STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide meals concurrently for residents in the same room for 2 of 2 dining observations (Room 513) allowing Resident #2 to sit and wait for her meal tray while her roommate was eating. Findings included: Resident #2 was admitted to the facility on 11/26/2007 with the diagnosis of multi infarct dementia, hypertension, hypothyroidism and osteoporosis. The most recent quarterly Minimum Data Set (MDS) assessment dated 7/19/16 revealed that Resident #2 was moderately cognitively impaired and was dependent on staff for activity of daily living (ADL ' s) except for eating. Resident #2 is independent with eating, set up help only. During a dining observation was conducted 11/2/16 at 6:10 PM on the 500 hall revealed a meal cart to be delivered and staff removing and delivering meal trays to the residents. The Resident in bed A, in room 513 was served her tray at 6:19 PM, staff continued serving until all trays were delivered. Resident #2 did not have a tray on the cart. During an interview with the 500 hall nurse on 11/2/16 at 6:39 PM revealed that Resident #2 ' s meal tray was found in the 600 hall meal cart and Resident #2 ' s tray was delivered 20 minutes	F 241	F241 Resident # 2 tray card was changed to come on 500 cart on 11/3/2016 by Food Service Director (FSD). 100% of all residents tray cards were audited to ensure that they reflected correct room numbers and locations to where residents receive their meals. Audit was complete on 11/22/2016 by FSD and Dietician. Center Executive Director (CED) in-serviced all department heads, Director of Nursing (DON) and Assistant Directors of Nursing(ADON) on 11/22/2016 in resident dignity and respect by ensuring that meal trays will be delivered to a room or in the dining room at a table at the same time. CED, DON, ADON and department heads began in-servicing all staff on 11/22/16 on resident dignity and respect by ensuring that meal trays will be delivered to a room or in the dining room at a table at the same time and how to use Meal Monitoring Tool. Dietary staff was in-serviced on 11/22/16 on grouping tray cards by rooms and	12/1/16

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

Electronically Signed | 11/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 241	Continued From page 1 after her roommate was served. A second dining observation was conducted on 11/3/16 at 8:15 AM on the 500 hall. Resident #2 was sitting in bed with her head of the bed elevated waiting on her breakfast tray, her roommate was served a breakfast tray at 8:15 AM. Resident #2 ' s breakfast tray was served at 8:35 AM. Resident #2 ' s tray was delivered 20 minutes after her roommate was served. During an interview with Resident #2 at 8:35 AM on 11/3/16 revealed that she didn ' t know why they waited, and she was not happy about it. An interview with the nurse aide on 500 hall at 8:45 AM on 11/3/16 revealed that trays are pulled in order and the staff work their way down from top to bottom from the meal cart. During an interview with the unit manager for 500 hall on 11/3/16 at 1:30 PM revealed that her expectations were to have staff deliver meal trays in a timely manner. Her expectation was that both residents in a room to be served at the same time. An interview with the administrator on 11/3/16 at 4:25 PM revealed that his expectations were that the meal trays were to be delivered in a room at the same time or if in the dining room all residents served at the table at the same time. The residents in room 513 should have been served together.	F 241	dining locations to ensure trays are placed in delivery cart in such a way that they reach residents rooms or tables at the same time. Meal distribution in dining rooms and residents rooms will monitored daily x 4 weeks then 2x weekly x 2 months by Administration staff, and /or hall nurses to ensure that meal trays are being delivered to rooms or in the dining room to tables the same time using the Meal Monitoring Tool. Meal Monitoring Tools will be reviewed by CED and/or DON 1x weekly to ensure they are being completed. CED and/or DON will bring monitoring tools to Executive Quality Assurance (QA) meeting for review.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 2 are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview the facility failed to honor a resident ' s choice to keep her previously grandfathered refrigerator in her room post a stay in the hospital and return to the facility for 1 of 1 sampled residents (Resident #31). The findings included: Review of a letter sent to resident family contacts dated 2/4/16 revealed the following, in part: " if one of our grandfathered residents should be discharged home or discharged to the hospital, and elect not to hold the bed, they will not be allowed to continue having refrigerators in their semiprivate skilled rooms " . Resident #31 was admitted 6/4/15. Review of the Quarterly Minimum Data Set (MDS) dated 10/7/16 revealed Resident #31 was cognitively intact. During interview with Resident #31 on 11/1/16 at 9:21 AM she stated that when she went to the hospital recently for 4 days she came back and the refrigerator that had been in her room was gone. She said she was told she could not have it anymore but she did not understand because other residents still had theirs. Resident #31 stated that she needed her refrigerator back to keep her drinks cold and for snacks because staff don ' t have time to go get things out of the hall fridge for her right away. Interview with the Administrator on 11/2/16 at 2:30 PM revealed that the facility had a new policy	F 242	F242 On 11/4/2016, resident #31 was informed by Center Executive Director (CED) that she could have refrigerator back in her room. On 11/7/2016 refrigerator was observed by CED to be back in resident□s room. On 1125/16 the list of residents grandfathered in to have refrigerators in room since January 2016 was reviewed for any residents that were asked to remove refrigerators. 1 resident was found that had been asked to remove their refrigerator. The family was immediately contacted and told they could bring it back. A revised letter was sent out on 11/22/2016 to all Responsible Parties (RP) indicating that we had changed the guideline regarding bed holds and refrigerators. The new guidelines read if a grandfathered resident is discharged to home or another facility and they returned, they would not be allowed to bring their refrigerator back if they were admitted to the skilled unit. A copy of the revised letter will be included in all admission packets and presented to all new admissions as of 11/21/2016. A copy of all grandfathered residents who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 3 because they could not police the refrigerators in resident ' s rooms. He indicated that the new policy was that in-room refrigerators in place when the policy came out would be grandfathered. However he added that if residents were discharged to the hospital, and did not pay to hold the bed, they would be considered new admissions and therefore would not be able to bring the refrigerator back. The Administrator said that the goal was to not have any refrigerators in resident rooms except for private rooms or Assisted Living designated rooms. In regards to Resident #31 the Administrator said that there had been no problems with this resident or family maintaining the refrigerator. He also said that when the resident went out to the hospital he had the Admission Coordinator remind the family of the policy and thy declined the Bed Hold. He acknowledged that Resident #31 was very upset about not having her refrigerator. The Administrator added that he could not let the resident have her refrigerator because the policy needed to be applied consistently and revealed that another resident had also had their grandfathered refrigerator removed. On 11/2/16 at 5:52 PM during meal observation Resident #31 indicated that if she had her own refrigerator still she could put mayonnaise on her grilled cheese sandwich but she could no longer do this because they had taken her refrigerator away when she was in the hospital. On 11/3/16 at 10:15 AM during interview with the Social Worker she stated that Resident #31 had been discharged to the hospital on 8/7/16 and readmitted on 8/10/16 however the refrigerator was not removed from the resident ' s room until	F 242	have refrigerators on the skilled unit will be reviewed in the monthly Executive Quality Assurance (QA) meeting for any changes or updates to the list.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4 8/24/16. On 11/3/16 at 11:15 AM interview with the Administrator revealed that he had not been aware that a grandfathered resident refrigerator was not able to be removed from a resident on readmission from the hospital as the resident ' s original admission date still applied. When provided the example of grandfathered smokers that are required to still be granted grandfathered smoking privileges on readmission from hospital, he indicated he understood.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and 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	F 278		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code PASRR (Preadmission Screening Resident Review) Level 2 on the MDS (Minimum Data Set) for one of one residents reviewed with a PASRR level 2 status (Resident # 44). The findings included: Resident # 44 was admitted to the facility on 12/30/2014, Cumulative diagnoses included major depression, anxiety, chronic pain, anxiety and insomnia. A review of Resident # 44 ' s medical record revealed that a comprehensive MDS dated 11/03/2015 was coded with a level 2 PASRR for mental illness on question A 1500. The medical record for Resident #44 also revealed that Resident # 44 had received a letter of determination notification of a PASRR level 2 effective 04/04/2016 through 07/04/2016. A review of an annual MDS dated 10/11/2016 revealed that Resident # 44 was not coded as a level 2 PASRR on question A 1500. An interview with the facility social worker on 11/03/2016 at 8:38 AM revealed that Resident # 44 remained a level 2 PASRR and that the social worker was responsible for requesting and verifying PASRR updates for the residents in the facility. The social worker also stated that Resident # 44 continued to remain at level 2 PASRR status and that Resident # 44 had received a confirmation that the level 2 PASRR	F 278	F278 A correction was completed for Resident #44□s MDS, section A1500 on 11/03/2016 and transmitted for the MDS dated 10/11/2016. A review of all other Resident□s with a PASRR was completed by Social Services on 11/4/2016 and were found to be coded correctly on the MDS. The Center Executive Director (CED) in-serviced the Social Workers and Clinical Reimbursement Coordinator (CRC) on appropriate coding for PASRR□s on 11/22/2016. A review of all PASRR□s will be conducted monthly for 3 months by Social Services to ensure proper coding on MDS. Findings will be reported to the Quality Assurance (QA).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 status for Resident # 44 would remain in place for life and that there was no need for any future updates. The confirmation letter was reviewed and the social worker stated that she would place it on the medical record of Resident #44 as well as update the face sheet of Resident # 44. The social worker revealed that she must have made a coding error on A 1500 of the MDS dated 10/11/2016 for Resident # 44. An interview with the MDS coordinator on 11/03/2016 at 10:20 AM revealed that a correction had been completed for Resident # 44 and had been transmitted for the MDS dated 10/11/2016 and that the facility would develop a communication system to be certain that the medical records would be updated for level 2 PASRRs and that the MDS coordinator would also verify proper coding of A 1500 the MDS for all residents for PASRR coding of A 1500.	F 278		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 334	Continued From page 7	F 334		

documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 334	Continued From page 8 pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide 5 of 5 sampled residents (Resident # 31, #84, #87, #93 and #118) with the required Vaccine Immunization Statement (VIS) education sheet when offering the influenza vaccine and failed to verify or track current pneumococcal immunization status for 1 of 5 sampled residents (Resident #31). The findings included: 1. Resident # 31 was admitted 6/4/15 and review of the medical record immunization tracking documentation revealed the resident ' s most recent influenza vaccination was completed on 10/30/15. Resident # 84 was admitted on 4/8/14 and review of the medical record immunization tracking documentation revealed the resident ' s most recent influenza vaccination was completed on 10/19/16. Resident #87 was admitted on 5/3/16 and review of the medical record immunization tracking documentation revealed the resident ' s most recent influenza vaccination was completed on 11/2/16.	F 334	F334 Residents #31, #84, #87, #93 and #118 have been given the correct Influenza Vaccine Information Sheet (VIS) on 11/22/16. All other residents in the facility or their Responsible Party were provided with the correct Influenza Vaccine Information Sheet (VIS) on 11/22/16. The Regional Clinical Educator Specialist provided Education to the Center Executive Director (CED) and the Center Nurse Executive (CNE) on 11/28/2016 on the correct VIS form to Be provided for the Influenza Vaccine for 2016 and the correct process to have the form completed correctly and documented in the resident’s medical record. All new residents admitted will be assessed for the Influenza Vaccine and will be provided the VIS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 334	Continued From page 9 Resident #93 was admitted on 6/17/15 and review of the medical record immunization tracking documentation revealed the resident ' s most recent influenza vaccination was completed on 10/27/16. Resident #118 was admitted on 7/17/13 and review of the medical record immunization tracking documentation revealed the resident ' s most recent influenza vaccination was completed on 10/28/15. Interview with the Nurse Practice Educator on 11/3/16 at 5:04 PM revealed she had recently started in her role and had not been the staff member who sent out the 2016/2017 influenza vaccination consent forms and education sheets to residents and/or family. She said that the Administrator had sent them out on 9/5/16. She added that as she got the consents back she was getting the immunization order if they consented and giving residents the vaccination as indicated on the consent form. The Nurse Practice Educator also said that she was going to start following up with people that had not yet returned the signed consent or refusal. On 11/3/16 at 6:18 PM interview with the Administrator revealed that he had sent out the influenza consent/refusal forms along with an education sheet to resident ' s/families in September 2016 as he knew this needed to get done. He indicated the Nurse Practice Educator would normally carry out this task but that position/ person in that position had been in transition. Observation of the education sheets that the Administrator stated were enclosed in the mailing revealed that they were not the required Influenza Vaccine Information Statements (VIS)	F 334	2016. Will monitor all New admissions monthly x 3 months to ensure all admissions were offered the Influenza Vaccine with proper documentation. The CNE will report the findings to Quality Assurance (QA) monthly x 3 months. Resident #31's medical record was up-dated to indicate that She had received the pneumococcal vaccine, but was not sure Of the date and indicated as historical data. This information was Received from a hospital record dated 5/15/2016. All other resident's medical records were reviewed for pneumococcal Consent, refusal or history of receiving Pneumococcal vaccine. 62 residents were found not to have received the pneumococcal vaccine. These residents will be offered the pneumococcal vaccine once consent has been received. This audit was completed by CNE, Nurse Unit Mangers and Clinical Educator Specialist on 11/28/16. Any information not on the resident record was obtained and placed on the resident record. An audit tool was developed to monitor and ensure that all residents receive the pneumococcal immunization. The CNE (Center Nurse Executive)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 334	Continued From page 10 from the Centers for Disease control. The Administrator added that he had been unaware of this requirement but would ensure the VIS was provided in future. 2. Resident #31 was admitted 6/4/15 and review of the medical record immunization tracking documentation revealed the resident ' s most recent influenza vaccination was completed on 10/30/15. There was no information regarding the resident ' s pneumococcal vaccination status. During interview with the Nurse Practice Educator on 11/3/16 at 5:04 PM she reviewed the resident ' s medical record and was able to locate an influenza vaccination consent from the 2015/2016 immunization season but there was not a pneumococcal consent, refusal or indication that the vaccination had been given previously and/or the resident was not eligible for the vaccine. She added that she had been trying to reach the resident ' s Family Member to verify the resident ' s immunization status as Resident #31 indicated she received the influenza vaccine in the hospital recently but the Nurse Practice Educator could not find this, or her pneumococcal vaccine status, in the hospital records that the facility had. During interview with the Nurse Consultant, Director of Nursing and Administrator on 11/3/16 at 5:32 PM they indicated that the facility should be aware of and have a system for tracking each resident ' s pneumococcal immunization status to be able to offer the vaccine to eligible residents. Documentation from the 5/15/16 Hospital Admission History, indicating Resident #31 stated she had previously been given the pneumococcal vaccine, was provided by facility staff after they	F 334	and the Nurse Unit Managers will be responsible for ensuring this tool is completed 3x weekly x 3 months then extended an additional 3 months if necessary to maintain compliance. This information will be presented for review in the monthly QA (Quality Assurance) meeting. The admission Department will be responsible for providing the immunization information and consents to new admits. The admitting nurse will follow up during the admission process to verify information and provide the immunizations if appropriate. In 72 hours the admitting nurse will verify historical information and document it in the medical record. On 11/28/16, the CNE was educated by the Clinical Educational Specialist on the proper procedure for obtaining this information. CNE will educated NPE once she returns from medical leave. When offering the pneumococcal vaccine, we will use the CDC guidelines provided information. We will verify, within 72 hours, using an audit tool, the pneumococcal vaccine status of all new admits. This will be done 3x weekly x 3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 334	Continued From page 11 obtained it from the hospital on 11/3/16.	F 334	then extended an additional 3 months if necessary to maintain compliance. This will be completed by the hall nurses and followed up by the Nurse Unit Managers. The audit tool will be brought to monthly QA (Quality Assurance) meeting for review. Education on use and monitoring of the pneumococcal vaccines was provided to the CED (Center Executive Director), CNE and Admissions Director on 11/28/16 by the Clinical Educational Specialist. Any new admissions that previously received the vaccine will be verified and placed in the medical record as historical data.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356		12/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 356	Continued From page 12 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post the required nurse staffing data for 4 of 4 days of the annual recertification survey conducted 10/31/16-11/3/16. The findings included: During the initial tour of the facility on 10/31/16 the " Daily Nursing Staff Form " was observed to be posted at the side A nurse ' s station to include the facility name, current date, total number of nursing staff and the census. The " Daily Nursing Staff Form " did not include the actual hours worked per shift. An observation for 4 consecutive days 10/31/16, 11/1/16, 11/2/16 and 11/3/16 at 10:00AM revealed a posting each morning that not include the actual hours worked for licensed and unlicensed nursing staff. A review was completed on 11/3/16 at 9:15 AM of the " Daily Nursing Staff Form " for the month of October 2016 and revealed that the forms did not include the total number of hours worked for the	F 356	F356 Updated Daily Nursing Staff Forms reflecting actual hours worked was created on 11/3/16 by scheduling manager Updated Daily Nursing Staff form reflecting actual hours worked was posted on 11/4/2016 by scheduling Manager Center Executive Director (CED) was in-serviced by corporate Nurse on 11/22/16 that the facility must post facility name, the current date, the total number and the actual hours worked by registered nurses, licensed practical nurses and certified nurse aids and the resident census. This information must be clear and in a readable format and must be posted in a prominent place readily accessible to residents and visitors. The Nursing Staff Data Sheet will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 356	Continued From page 13 licensed and unlicensed nursing staff. During an interview with the scheduling manager on 11/3/16 at 12:55 PM who is responsible for posting the " Daily Nursing Staff Form " indicated that each morning she posted the " Daily Nursing Staff Form " and made sure it included the date, census, number of licensed and unlicensed nursing staff and provided the data for 1st and 2nd shifts and 3rd shift nurse provided the data at the beginning of 3rd shift. She further indicated that she was not aware that the data needed to include the total number of hours worked for licensed and unlicensed nursing staff. An interview with the administrator on 11/3/16 at 4:25 PM revealed that he knew the " Daily Nursing Staff Form " was being completed and posted, but he was not aware that it had to have the total number of hours worked for the licensed and unlicensed nursing staff.	F 356	posted at the beginning of each shift beginning with the 3rd shift RN and them by Scheduling Manager. The CED in- serviced scheduling manager, payroll bookkeeper, scheduling managers back-up, and weekend nurse supervisor on 11/22/16 that the facility must post facility name, the current date, the total number and the actual hours worked by registered nurses, licensed practical nurses and certified nurse aids and the resident census. This information must be clear and in a readable format and must be posted in a prominent place readily accessible to residents and visitors. The Daily Nursing Staff Forms will be reviewed by CED and/or Center Nurse Executive (CNE) and/or Assistant Director of Nursing (ADON) daily x 4 weeks then 2x weekly x 2 months to ensure actual hours worked are posted in a prominent place readily accessible to residents and visitors. CED, CNE and/or ADON will bring Daily Nursing Staff forms to Executive Quality Assurance (QA) meeting monthly.	