed by nursing staff prior to the ARD of the MDS. She stated this new system began its implementation about three weeks ago. MDS Nurse #1 indicated she had seen an improvement with nursing staff's completion of the resident pain assessment interview prior to the ARD of the MDS. An interview was conducted with the Director of Nursing on 8/18/16 at 11:10 AM. She stated she expected the MDS to be fully completed for all residents. She revealed she was aware of issues	F 272	accuracy prior to transmission each week on 100% of residents x 4 weeks then 50% of residents x 4 weeks then 25% of residents x 4 weeks and 10% of residents quarterly thereafter. 4. Center Nurse Executive will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 272	Continued From page 8	F 272		

with the resident pain assessment interview not being completed and the facility was working on improving this issue.

2. Resident #44 was admitted to the facility on 6/10/16 with multiple diagnoses including heart failure, depression, and chronic pain.

The admission Minimum Data Set (MDS) assessment dated 6/17/16 indicated Resident #44 had significant cognitive impairment. She was assessed as usually able to make herself understood and usually able to understand others. Section J, the Health Conditions section, was not fully completed. Question J0200 indicated a pain assessment interview was to be completed with Resident #44. The remaining questions in the resident pain assessment interview, questions J0300 through J0600, were not assessed. The staff assessment for pain, question J0700, indicated it was not assessed. The admission MDS dated 6/17/16 for Resident #44 indicated MDS Nurse #1 completed Section J.

An interview was conducted on 8/18/16 at 9:20 AM with MDS Nurse #1. Section J of the 6/17/16 admission MDS for Resident #44 was reviewed with MDS Nurse #1. She indicated she had completed Section J of the 6/17/16 admission MDS for Resident #44. She revealed it was not a surprise to her that this section was incomplete. MDS Nurse #1 stated that nursing staff was responsible for conducting and documenting in the Electronic Medical Record (EMR) the resident pain assessment interview prior to the assessment reference date (ARD) of the MDS. MDS Nurse #1 indicated she took the documented answers from the EMR and

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 272	Continued From page 9 completed the resident pain assessment interview questions on Section J of the MDS. She explained that sometimes nursing staff had not completed the resident pain assessment interview prior to the ARD and therefore, she was unable to complete the resident pain assessment interview questions on the MDS. She revealed this is what must have happened for the 6/17/16 annual MDS for Resident #44. She indicated when this occurred she reported to the nursing supervisor or the Director of Nursing (DON). She stated this had not happened "frequently", but it had happened "occasionally". MDS Nurse #1 reported the facility was working on a monitoring system to double check that the resident pain assessment interview was completed by nursing staff prior to the ARD of the MDS. She stated this new system began its implementation about three weeks ago. MDS Nurse #1 indicated she had seen an improvement with nursing staff's completion of the resident pain assessment interview prior to the ARD of the MDS. An interview was conducted with the Director of Nursing on 8/18/16 at 11:10 AM. She stated she expected the MDS to be fully completed for all residents. She revealed she was aware of issues with the resident pain assessment interview not being completed and the facility was working on improving this issue.	F 272		
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	F 278		9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 278	Continued From page 10 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 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 observation, medical record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for three of seventeen sampled residents reviewed in the areas of medications (Resident #11) and dental (Resident #28, #59). The findings included: 1. Resident #110 was admitted to the facility originally 12/15/14 and last readmitted 7/29/16. Cumulative diagnoses included: Dementia without behavioral disturbance, Diabetes, Major depressive disorder, Psychosis, Anxiety, Mood	F 278	1. Modifications were made to the Minimum Data Set for Resident #11, Resident #28 and Resident #59 on 08/18/2016. The modification for Resident #42 and Resident #59 included changing Section LO200B status from no to yes. For Resident #11 the ARD dates were reviewed and Sections NO300 & NO410 ABC were modified to reflect the correct number of insulin injections. 2. Clinical Reimbursement Coordinators (CRC) completed audit on 09/02/16 of	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 278	Continued From page 11 disorder and Adjustment disorder. Physician orders for July 2016 were reviewed and noted the following: Ativan (medication used for anxiety) 0.5 milligrams every 8 hours as needed for anxiety Lexapro (antidepressant) 20 milligrams by mouth once a day Humulin 70/30 insulin inject 5 units subcutaneously two times a day for diabetes Seroquel (antipsychotic medication) 50 milligrams by mouth at bedtime Physician orders for 7/29--7/31/16 were reviewed and noted the following medications ordered on Resident #110's return to the facility on 7/29/16: Lexapro 20 milligrams by mouth daily Humulin 70/30 5 units subcutaneously two times daily Ativan 0.5 milligrams every 8 hours as needed for anxiety Remeron (antidepressant) 7.5 milligrams by mouth at bedtime Risperdal (antipsychotic medication) 0.5 milligrams by mouth at bedtime for psychosis. An Annual Minimum Data Set (MDS) dated 8/2/16 indicated Resident #110 was moderately impaired in cognition. Medications administered during the seven day look-back period was documented as 7 days of injections, 7 days of insulin and 7 days of antidepressant medications. The use of antipsychotic medication and anti-anxiety medication was not noted. A review of the Medication Administration Records (MARs) for the 7 day look back period: (7/27/16--8/2/16) indicated Resident #110 was not in the facility on 7/28/16. Medications	F 278	Minimum Data Set for last 90 days (05/01/16-08/31/16) for those residents who were coded for medications and dental. No other residents were identified with incorrect coding of insulin. 6 residents were identified with incorrect coding of dental and were modified on 09/02/16 by Clinical Reimbursement Coordinator. 3. Regional Clinical Reimbursement Coordinator will provide re-education to Clinical Reimbursement Coordinators on MDS accuracy 09/07/2016. The Interdisciplinary Team, including Director of Nursing, Clinical Reimbursement Coordinator, Recreation Director, Social Worker and Register Dietitian will review Minimum Data Set for accuracy prior to transmission each week on 100% of residents x 4 weeks then 50% of residents x 4 weeks then 25% of residents x 4 weeks and 10% of residents quarterly thereafter. 4. The centers Clinical Reimbursement Coordinator will present the results of the audit for accuracy for the entire Minimum Data Set that was completed prior to submission monthly to the Performance Improvement meeting for 3 months then quarterly.	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 278	Continued From page 12	F 278		

administered during the 7 day look-back period were as follows:
Humulin 70/30 insulin was administered 7/27/16, 7/30/16, 7/31/16. 8/1/16 and 8/2/16 (5 days)
Lexapro 20 milligrams and Remeron 7.5 milligrams were administered 7/27/16, 7/29/16, 7/30/16, 7/31/16, 8/1/16 and 8/2/16 (6 days).
Risperdal 0.5 milligrams at bedtime was administered 7/27/16, 7/29/16, 7/30/16, 7/31/16, 8/1/16 and 8/2/16 (6 days).
Ativan 0.5 milligrams was administered 8/2/16 at 9PM (1 day)

On 08/18/2016 t 9:34Am, an interview was conducted with MDS Nurse #2. She stated she usually made a copy of the MARs for the look-back period and obtained her information from the MAR to complete the medication section of the MDS. She reviewed the MARs and stated the insulin should have been documented as having been administered 5 days. MDS Nurse #2 said she may have seen documentation on 7/28 and 7/29 and did not realize it was documentation that Resident #110 was at the hospital. She further stated she should have also documented the use of the antipsychotic and antianxiety medications as noted per the MAR.

On 08/18/2016 at 10:07AM, an interview was conducted with MDS Nurse #2. She stated she went back and reviewed information and Resident's ARD date was originally 8/5/16 but was changed to 8/2/16 and she did not realize the date had been changed.

On 08/18/2016 at 11:00AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 278	Continued From page 13	F 278		

2. Resident #59 was admitted to the facility on 4/10/09 with multiple diagnoses including Vascular Dementia. The annual Minimum Data Set (MDS) assessment dated 9/16/15 indicated that Resident #59 had moderate cognitive impairment and was not edentulous.

The dental consult for Resident #59 dated 7/30/15 was reviewed. The dental consult indicated that the resident was edentulous and had no dental appliances.

On 8/17/16 at 2:05 PM, Resident #59 was observed. Resident #59 was observed to be edentulous.

On 8/17/16 at 2:14 PM, NA #2 was interviewed. NA #1 stated that she had known Resident #59 for years and the resident was edentulous.

On 8/18/16 at 10:05 AM, MDS Nurse #1 was interviewed. MDS Nurse #1 stated that the information from the nursing assessment were carried over to the MDS and the assessment did not indicate that Resident #59 was edentulous. MDS Nurse #1 further stated that she had observed Resident #59 and the resident was edentulous and the annual assessment was incorrect.

3. Resident #28 was admitted to the facility on 1/17/14 with multiple diagnoses including heart failure and depression.

The annual Minimum Data Set (MDS) assessment dated 7/1/16 indicated Resident #28 had significant cognitive impairment. The Oral/Dental Status section (Section L) of Resident

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 278	Continued From page 14	F 278		

#28's 7/1/16 annual MDS indicated she had no dental conditions.

An interview was conducted on 8/16/16 at 3:12 PM with a family member of Resident #28. The family member indicated Resident #28 had no natural teeth.

An observation of Resident #28 on 8/16/16 at 3:15 PM revealed she had no natural teeth.

An interview was conducted on 8/18/16 at 9:20 AM with MDS Nurse #1. She indicated she completed the Oral/Dental Status section of the MDS. She stated she utilized information from nursing assessments when she completed this section of the MDS. She indicated sometimes she also conducted resident observations to verify the information from the nursing assessments. The Oral/Dental Status section of Resident #28's 7/1/16 annual MDS was reviewed with MDS Nurse #1. The family interview information and resident observation information for Resident #28 was reviewed with MDS Nurse #1. MDS Nurse #1 revealed was unable to recall why the 7/1/16 annual MDS indicated Resident #28 had no dental conditions. She indicated she needed to review her documentation.

A follow up interview was conducted on 8/18/16 9:20 AM with MDS Nurse #1. She revealed the 7/1/16 annual MDS for Resident #28 was coded incorrectly for Oral/Dental Status. She stated this section should have indicated Resident #28 had no natural teeth. She indicated she may not have conducted an observation of Resident #28 to verify the information from the nursing assessments when she completed this section of the 7/1/16 annual MDS.

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 278	Continued From page 15 An interview was conducted on 8/18/16 at 11:00 AM with the Director of Nursing. She indicated her expectation was for the MDS to be coded accurately.	F 278		
F 279 SS=D	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 record review and staff interview, the facility failed to develop a care plan with measurable goals to address the care and treatment related to hospice for 1 (Resident # 79) of 1 sampled resident reviewed for hospice. Findings included:	F 279	1. Hospice care plan for Resident #79 was added on 08/18/16 to reflect her care and treatment related to Hospice. 2. Social Services completed an audit of all Hospice residents on 08/22/16 to	9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 279	Continued From page 16 Resident #79 was admitted to the facility on 7/15/16 with multiple diagnoses including Congestive Heart Failure. The admission Minimum Data Set (MDS) assessment dated 7/22/16 indicated that Resident #79 had received hospice care while a resident at the facility. The care plan dated 7/22/16 for Resident #79 were reviewed. There was no care plan problem, goal and interventions to address care and treatment related to hospice. On 8/18/16 at 9:25 AM, MDS Nurse #1 was interviewed. MDS Nurse #1 reviewed the care plan for Resident #79 and acknowledged that the care plan for hospice for Resident #79 was missed.	F 279	ensure appropriate Hospice care plans were in place. Care plans were in place for all current hospice residents. 3. Center Executive Director provided re-education to the Director of Social Services and Social Worker on developing a care plan with measurable goals to address care and treatment related to our hospice residents on 08/31/16. Interdisciplinary Team will review hospice residents for appropriate care plan each week in clinical stand-up indefinitely. 4. Director of Social Services will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 17 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed implement effective interventions to prevent a resident to resident physical altercation for a resident with a pattern of physical behaviors, verbal behaviors, and wandering behaviors (Resident #44). The findings included: Resident #44 was admitted to the facility on 6/10/16 with multiple diagnoses that included psychosis, anxiety, depression, dementia, and toxic encephalopathy (disorder of the brain). A physician's order dated 6/10/16 indicated Xanax (antianxiety medication) 0.25 milligrams (mg) every six hours as needed (PRN) for anxiety. The admission Minimum Data Set (MDS) assessment dated 6/17/16 indicated Resident #44 had significant cognitive impairment and had been evaluated as a level II Preadmission Screening and Resident Review (PASRR) for mental illness. Resident #44 was assessed as having had delusions and hallucinations. She was indicated to have had no behaviors or wandering during the 6/17/16 MDS look back period. Resident #44 received antipsychotic medication on 7 days, antidepressant medication on 7 days, and antianxiety medication on 2 days during the 7 day MDS look back period.	F 280	1. Wandering care plan for Resident #44 was added on 08/19/16 to reflect her care and treatment related to wandering. Behavioral care plans for Resident #44 were revised on 09/07/16 by the Center Nurse Executive to reflect appropriate interventions when displaying aggressive/combative behaviors. 2. Social Services completed an audit of all wandering residents on 08/22/16 to ensure appropriate wandering care plans were in place. Care plans were in place for all current wandering residents. Interdisciplinary Team completed a review on 09/06/16 & 09/08/16 of those residents who have displayed physical behavioral symptoms, verbal behavioral symptoms, inappropriate behaviors (pacing, rummaging, disrobing, etc&), delusional behaviors and wandering behaviors in the last 90 days (05/01/16-08/31/16). Revisions were made to care plans that did not have effective interventions to address the behaviors. 3. Center Executive Director provided re-education to the Clinical Reimbursement Coordinators, Director of Social Services and Social Worker on revising care plans appropriately on	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 18 Nursing documentation dated 6/26/16 and 6/27/16 indicated Resident #44 was physically and verbally aggressive toward staff. The plan of care for Resident #44 indicated a focus area was initiated on 6/27/16 for resistance to care, combative behavior and occasional cursing. The goals indicated Resident #44 was to have no more than 2 episodes of combative behavior per week for 90 days and she was to demonstrate less than 2 episodes of cursing by the next review period (target date 10/6/16). The interventions, initiated and revised on 6/27/16, read: - If resident/patient becomes combative or resistive, postpone care/activity and allow time for her to regain composure. - Approach the resident/patient in a calm, unhurried manner; reassure as needed - Explain all care/procedures (one step at a time) as resident will allow before initiating - Redirect resident as needed Nursing documentation dated 6/28/16 indicated Resident #44 was verbally aggressive toward staff. Nursing documentation dated 6/29/16 indicated Resident #44 had physical behaviors directed toward staff. The June 2016 Medication Administration Record (MAR) indicated Resident #44 was administered PRN Xanax eight times (6/11, 6/16, 6/22, 6/23, 6/24, 6/27, 6/28, and 6/29). Nursing documentation dated 7/1/16 and 7/4/16 indicated Resident #44 was verbally aggressive toward staff.	F 280	08/31/16. Nurse Practice Educator (NPE) will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), concerning wandering residents and those residents that are displaying aggressive/combative behavior on the importance or documenting and reporting to ensure that care plans are updated and revised with the most effective interventions by 09/16/16. 24 Hour Report will be reviewed by Interdisciplinary Team for any occurrences of wandering and/or aggressive residents five days/weekly at Clinical Stand-up. Documentation of interdisciplinary notes which includes documented wandering and behaviors is populated and is carried over to the 24 hour report from Point Click Care (PCC). Any occurrences that are identified, the care plans will be reviewed for effective interventions and revised as needed. 4. Center Nurse Executive will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 19	F 280		

A psychiatric consultation dated 7/6/16 for Resident #44 recommended no medication changes. Resident #44 was noted to have dementia, she was short tempered, and had periods of confusion.

The nursing assessment, dated 7/8/16, indicated Resident #44 had delusions and behaviors in the last 7 days. The behaviors were indicated to put Resident #44 at significant risk for physical injury or illness, significantly interfered with Resident #44's care, significantly interfered with Resident #44's participation in activities or social interactions, and disrupted the care or living environment. The behaviors were indicated not to have put others at significant risk of physical injury and had not intruded on the privacy of others activities.

Resident #44's quarterly MDS dated 7/8/16 indicated she had significant cognitive impairment and delusions. She had verbal behaviors directed toward others on 1 to 3 days during the 7 day look back period of the 7/8/16 MDS. Resident #44 received antipsychotic medication on 7 days, antidepressant medication on 7 days, and antianxiety medication on 4 days during the 7 day MDS look back period.

Nursing documentation dated 7/10/16 indicated Resident #44 was verbally aggressive toward staff and had physical behaviors directed toward staff.

Nursing documentation dated 7/11/16 indicated Resident #44 was wandering into other residents' rooms and was verbally aggressive toward staff.

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 20	F 280		

Nursing documentation dated 7/12/16 indicated Resident #44 was wandering around the unit by self-propelling her wheelchair.

Nursing documentation dated 7/14/16 indicated Resident #44 was verbally aggressive toward staff.

Nursing documentation dated 7/17/16 indicated Resident #44 was combative with staff, verbally aggressive toward staff, and was wandering throughout the halls and into other residents' rooms.

A social service note dated 7/22/16 indicated Resident #44 had increased wandering over the past 2 days. Resident #44 was to be moved to the locked unit.

Nursing documentation dated 7/22/16 indicated Resident #44 was self-propelling her wheelchair into other residents' rooms and was taking their belongings.

Nursing documentation dated 7/30/16 indicated Resident #44 was combative with staff and was taking items out of other residents' rooms.

The July 2016 MAR indicated Resident #44 was administered PRN Xanax sixteen times (7/1, 7/2, 7/3, 7/5, 7/8, 7/9, 7/10, 7/13, 7/14, 7/15, 7/17, 7/20 (x2), 7/29, 7/30, and 7/31).

Resident #44's 60 day review MDS dated 8/5/16 indicated she had significant cognitive impairment. She had physical behaviors directed toward others, verbal behaviors directed toward others, other behavioral symptoms not directed toward others, and wandering behaviors on 7 of 7

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 21	F 280		

days during the 8/5/16 MDS look back period. Resident #44 received antipsychotic medication on 7 days, antidepressant medication on 7 days, and antianxiety medication on 2 days during the 7 day MDS look back period.

Nursing documentation dated 8/7/16 at 10:06 AM revealed a late entry was documented for an incident that occurred with Resident #44 on 8/6/16 after dinner. Resident #44 was indicated to have been sitting outside of another resident's doorway. Resident #44 was yelling and cursing at the other resident. Nursing staff indicated they attempted to redirect Resident #44 to another location. Resident #44 was redirected after the third staff attempt. The documentation indicated Resident #44 continued to wander in and out of other residents' rooms.

Nursing documentation dated 8/7/16 at 10:55 AM revealed a late entry was documented for an incident that occurred with Resident #44 on 8/6/16. "At 6:35 PM [Resident #44] went into another resident room, cussing was heard from outside the door, [Nursing Assistant] went in immediately and saw [Resident #44] with her hands on the other resident neck area, residents were separated and assessed with no injuries noted at this time."

Nursing documentation dated 8/7/16 at 3:22 PM indicated Resident #44 was wandering into other residents' rooms throughout the shift. Resident #44 was noted to go through other residents' dresser drawers and closets and remove items. Resident #44 was argumentative with staff and resisted returning the other residents' items.

The plan of care for Resident #44 was updated

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 22	F 280		

on 8/8/16 and indicated the focus area, "Resident involved in an altercation with another female resident on 8/7 - put her hands around that woman's neck." The goal indicated Resident #44 was to inflict no harm on other residents for 90 days (target date 10/6/16). The interventions, initiated on 8/8/16, read:
- Monitor her interactions with other residents for clues that they may not be getting along and separate as needed
- Staff to monitor resident's whereabouts and redirect her out of others' rooms

There was no plan of care to address wandering for Resident #44.

Nursing documentation dated 8/18/16 indicated Resident #44 was loud and disruptive, cursing and hitting staff, and was going to into other residents' rooms.

The August 2016 MAR indicated Resident #44 was administered PRN Xanax 3 times (8/7, 8/17, and 8/18).

An interview was conducted with Nurse #1 on 8/18/16 at 11:50 AM. She indicated Resident #44 was noted to have behaviors. She stated Resident #44 wandered throughout the unit. She stated sometimes Resident #44 self-propelled herself in her wheelchair and other times she ambulated. She indicated Resident #44 went in and out of other residents' rooms. Nurse #1 indicated a lot of the residents on the locked unit wandered throughout the halls. She stated the staff just tried to monitor residents' whereabouts as much as possible.

An interview was conducted with Social Worker

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 23	F 280		

(SW) #1 on 8/18/16 at 3:30 PM. She stated she was familiar with Resident #44. She reported Resident #44 had a room change to the locked unit a few weeks due to her wandering behaviors. She stated Resident #44 went into other residents' rooms and picked up their belongings. SW #1 revealed Resident #44 had no care plan for wandering. She stated that there wasn't much to care plan for wandering other than staff trying to watch Resident #44 more often. She indicated Resident #44 was not exit seeking and therefore was not an elopement risk. She stated the wandering behaviors had been ongoing since her admission. SW #1 indicated she was aware of the physical altercation that occurred on 8/6/16 between Resident #44 and another resident. She reported the incident was discussed on 8/9/16 in the morning staff meeting. She stated Resident #44's plan of care was updated to include the focus area of the physical altercation with another resident. She indicated Resident #44 continued her wandering behaviors. SW #1 reported that there were no new interventions in the care plan to prevent wandering for Resident #44. She stated Resident #44 was seen for a psychiatric consultation on 8/17/16 and she was hoping a medication adjustment was going to be helpful for the management of her behaviors.

An interview was conducted with Nurse #3 on 8/18/16 at 4:10 PM. She indicated she worked on the locked unit with Resident #44 about once per week. She stated she had observed Resident #44 with physical behaviors and verbal behaviors directed toward staff as well as wandering behaviors. She reported she had never observed Resident #44 with physical behaviors directed toward any other resident. She revealed she had not heard about the

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 24	F 280		

incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She stated Resident #44 continued to wander throughout the unit, up and down the halls, and in and out of other residents' rooms. She indicated that to her knowledge there were no new interventions put into place for Resident #44's physical behaviors, verbal behaviors, or wandering behaviors.

An interview was conducted with NA #1 on 8/18/16 at 4:30 PM. She stated she usually worked on the locked unit. She indicated she was familiar with Resident #44. She stated she had observed Resident #44 hitting and kicking at staff and wandering throughout the unit and into other residents' rooms. She indicated that staff tried to redirect Resident #44, but that was when she became most combative. She stated she had heard about the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She indicated she had not heard about all of the details about the incident. She revealed that she was not aware of any new interventions that were put into place for Resident #44's physical behaviors, verbal behaviors, or wandering behaviors.

An interview was conducted with the Director of Nursing (DON) on 8/19/16 at 8:55 AM. She indicated she was aware of the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She stated that a lot of the residents on the locked unit wandered around throughout the day. She revealed she was not aware Resident #44 had no plan of care wandering. She stated she was unable to say if any new interventions were put into place after the incident with Resident #44 on

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 280	Continued From page 25 8/6/16. An interview was conducted with the Administrator on 8/19/16 at 10:00 AM. She stated she was aware of the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She indicated the facility had failed to develop effective interventions to prevent to the incident.	F 280		
F 323 SS=D	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 record review and staff interview the facility failed to manage inappropriate behaviors and implement effective interventions to prevent a resident to resident physical altercation for a resident with a pattern of physical behaviors, verbal behaviors, and wandering behaviors (Resident #44). The findings included: Resident #44 was admitted to the facility on 6/10/16 with multiple diagnoses that included psychosis, anxiety, depression, dementia, and toxic encephalopathy (disorder of the brain). A physician's order dated 6/10/16 indicated Xanax (antianxiety medication) 0.25 milligrams	F 323	1. Resident #44 was separated and redirected from the other resident. No injuries were noted and no other incidents noted. 2. Social Services completed an audit of all wandering residents on 08/22/16 to ensure appropriate wandering care plans were in place. Care plans were in place for all current wandering residents. Interdisciplinary Team completed a review on 09/06/16 & 09/08/16 of those residents who have displayed physical behavioral symptoms, verbal behavioral symptoms, inappropriate behaviors (pacing,	9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 26 (mg) every six hours as needed (PRN) for anxiety. The admission Minimum Data Set (MDS) assessment dated 6/17/16 indicated Resident #44 had significant cognitive impairment and had been evaluated as a level II Preadmission Screening and Resident Review (PASRR) for mental illness. Resident #44 was assessed as having had delusions and hallucinations. She was indicated to have had no behaviors or wandering during the 6/17/16 MDS look back period. Resident #44 received antipsychotic medication on 7 days, antidepressant medication on 7 days, and antianxiety medication on 2 days during the 7 day MDS look back period. Nursing documentation dated 6/26/16 and 6/27/16 indicated Resident #44 was physically and verbally aggressive toward staff. The plan of care for Resident #44 indicated a focus area was initiated on 6/27/16 for resistance to care, combative behavior and occasional cursing. The goals indicated Resident #44 was to have no more than 2 episodes of combative behavior per week for 90 days and she was to demonstrate less than 2 episodes of cursing by the next review period (target date 10/6/16). The interventions, initiated and revised on 6/27/16, read: - If resident/patient becomes combative or resistive, postpone care/activity and allow time for her to regain composure. - Approach the resident/patient in a calm, unhurried manner; reassure as needed - Explain all care/procedures (one step at a time) as resident will allow before initiating - Redirect resident as needed	F 323	rummaging, disrobing, etc.&), delusional behaviors and wandering behaviors in the last 90 days (05/01/16-08/31/16). Revisions were made to care plans that did not have effective interventions to address the behaviors. 3. Center Executive Director provided re-education to the Clinical Reimbursement Coordinators, Director of Social Services and Social Worker on revising care plans appropriately on 08/31/16. Nurse Practice Educator (NPE) will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), concerning wandering residents and those residents that are displaying aggressive/combative behavior on the importance or documenting and reporting to ensure that care plans are updated and revised with the most effective interventions by 09/16/16. Licensed Charge Nurse on each hall will monitor that intervention on care plans are utilized by the certified nursing assistants as needed. 24 Hour Report will be reviewed by Interdisciplinary Team for any occurrences of wandering and/or aggressive residents five days/weekly at Clinical Stand-up. Any occurrences that are identified, the care plans will be reviewed for effective interventions. 4. Center Nurse Executive will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 27	F 323		

Nursing documentation dated 6/28/16 indicated Resident #44 was verbally aggressive toward staff.

Nursing documentation dated 6/29/16 indicated Resident #44 had physical behaviors directed toward staff.

The June 2016 Medication Administration Record (MAR) indicated Resident #44 was administered PRN Xanax eight times (6/11, 6/16, 6/22, 6/23, 6/24, 6/27, 6/28, and 6/29).

Nursing documentation dated 7/1/16 and 7/4/16 indicated Resident #44 was verbally aggressive toward staff.

A psychiatric consultation dated 7/6/16 for Resident #44 recommended no medication changes. Resident #44 was noted to have dementia, she was short tempered, and had periods of confusion.

The nursing assessment, dated 7/8/16, indicated Resident #44 had delusions and behaviors in the last 7 days. The behaviors were indicated to put Resident #44 at significant risk for physical injury or illness, significantly interfered with Resident #44's care, significantly interfered with Resident #44's participation in activities or social interactions, and disrupted the care or living environment. The behaviors were indicated not to have put others at significant risk of physical injury and had not intruded on the privacy of others activities.

Resident #44's quarterly MDS dated 7/8/16 indicated she had significant cognitive impairment

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 28	F 323		

and delusions. She had verbal behaviors directed toward others on 1 to 3 days during the 7 day look back period of the 7/8/16 MDS. Resident #44 received antipsychotic medication on 7 days, antidepressant medication on 7 days, and antianxiety medication on 4 days during the 7 day MDS look back period.

Nursing documentation dated 7/10/16 indicated Resident #44 was verbally aggressive toward staff and had physical behaviors directed toward staff.

Nursing documentation dated 7/11/16 indicated Resident #44 was wandering into other residents' rooms and was verbally aggressive toward staff.

Nursing documentation dated 7/12/16 indicated Resident #44 was wandering around the unit by self-propelling her wheelchair.

Nursing documentation dated 7/14/16 indicated Resident #44 was verbally aggressive toward staff.

Nursing documentation dated 7/17/16 indicated Resident #44 was combative with staff, verbally aggressive toward staff, and was wandering throughout the halls and into other residents' rooms.

A social service note dated 7/22/16 indicated Resident #44 had increased wandering over the past 2 days. Resident #44 was to be moved to the locked unit.

Nursing documentation dated 7/22/16 indicated Resident #44 was self-propelling her wheelchair into other residents' rooms and was taking their

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 29	F 323		

belongings.

Nursing documentation dated 7/30/16 indicated Resident #44 was combative with staff and was taking items out of other residents' rooms.

The July 2016 MAR indicated Resident #44 was administered PRN Xanax sixteen times (7/1, 7/2, 7/3, 7/5, 7/8, 7/9, 7/10, 7/13, 7/14, 7/15, 7/17, 7/20 (x2), 7/29, 7/30, and 7/31).

Resident #44's 60 day review MDS dated 8/5/16 indicated she had significant cognitive impairment. She had physical behaviors directed toward others, verbal behaviors directed toward others, other behavioral symptoms not directed toward others, and wandering behaviors on 7 of 7 days during the 8/5/16 MDS look back period. Resident #44 received antipsychotic medication on 7 days, antidepressant medication on 7 days, and antianxiety medication on 2 days during the 7 day MDS look back period.

Nursing documentation dated 8/7/16 at 10:06 AM revealed a late entry was documented for an incident that occurred with Resident #44 on 8/6/16 after dinner. Resident #44 was indicated to have been sitting outside of another resident's doorway. Resident #44 was yelling and cursing at the other resident. Nursing staff indicated they attempted to redirect Resident #44 to another location. Resident #44 was redirected after the third staff attempt. The documentation indicated Resident #44 continued to wander in and out of other residents' rooms.

Nursing documentation dated 8/7/16 at 10:55 AM revealed a late entry was documented for an incident that occurred with Resident #44 on

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 30	F 323		

8/6/16. "At 6:35 PM [Resident #44] went into another resident room, cussing was heard from outside the door, [Nursing Assistant] went in immediately and saw [Resident #44] with her hands on the other resident neck area, residents were separated and assessed with no injuries noted at this time."

Nursing documentation dated 8/7/16 at 3:22 PM indicated Resident #44 was wandering into other residents' rooms throughout the shift. Resident #44 was noted to go through other residents' dresser drawers and closets and remove items. Resident #44 was argumentative with staff and resisted returning the other residents' items.

The plan of care for Resident #44 was updated on 8/8/16 and indicated the focus area, "Resident involved in an altercation with another female resident on 8/7 - put her hands around that woman's neck." The goal indicated Resident #44 was to inflict no harm on other residents for 90 days (target date 10/6/16). The interventions, initiated on 8/8/16, read:
- Monitor her interactions with other residents for clues that they may not be getting along and separate as needed
- Staff to monitor resident's whereabouts and redirect her out of others' rooms

There was no plan of care to address wandering for Resident #44.

Nursing documentation dated 8/18/16 indicated Resident #44 was loud and disruptive, cursing and hitting staff, and was going to into other residents' rooms.

The August 2016 MAR indicated Resident #44

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 31	F 323		

was administered PRN Xanax 3 times (8/7, 8/17, and 8/18).

An interview was conducted with Nurse #1 on 8/18/16 at 11:50 AM. She indicated Resident #44 was noted to have behaviors. She stated Resident #44 wandered throughout the unit. She stated sometimes Resident #44 self-propelled herself in her wheelchair and other times she ambulated. She indicated Resident #44 went in and out of other residents' rooms. Nurse #1 indicated a lot of the residents on the locked unit wandered throughout the halls. She stated the staff just tried to monitor residents' whereabouts as much as possible.

An interview was conducted with Social Worker (SW) #1 on 8/18/16 at 3:30 PM. She stated she was familiar with Resident #44. She reported Resident #44 had a room change to the locked unit a few weeks due to her wandering behaviors. She stated Resident #44 went into other residents' rooms and picked up their belongings. SW #1 revealed Resident #44 had no care plan for wandering. She stated that there wasn't much to care plan for wandering other than staff trying to watch Resident #44 more often. She indicated Resident #44 was not exit seeking and therefore was not an elopement risk. She stated the wandering behaviors had been ongoing since her admission. SW #1 indicated she was aware of the physical altercation that occurred on 8/6/16 between Resident #44 and another resident. She reported the incident was discussed on 8/9/16 in the morning staff meeting. She stated Resident #44's plan of care was updated to include the focus area of the physical altercation with another resident. She indicated Resident #44 continued her wandering behaviors. SW #1 reported that

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 32	F 323		

there were no new interventions in the care plan to prevent wandering for Resident #44. She stated Resident #44 was seen for a psychiatric consultation on 8/17/16 and she was hoping a medication adjustment was going to be helpful for the management of her behaviors.

An interview was conducted with Nurse #3 on 8/18/16 at 4:10 PM. She indicated she worked on the locked unit with Resident #44 about once per week. She stated she had observed Resident #44 with physical behaviors and verbal behaviors directed toward staff as well as wandering behaviors. She reported she had never observed Resident #44 with physical behaviors directed toward any other resident. She revealed she had not heard about the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She stated Resident #44 continued to wander throughout the unit, up and down the halls, and in and out of other residents' rooms. She indicated that to her knowledge there were no new interventions put into place for Resident #44's physical behaviors, verbal behaviors, or wandering behaviors.

An interview was conducted with NA #1 on 8/18/16 at 4:30 PM. She stated she usually worked on the locked unit. She indicated she was familiar with Resident #44. She stated she had observed Resident #44 hitting and kicking at staff and wandering throughout the unit and into other residents' rooms. She indicated that staff tried to redirect Resident #44, but that was when she became most combative. She stated she had heard about the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She indicated

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 33 she had not heard about all of the details about the incident. She revealed that she was not aware of any new interventions that were put into place for Resident #44's physical behaviors, verbal behaviors, or wandering behaviors. An interview was conducted with the Director of Nursing (DON) on 8/19/16 at 8:55 AM. She indicated she was aware of the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She stated that a lot of the residents on the locked unit wandered around throughout the day. She revealed she was not aware Resident #44 had no plan of care wandering. She stated she was unable to say if any new interventions were put into place after the incident with Resident #44 on 8/6/16. An interview was conducted with the Administrator on 8/19/16 at 10:00 AM. She stated she was aware of the incident that occurred on 8/6/16 in which Resident #44 had a physical altercation with another resident. She indicated the facility had failed to prevent to the incident.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from 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.	F 329		9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 329	Continued From page 34 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 record review and staff interview, the facility failed to monitor the effectiveness of antianxiety medications for 1 of 5 residents (Resident #44) reviewed for unnecessary medications. The findings included: Resident #44 was admitted to the facility on 6/10/16 with multiple diagnoses that included anxiety disorder. A physician's order dated 6/10/16 indicated Xanax (antianxiety medication) 0.25 milligrams (mg) every six hours as needed (PRN) for anxiety. The admission Minimum Data Set (MDS) assessment dated 6/17/16 indicated Resident #44 had significant cognitive impairment and had received antianxiety medications on 2 out of 7 days during the MDS review period.	F 329	1. Resident #44 has not received any doses of Xanax since 08/18/16. 2. Center Nurse Executive and Regional Resource Nurse completed an audit of residents medication administration record on 09/08/16. Audit concluded that 12 of 39 residents receiving as needed (prn) antianxiety medication did not have documentation of effectiveness noted. 3. Nurse Practice Educator (NPE) will re-educate licensed nurses, including weekend and prn licensed nurses by 09/16/16, concerning prn medication sheets and the centers policy and procedure of documenting and monitoring the effectiveness of the medications administered. Policy and procedures states that prn medication that is administered will be documented for	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 329	Continued From page 35 The June 2016 Medication Administration Record (MAR) indicated Resident #44 was administered PRN Xanax eight times. Resident #44 was administered PRN Xanax on 6/29/16 for increased agitation and the medication was effective. There was no documentation on the MAR for 7 out of 8 administrations of PRN Xanax for Resident #44 that indicated the reason for the administration or its effectiveness (6/11, 6/16, 6/22, 6/23, 6/24, 6/27, and 6/28). The plan of care for Resident #44 included the focus area of psychotropic medications: antidepressants, antipsychotics, and antianxiety medications. The goal, initiated on 7/1/16, indicated Resident #44 was to have the smallest and most effective dose without side effects. The July 2016 MAR indicated Resident #44 was administered PRN Xanax sixteen times. Resident #44 was administered PRN Xanax on 7/13/16 for increased anxiety and the medication was effective. There was no documentation on the MAR for 15 out of 16 administrations of PRN Xanax for Resident #44 that indicated the reason for the administration or its effectiveness (7/1, 7/2, 7/3, 7/5, 7/8, 7/9, 7/10, 7/14, 7/15, 7/17, 7/20 (x2), 7/29, 7/30, and 7/31). The August 2016 MAR indicated Resident #44 was administered PRN Xanax 3 times. There was no documentation on the MAR for 3 out of the 3 administrations of PRN Xanax for Resident #44 that indicated the reason for the administration or its effectiveness (8/7, 8/17, and 8/18). An interview was conducted on 8/18/16 at 11:50 AM with Nurse #1. She stated that PRN	F 329	effectiveness. Nurse Management including Center Nurse Executive, Assistant Director of Nursing, RN Supervisors will audit the prn medication sheets daily times one week then three times a week for three weeks then weekly times two month. 4. Center Nurse Executive will report the findings of audits to the Performance Improvement meeting monthly times 3 months then quarterly.	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 329	Continued From page 36 medications were documented in the MAR and were to include the reason for the administration as well as its effectiveness. An interview was conducted on 8/18/16 at 11:52 AM with Nurse #2. She stated that PRN medications were documented in the MAR and were to include the reason for the administration as well as its effectiveness. She revealed that there may have been instances in the past when a nurse got off track with another task and would then forget to go back to the MAR to document the effectiveness. An interview was conducted with the Nurse Supervisor on 8/18/16 at 4:20 PM. She stated that PRN medications were documented in the MAR and were to include the reason for the administration as well as its effectiveness. She revealed that a lack of documentation for the reason for use and the effectiveness of PRN medications had been brought to her attention earlier today. She indicated an inservice was in the process of being planned to re-educate staff on this issue. An interview was conducted with the Director of Nursing on 8/19/16 at 8:55 AM. She stated that PRN medications were expected to be documented in the MAR and were to include the reason for the administration as well as its effectiveness.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353		9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 353	Continued From page 37 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, family and resident interviews, the facility failed to provide sufficient number of direct care nursing staff to meet the needs of residents as evidenced by not providing incontinent care timely for 1 (Resident #40) of 4 sampled residents reviewed for ADL and failed to prevent resident to resident physical altercation for 1 (Resident #44) of 5 sampled residents reviewed for unnecessary medications. Findings included: Cross reference to tag F312 - Based on record review, observation and family and staff interview, the facility failed to provide incontinent care timely for 1 (Resident # 40) of 4 sampled residents reviewed for Activities of daily Living (ADL).	F 353	1. Resident #99 has been discharged from the center, Resident #98 was interviewed on 09/08/16 by Center Executive Director regarding call light responsiveness and if she has had timely incontinent care provided. Resident #98 stated during interview that the response time had improved with call lights as well as incontinent care. She also stated that second shift was not taking as long as before. Much better she said. Resident #33 was interviewed on 09/08/16 by Center Executive Director regarding call light responsiveness and if she has had timely incontinent care provided. Resident #33 stated that it was some better, but that she had to wait this morning to be put	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 353	Continued From page 38 Cross reference to tag F323 - Based on record review and staff interview the facility failed to manage inappropriate behaviors and implement effective interventions to prevent a resident to resident physical altercation for a resident with a pattern of physical behaviors, verbal behaviors, and wandering behaviors (Resident #44). On 8/17/16 at 3:30 PM, a family interview was conducted for Resident #40. The family member indicated that the facility was always short of staff on all shifts. The family member indicated that most of the time, she found the resident soaking wet. In April 2016, she found the resident's bed wet and a sheet was placed over the wet bed sheet so the aide would not change the bed. In July 2016, she found the resident soaking wet from top to bottom sheets, his gown and draw sheet. Most of the time only one nurse aide (NA) on the hall and a splitter (a nurse aide assigned to help 2 different halls). There were 30 residents on the hall and most of the residents needed 2 person assist for transfer and personal hygiene. This was brought to the attention of the administration and the only answer was they were trying to get more help. On 8/17/16 at 3:40 PM, NA #2 was interviewed. NA #2 stated that she was employed at the facility for 15 years as nurse aide. She stated that for the last few years the staffing was so bad. There was one nurse aide on each hall with 30 residents and at times a splitter. Most of the residents needed 2 person assist with activities of daily living (ADL) and have to wait until the splitter was available. NA #2 further stated that when they were short staff, the residents were not getting their showers or have to wait to be put back to	F 353	on the bedpan. Education was provided to certified nursing assistants assigned to her hall on 09/08/16 by Center Nurse Executive. Resident #123 was interviewed on 09/08/16 by Center Executive Director regarding being assisted to bed timely. Resident #123 stated that she went to bed when she wanted to go to bed. She stated that the girls put her to bed when she is ready. Resident #123 said that she may have to wait for just a few minutes, but they always put her to bed when she was ready and they were good to her. Resident # 40 was provided incontinent care timely and appropriately on 07/18/16. Resident #44 was separated and redirected from the other resident. No injuries were noted and no other incidents have occurred. 2. Interviews will be conducted of all alert and oriented residents regarding responsiveness to call lights and timely incontinent care by Social Services by 09/09/16. Two family members of non interviewable residents from each hall will be interviewed by Social Services by 09/16/16 concerning responsiveness to call lights and timely incontinent care. Nursing Supervisor completed incontinent rounds on incontinent resident on 09/08/16. Incontinent rounds concluded that no residents were found to be excessively wet; the residents that were identified as being wet were changed immediately. Social Services completed an audit of all wandering residents on 08/22/16 to ensure appropriate wandering care plans	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 353	Continued From page 39 bed or get out of bed. On 8/17/16 at 3:45 PM, NA #3 was interviewed. NA#3 stated that she was employed at the facility for 22 years as a nurse aide (NA). She stated that the normal staffing should be 3 NAs on each hall for 7-3 shift, 2 NAs for 3-11 shift and 1 NA for 11-7 shift. NA #3 added that lately, the staffing was really bad. One nurse aide and a splitter was assigned on each hall. Most of the residents needed 2 person assist and so the residents have to wait until the splitter was available. She stated that it was so hard to get the job done but she had to do the best she could. NA #3 further indicated she had found residents soaking wet due to short of staff. The resident council minutes were reviewed for the last 6 months. The July 20, 2016 meeting minutes indicated that several residents reported that they were concerned about the nurse aides when they have to work short - handed. On 8/18/16 at 11:00 AM, the Director of Nursing (DON) was interviewed. The DON indicated that the normal staffing for each hall was 3 NAs on 7-3 shift, 2 NAs on 3-11 shift and 1 NA for 11-7 shift. There were 27 residents on 100 hall, 30 residents on 200, 400 ad 500 hall and 33 residents on 300 hall. The DON further indicated that she was aware that the normal staffing was not always met but the facility had met the required number of staff. The quarterly MDS assessment for Resident #99 dated 7/14/16 indicated that his cognition was intact with Brief Interview for Mental Status (BIMS) score of 15, no behavior and totally dependent with bathing. On 8/18/16 at 11:50 AM,	F 353	were in place. Care plans were in place for all current wandering residents. Interdisciplinary Team completed a review on 09/06/16 & 09/08/16 of those residents who have displayed physical behavioral symptoms, verbal behavioral symptoms, inappropriate behaviors (pacing, rummaging, disrobing, etc&), delusional behaviors and wandering behaviors in the last 90 days (05/01/16-08/31/16). Revisions were made to care plans that did not have effective interventions to address the behaviors. 3. Nurse Practice Educator (NPE) will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), concerning providing timely incontinent care and timely call light responsiveness by 09/16/16. Nurse Management including Center Nurse Executive, Assistant Director of Nursing, RN Supervisors (first, second and third shifts) and Nurse Practice Educator will complete rounds of two resident on each hall, each shift three times weekly times one month then two residents per hall per shift weekly times two months to ensure the incontinent care is being provided timely. Center Executive Director provided re-education to the Clinical Reimbursement Coordinators, Director of Social Services and Social Worker on revising care plans appropriately on 08/31/16. Nurse Practice Educator (NPE) will reeducate licensed nurses and certified nursing assistants (including	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 353	Continued From page 40 Resident #99, the president of the resident council, was interviewed. Resident #99 stated that the concerns about short staff was brought to the resident council meeting on several occasions. The response from Social Worker was " we were working on it." Resident #99 indicated that last Tuesday, he was scheduled to have a shower in the morning. He asked his aide for a shower that morning and his aide told him it will be later because they were short of staff. He asked the aide if he can have the shower before lunch so he could attend the activities at 2 PM. Resident #99 stated that he received the shower at 1:30 PM and was late for the activities. Resident #99 also indicated that 1 aide and a splitter assigned to the hall was an issue. Most of the residents needed 2 person assist with transfer and they have to wait until the splitter was available before they were put back to bed. Resident # 98's annual MDS assessment dated 7/1/16 indicated that her cognition was intact with a BIMS score of 15, no behavior and needed extensive assist with personal hygiene. On 8/18/16 at 12:05 PM, the resident was inter viewed. The resident stated that she attended the resident council meeting every month and she had brought up the issue of short staff on all shift. The resident indicated that she had to wait more than 30 minutes for the call light to be answered and she had to lay on a wet diaper. Resident #33's quarterly MDS assessment dated 7/26/16 indicated that her cognition was intact with a BIMS score of 14, no behavior and needed extensive assist with toilet use. The assessment also indicated that the resident was occasionally incontinent of bowel and bladder. On 8/18/16 at	F 353	weekend and prn licensed nurses and nursing assistant), concerning wandering residents and those residents that are displaying aggressive/combative behavior on the importance or documenting and reporting to ensure that care plans are updated and revised with the most effective interventions by 09/16/16. Social Services will conduct interviews of alert and oriented residents. Two residents on each hall, each shift three times weekly times one month then two residents per hall per shift weekly times two months regarding timely response to call lights. 24 Hour Report will be reviewed by Interdisciplinary Team for any occurrences of wandering and/or aggressive residents five days/weekly at Clinical Stand-up. Any occurrences that are identified, the care plans will be reviewed for effective interventions. Nurse Management including Center Nurse Executive, Assistant Director of Nursing and RN Supervisors (first, second and third shifts) will complete rounds of two resident on each hall, each shift three times weekly times one month then two residents per hall per shift weekly times two months to ensure the incontinent care is being provided timely. Certified Nursing Assistants assignments will be assessed and adjustments will be made based on resident acuity to provide nursing care to all residents in accordance with resident care plans. The number of staff working each hall is looked at on a daily basis and the staff to resident ratio is adjusted according to census numbers. Center	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 353	Continued From page 41 12:20 PM, Resident # 33 was interviewed. The resident stated that the facility was very short of staff on all shift. She was mostly continent of bowel and bladder and needed a bedpan when she called for the staff. She had to wait an hour before the staff answered the call light and the staff informed her that they were short of staff. On 8/18/16 at 4:00 PM, Social Worker (SW) #1 was interviewed. She stated that she was responsible for the resident council meeting. She stated that the issue about short staff was brought up in the resident council meeting. She stated that she didn't write a grievance form because there was no care issues mentioned. SW #1 stated that she informed the residents that they were trying to hire more aides. Resident #123's quarterly MDS assessment dated 7/26/16 indicated that her cognition was intact with a BIMS score of 13, no behavior and needed extensive assist with transfer. On 8/19/16 at 9:25 AM, Resident #123 was interviewed. The resident stated that last Wednesday she asked the staff to be put back to bed 5 times and the staff told her to wait a minute. The resident stated that she was put back to bed at 10:30 PM. On 8/19/16 at 10:05 AM, the administrator and the DON were informed of the staffing concerns. They stated that they understood the concerns and no additional information provided.	F 353	has been and is continuing to recruit for certified nursing assistants by doing the following: advertising in the local newspapers (Siler City, Asheboro & Sanford), advertising on Career Builder, Indeed, Health Jobs Nationwide, Nurse Career Board ZipRecruiter, Craigslist, and Facebook. Center has completed a Wage Analysis, offering Sign-on Bonuses, email blasts within 50 mile radius and following supplemental staffing bonus to current employees. 4. Center Nurse Executive and Director of Social Services will report the findings of audits and interviews to the Performance Improvement meeting monthly times 3 months then quarterly.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		9/16/16

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 520	Continued From page 42 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 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, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 10/22/15 recertification survey. This was for two recited deficiencies in the areas of assessment accuracy (F278) and accidents (F323). These deficiencies were cited again on the current recertification survey of 08/19/16. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality	F 520	1. Modifications were made to the Minimum Data Set for Resident #11, Resident #28 and Resident #59 on 08/18/2016. The modification for Resident #42 and Resident #59 included changing Section LO200B status from no to yes. For Resident #11 the ARD dates were reviewed and Sections NO300 & NO410 ABC was modified to reflect the correct number of insulininjections. Resident #44 was separated and redirected from the other resident. No injuries were noted and no other incidents	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 520	Continued From page 43 Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F278 - Assessment Accuracy: Based on observation, medical record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for three of seventeen sampled residents reviewed in the areas of medications (Resident #11) and dental (Resident #28, #59). During the recertification survey of 10/22/15 the facility was cited F278 for failing to accurately assess residents in the areas of pressure ulcer and hydration on the MDS. On the current recertification survey of 8/19/16, the facility failed to accurately assess residents in the areas of medications and dental. 2. F323 - Accidents: Based on record review and staff interview the facility failed to manage inappropriate behaviors and implement effective interventions to prevent a resident to resident physical altercation for a resident with a pattern of physical behaviors, verbal behaviors, and wandering behaviors (Resident #44). During the recertification survey of 10/22/15 the facility was cited F323 for failing to follow the facility's policy on smoking. On the current recertification survey of 08/19/16, the facility failed to manage inappropriate behaviors and implement effective interventions to prevent a resident to resident physical altercation. An interview was conducted with the Administrator on 8/19/16 at 10:00 AM. She	F 520	noted. 2. Clinical Reimbursement Coordinators (CRC) completed audit on 09/02/16 of Minimum Data Set for last 90 days (05/01/16-08/31/16) for those residents who were coded for medications and dental. No other residents were identified with incorrect coding of insulin. 6 residents were identified with incorrect coding of dental and were modified on 09/02/16 by Clinical Reimbursement Coordinator. Social Services completed an audit of all wandering residents on 08/22/16 to ensure appropriate wandering care plans were in place. Care plans were in place for all current wandering residents. Interdisciplinary Team completed a review on 09/06/16 & 09/08/16 of those residents who have displayed physical behavioral symptoms, verbal behavioral symptoms, inappropriate behaviors (pacing, rummaging, disrobing, etc&), delusional behaviors and wandering behaviors in the last 90 days (05/01/16-08/31/16). Revisions were made to care plans that did not have effective interventions to address the behaviors. Social Work interviewed current smokers to ensure that they did not have material for lighting cigarettes in their possession. No resident had lighting material in their possession on 09/08/16. Director of Nursing and/or Licensed Nurse reviewed each resident Smoking Assessment on 09/08/16 to ensure accuracy. All resident smoking assessments are appropriate. Social Worker and Clinical	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 520	Continued From page 44 stated she was the head of the facility's QAA Committee. She stated the QAA Committee consisted of the Director of Nursing, Assistant Director of Nursing, Maintenance Director, Environmental Services, Admissions Director, Business Office Manager, Nurse Practice Educator/Staff Development, Director of Therapy, Director of Dining Services, Director of Social Services, Health Information Management Director, Registered Dietician, Pharmacist, and Medical Director. She stated all members of the committee met quarterly, as well as monthly meetings without the pharmacist. The Administrator indicated she was aware assessment accuracy was a repeat deficiency from the previous recertification survey. She stated the facility had been auditing assessments since their previous action plan. She indicated the facility presently audited 10% of all transmitted MDS assessments. The Administrator stated the facility utilized an electronic medical records (EMR) system that automatically populated some areas of the MDS assessments from completed nursing assessments. She indicated the MDS Nurses had not double checked all of the automatically populated areas which led to some inaccuracies. The Administrator stated that MDS Nurse #2 was hired earlier this year to assist MDS Nurse #1. She indicated both MDS Nurse #1 and MDS Nurse #2 were scheduled to attend the state MDS training on October 25, 2016. The Administrator indicated she was aware accidents was a repeat deficiency from the previous recertification survey. She stated the facility had developed an audit tool that was initially completed daily and then progressed to	F 520	Reimbursement Coordinator completed an audit of those residents requiring a Level II PASARR on 09/08/16 to ensure their individual Minimum Data Sets are coded correctly. All residents were found to be coded correctly. Clinical Reimbursement Coordinators completed audit on 09/08/16 of Minimum Data Set for those residents who were coded for dehydration and pressure ulcers. All residents were found to be coded correctly. Center Executive Director and Maintenance Director completed an audit of pipe access portals on each hall on 09/07/16 to ensure that all access portals are at the same level as the surrounding flooring and do not pose a hazard for residents, as well as employees and visitors. 3. Administrator will provide re-education to the Quality Improvement Members including Medical Director, Director of Nursing, and Assistant Director of Nursing, Clinical Reimbursement Coordinator, Recreation Director, Social Worker, Register Dietitian, Food Service Director, Housekeeping Supervisor and Medical Records on 09/08/16. Regional Clinical Reimbursement Coordinator provided re-education to Clinical Reimbursement Coordinator on MDS accuracy 09/07/16. The Interdisciplinary Team, including Director of Nursing, Clinical Reimbursement Coordinator, Recreation Director, Social Worker and Register Dietitian will review the entire Minimum Data Set for accuracy prior to transmission each week on 100% of	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 520	Continued From page 45 weekly. The audit tool was used to assess any safety or accident hazards. She indicated that monitoring for potential accidents was something that needed to happen daily. The Administrator indicated the facility failed to sustain their monitoring plan from the previous recertification survey as they failed to prevent an accident.	F 520	residents x 4 weeks then 50% of residents x 4 weeks then 25% of residents x 4 weeks and 10% of residents quarterly thereafter. Center Executive Director provided re-education to the Clinical Reimbursement Coordinators, Director of Social Services and Social Worker on revising care plans appropriately on 08/31/16. Nurse Practice Educator (NPE) will reeducate licensed nurses and certified nursing assistants (including weekend and prn licensed nurses and nursing assistant), concerning wandering residents and those residents that are displaying aggressive/combative behavior on the importance or documenting and reporting to ensure that care plans are updated and revised with the most effective interventions by 09/16/16. 24 Hour Report will be reviewed by Interdisciplinary Team for any occurrences of wandering and/or aggressive residents five days/weekly at Clinical Stand-up. Any occurrences that are identified, the care plans will be reviewed for effective interventions. Maintenance Director, Maintenance Assistant and/or Housekeeping Supervisor will audit pipe access portals weekly x 2 months then monthly x 3 months and quarterly thereafter. RN Supervisor will make Environmental Rounds to identify any fall and/or environmental hazards daily x 4 weeks, 2 times weekly x 4 weeks, weekly x 2 months, then quarterly. Any hazards identified will be addressed immediately and reviewed at stand-up 5 days/week. All incidents/accidents are reviewed at	

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 08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	900 W DOLPHIN STREET 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 520	Continued From page 46	F 520	clinical stand-up 5 days/week. 4. Clinical Reimbursement Coordinator, Director of Nursing and Maintenance Director will report the findings of audits of MDS accuracy and accident/hazards to the Performance Improvement Committee two times a month for three months then monthly.	