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 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 The Statement of Deficiencies was amended on 9/14/17 at tag F278 and tag F520.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		9/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/13/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment in the area of behaviors for 2 of 3 residents (Residents #121 and #28) reviewed for behavioral and emotional status and in the area of life expectancy/prognosis for 1 of 1 residents (Resident #90) reviewed for hospice. The findings included: 1. Resident #121 was admitted to the facility on 4/7/17 with diagnoses that included Alzheimer's, anxiety, and depression. The quarterly Minimum Data Set (MDS) assessment dated 7/5/17 indicated Resident #121's cognition was severely impaired. She was assessed with physical behaviors on 1-3 days, verbal behaviors 1-3 days, and rejection of care on 0 days during 7 day MDS look back period (6/29/17 through 7/5/17). Record review of the look back period of the 7/5/17 quarterly MDS (6/29/17 through 7/5/17) for Resident #121 showed no documentation of physical behaviors, verbal behaviors, or rejection of care. The 7/4/17 Social Service Assessment indicated the staff had reported Resident #121 was sometimes resistive to care. There were no staff names noted and no specific dates referred to in this assessment. An interview was conducted with the Social Worker (SW) on 8/23/17 at 3:40 PM. She	F 278	Modifications were made to the Minimum Data Set (MDS) for resident #28, #90, and #121 on 9/13/2017 by the Clinical Reimbursement Coordinator(CRC). They were resubmitted and transmitted on 9/13/17 The week of September 18, 2017 audit to be completed by Assistant Director of Nurses (ADNS) on residents' last MDS to ensure that behaviors coded in Section E had supporting documentation during the look back period. ADNS reviewed the last MDS of residents receiving Hospice Services to ensure that Section J1400 was coded correctly the week of September 18, 2017. Modifications will be completed by the CRC of any residents that had errors in coding in Section E or Section J1400 the week of September 18th. On September 14, 2017 the Director of Nurses re-educated the CRC and Social Service Department on coding Section E and Section J1400 to ensure, that if coded, there was supporting documentation during the look back period. ADNS to audit Section E to ensure that behavior coding has the appropriate supporting documentation 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 then 10% of resident quarterly thereafter. ADNS will	

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SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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F 278	Continued From page 2 indicated she completed Section E of the MDS. She reported she reviewed the nursing notes and behavior monitoring documentation to assist her with completing Section E. She revealed there had been concerns for several months of the nurses not documenting behaviors that occurred. She indicated this was an ongoing problem. An interview was conducted with Nurse Supervisor #1 on 8/23/17 at 3:48 PM. She stated that behaviors were to be documented in the nursing notes of the behavior monitoring documentation. She reported if a resident had a behavior it was to be documented in the medical record. She confirmed the SW's interview that there were ongoing concerns for several months with the nursing staff's documentation of behaviors. She indicated the Administrative Nursing Staff were all aware of the concerns and were working on a Performance Improvement Plan to improve behavior documentation. An interview with the Director of Nursing on 8/23/17 at 4:46 PM indicated she expected the MDS to be coded accurately. She also reported that behaviors were to be documented on the behavior monitoring sheet, in the nursing notes, or in the electronic Medication Administration Record (MAR) if a PRN (as needed) medication was administered. She verified Nurse Supervisor #1's interview and the SW's interview that there were ongoing concerns for several months with the nursing staff ' s documentation of behaviors. A follow up interview was conducted with the SW on 8/24/17 at 8:21 AM. She confirmed she completed Section of E, the Behavior Section, of the 7/5/17 quarterly MDS assessment for Resident #121. Section E of Resident #121's	F 278	audit the area of life expectancy/progress in Section J1400 to ensure appropriate coding 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. ADNS will report the findings of the audits to the Performance Improvement Committee (PI) every 2 weeks for two months then monthly x 2 months	

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F 278	Continued From page 3 quarterly MDS dated 7/5/17 that indicated she had physical behaviors on 1-3 days, verbal behaviors on 1-3 days, and no rejection of care was reviewed with the SW. The nursing notes and behavior documentation from the time period of the MDS look back period (6/29/17 through 7/5/17) that showed no documentation of behaviors for Resident #121 was reviewed with the SW. The Social Service Assessment dated 7/4/17 that indicated staff had reported Resident #121 was sometimes resistive to care was reviewed with the SW. The SW revealed there was no evidence to support the accuracy of the MDS coding of physical and verbal behaviors for Resident #121 on 1-3 days during the 7/4/17 MDS look back period. 2. Resident #28 was admitted to the facility 3/31/17. Diagnoses included advanced dementia. An Admission Minimum Data Set (MDS) dated 4/7/17 indicated Resident #28 was severely impaired in cognition. Behaviors noted that rejection of care occurred 4-6 days during the assessment period. An initial psychiatric evaluation dated 5/9/17 revealed Resident #28 was being seen due to dementia, verbal aggression and biting other. A Quarterly MDS dated 7/4/17 indicated Resident #28 was severely impaired on cognition. Behaviors noted during the assessment period indicated the following: physical behaviors directed towards others 1--3 days, verbal behaviors--4-6 days and rejection of care- 4-6 days. A nursing assessment dated 7/3/17 stated no	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 4	F 278		

behaviors had been documented in the last 7 days from the MDS assessment reference date or since admission/ reentry on the behavior flow record and/or nurses notes.

A review of nursing notes from 6/28/17--7/4/17 revealed no documentation was recorded of any behaviors displayed by Resident #28 during the assessment period.

A review of the behavior monitoring sheets for June 2017 revealed no documentation of any behaviors occurring from 6/28/17 through 6/30/17. There was no behavior monitoring sheet for July 2017 in the medical record.

On 8/23/17 at 2:16 PM, an interview was conducted with Nurse #1 who stated behaviors were documented on the behavior sheets and/or in the nursing notes or both.

On 8/23/2017 at 2:45 PM, an interview was conducted with the Social Worker who stated she was responsible for completing section E for behaviors on the MDS. She said she talked to nursing staff and reviewed the behavior sheets and nursing notes prior to completion of section E. The Social Worker stated Resident #28 had displayed behaviors of biting and kicking staff and had been started on a new medication that seemed to be effective in improvement of her behaviors. She stated she expected those behaviors to be documented in Resident #28 ' s record. The Social Worker said she had not documented in her social work notes the information obtained from interviews with nursing staff. She said she would expect those behaviors to be documented in the nursing notes and/or on the behavior sheets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 5	F 278		

On 8/23/17 at 3:27 PM, an interview was conducted with the Social Worker. The Social Worker stated Resident #28 ' s behaviors started the end of May and beginning of June. On 6/6/17, the Social Worker stated she modified the care plan for Resident #28 to include the biting, swearing and screaming. When she completed the Quarterly MDS on 7/4/17, she coded the information based on staff interviews. The Social Worker stated she did not have any documentation of where she obtained that information. She said she had a concern with the lack of behavior documentation and behavior monitoring sheets for several months. It had been discussed in the July performance improvement meeting and the nursing supervisors were now supposed to be monitoring the behavior monitoring documentation. Auditing of the behavior documentation had begun for the past two weeks.

On 8/23/17 at 3:27 PM, an interview was conducted with Medical Records personnel. She stated the pharmacy sent out behavior monitoring sheets monthly and there were blank behavior monitoring sheets available for nursing staff to complete until the pharmacy sent out the monthly sheets. She stated she was unable to find a behavior monitoring sheet for Resident #28 for July 2017.

On 8/23/2017 at 3:48 PM, an interview was conducted with Nursing Supervisor #1. She stated there were concerns in the past about staff completing the behavior monitoring sheets. It had been an ongoing problem and more of a concern recently. She said the nursing supervisors had begun doing audits on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 6	F 278		

behavior monitoring for a couple of weeks. Nursing Supervisor #1 stated they reviewed the 24 hour report for reports for behaviors. If a resident had behaviors and it was documented on the 24 hr. sheet, the nursing supervisor would check the behavior sheet and the nursing notes and would expect documentation to be present.

On 8/23/2017 at 4:46 PM, an interview was conducted with the Director of Nursing who stated she would expect the MDS information to be accurate. Behavior documentation should be in the nursing note, behavior sheet or with the as needed (prn) medication documentation if a prn medication was administered due to a behavior.

3. Resident #90 was admitted to the facility 8/16/12. Cumulative diagnoses included: end stage heart disease.

A significant correction Minimum Data Set (MDS) dated 7/25/17 indicated Resident #90 received hospice services. Section J1400 for prognosis indicated "No" for resident having a condition or chronic disease that may result in a life expectancy of less than 6 months.

A review of the medical record revealed Resident #90 received hospice services since 8/29/16.

A hospice physician note dated 12/1/16 indicated Resident #90 continued to meet hospice criteria due to end stage heart disease with prognosis of less than 6 months.

On 8/23/17 at 4:46PM, an interview was conducted with the Director of Nursing who stated she expected the MDS information 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 08/24/2017

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F 278	Continued From page 7 On 8/23/17 at 5:03 PM, an interview was conducted with the MDS Coordinator. She reviewed the MDS and medical record for Resident #90 and said that section J1400 for prognosis of less than 6 months should have been coded "Yes"on the MDS.	F 278		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	F 329		9/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 8 medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 observations, staff interviews and record review, the facility failed to provide evidence of behavior monitoring for 1 of 5 residents (Resident #10) prescribed multiple psychotropic medications reviewed for unnecessary medications. Findings included: Resident #10 was admitted 8/14/12 with cumulative diagnoses of dementia, depression, anxiety and psychosis. A review of Resident #10 ' s August 2017 physician orders listed the following prescribed psychotropic medications: Ativan 0.5 milligrams (mg) three times daily for anxiety adjusted 3/16/17 Lamictal 50 mg twice daily to stabilize mood adjusted 7/14/17 Seroquel 50 mg every morning and 100 mg twice daily for psychosis started 7/13/15 Trazadone 100mg by mouth at bedtime for psychosis adjusted 3/16/17 Zoloft 100mg by mouth every morning for depression started 8/16/16 A review of a behavioral health note dated 2/21/17 read that staff reported no complaints related to Resident #10 ' s behaviors. The	F 329	Resident # 10 has had no observed behaviors. Last MDS modified to reflect no behaviors observed. MDS was resubmitted and transmitted on 9/13/2017 100 % of residents' medication orders were reviewed to identify any use of psychotropic medication by the Assistant Director of Nursing and Unit Managers the week of September 18, 2017. Residents that were identified to be receiving psychotropic medications, will have an order for behavioral monitoring questions added to electronic medical record: 1) Is resident free of behaviors document Yes or No. If No a nurses note to be added to describe type of behaviors, interventions used to redirect, and outcomes. These orders to be completed the week of September 18, 2017 by the Unit Managers. Licensed nurses, including full-time, part-time, and PRN were re-educated on documenting behaviors as behaviors are exhibited. Education provided by Nurse Educator the week of September 11, 2017. Residents that receive psychotropic	

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F 329	Continued From page 9 recommendation was to discontinue her Trazadone prescribed for psychosis and increase the night time dose of Lamictal, a mood stabilizer. The physician approved the recommendations and her medications were adjusted accordingly. A review of the Behavioral Monitoring documentation for February 2017 indicated Resident targeted #10 ' s behaviors were hitting, anxiety and rejection of care. There was no documented display of her targeted behaviors for February 2017. A review of the nursing notes for February 2017 included no documented targeted behaviors for Resident #10. A general nursing note titled "Assessment" dated 3/6/17 at 12:25 PM read the following: "Since the last evaluation there has been no change in behavior symptoms. There have been no increases in doses or new initiated psychotherapeutic/antipsychotic meds in the past 30 days." A review of a monthly nurse practitioner progress note dated 3/16/17 read Resident #10 was not exhibiting any depressive symptoms but was anxious with increased wandering and hyper-verbalization. The note read that these behaviors had been continuing for several weeks. The Trazadone was restarted, the Zoloft for depression was increased and the Lamcital was also restarted due to uncontrolled depression and anxiety. A general nursing note titled "Assessment" dated 3/27/17 at 2:03 PM read the following: "Since the last evaluation there has been no change in behavior symptoms. None documented. There	F 329	medication will have an order entered into Point Click Care which will require a response on the medication administration record whether the resident is exhibiting behaviors the week of September 11, 2017 by the Supervisors. If behaviors are exhibited the nurse will be required to write a progress note addressing type of behavior and intervention to redirect behavior. The licensed nurses were educated on the new process on the week of September 11, 2017 by the Nurse Educator. The Assistant Director and the Supervisors will audit the residents on psychotropic medication for behavior documentation 5 days per week to included one day during the weekend and alternating all three shifts for one month; 3 times a week to include one day during the weekend and alternating all three shifts for one month; and once weekly to include all three shifts for one month. Newly admitted residents with psychotropic medications orders will be reviewed at Clinical Stand-up daily indefinitely. Center Nurse Executive will audit weekly for any trends and report the findings of audits to the Performance Improvement Committee every two weeks x 2 months, then monthly x 2.	

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SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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F 329	Continued From page 10 have been no increases in doses or new initiated psychotherapeutic/antipsychotic meds in the past 30 days." A review of the Behavioral Monitoring documentation for March 2017 indicated Resident #10 ' s targeted behaviors were hitting, anxiety and rejection of care. There was no documented display of her targeted behaviors for March 2017. A review of the nursing notes for March 2017 included no documented targeted behaviors for Resident #10. A review of a behavioral health note dated 4/18/17 read the staff reported no complaints of function with days of intermittent agitation and mood instability. The recommendation was to increase the Lamictal from once daily to twice daily. The physician approved the recommendation. A review of the Behavioral Monitoring documentation for April 2017 indicated Resident #10 ' s targeted behaviors were hitting, anxiety and rejection of care. There was no documented display of her targeted behaviors for April 2017. A review of the nursing notes for April 2017 included no documented targeted behaviors for Resident #10. A general nursing note titled "Assessment" dated 5/8/17 at 3:30 PM read the following: "Since the last evaluation there has been no change in behavior symptoms. None documented. There have been no increases in doses or new initiated psychotherapeutic/antipsychotic meds in the past 30 days." A review of the Behavioral Monitoring documentation for May 2017 indicated Resident #10 ' s targeted behaviors were hitting,	F 329		

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F 329	Continued From page 11	F 329		

wandering, rejection of care and depression. There was no documented display of her targeted behaviors for May 2017.

A review of the nursing notes for May 2017 included no documented targeted behaviors for Resident #10.
A general nursing note titled "Assessment" dated 6/1/17 at 10:15 AM read the following: "Since the last evaluation there have been no behavior symptoms present. None documented. There have been no increases in doses or new initiated psychotherapeutic/antipsychotic meds in the past 30 days."
Resident #10 ' s annual Minimum Data Set (MDS) dated 6/2017 indicated severe cognitive impairment and she was only coded for wandering behaviors.

The Care Area Assessment (CAA) dated 6/20/17 for behaviors read Resident #10 exhibited increased confusion at times and wandered through the hallways
.
The CAA also dated 6/20/17 for psychotropic medication use read Resident #10 was pleasantly confused because of dementia. Any observed side effects/adverse reaction were to be reported to physician promptly and staff were to monitor for side effects of adverse reactions such as increased confusion, decline in cognitive status, extrapyramidal side effects, decline in her activities of daily living (ADLs) and mental status change. Resident #10 ' s medications were to be administered as ordered and psychological services consult as needed or indicated. The CAA indicated the area would be care planned and the information was obtained from chart and 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 08/24/2017

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

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F 329	Continued From page 12	F 329		

Continued From page 12

A review of last revised care plan dated 6/23/17 read Resident #10 was at risk for complications related to: the use of psychotropic medications to include: antipsychotic, antianxiety and antidepressant. Interventions included staff to complete the behavior monitoring flow sheets.

A general nursing note titled "Assessment" dated 6/27/17 at 11:38 AM read the following: "Since the last evaluation there have been no behavior symptoms present. None documented. There have been no increases in doses or new initiated psychotherapeutic/antipsychotic meds in the past 30 days."

A review of the Behavioral Monitoring documentation for June 2017 indicated Resident #10 ' s targeted behaviors were hitting, wandering, rejection of care and depression. There was no documented display of her targeted behaviors for June 2017.

A review of the nursing notes for June 2017 included no documented targeted behaviors for Resident #10.

A review of a behavioral health note dated 7/11/17 read staff reported no complaint of function but noted continued episodes of tearfulness/crying and mood instability. Her Lamictal was increase to twice daily. The physician approved the recommendation and her Lamictal was adjusted to twice daily.

A review of a monthly nurse practitioner progress note dated 7/27/17 read Resident #10 Lamictal was increased psychological services due to increased agitation.

A review of the Behavioral Monitoring documentation for July 2017 indicated 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 08/24/2017

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 13	F 329		

#10 ' s targeted behaviors were hitting, wandering, rejection of care and depression. There was no documented display of her targeted behaviors for July 2017.

A review of the nursing notes for July 2017 included no documented targeted behaviors for Resident #10.
A general nursing note dated 8/16/17 at 9:52 AM read Resident #10 was noted with increased agitation and trying to get behind nurse ' s desk. She was trying to open drawers on treatment carts, digging in the trash can and trying to get into the kitchen. Resident #10 was redirected multiple times without success.

A review of the Behavioral Monitoring documentation for August 2017 indicated Resident #10 ' s targeted behaviors were hitting, wandering, rejection of care and depression. There was a documented episode of wandering on 8/16/17.

A review of a monthly nurse practitioner progress note dated 8/18/17 read Resident #10 was wandering in her wheelchair with increased agitation today.

In an observation on 8/23/17 at 9:00 AM, Resident #10 was up in her wheelchair sitting in the common area watching TV. She was not conservational but exhibited no evidence of sadness or agitation.

In an interview on 8/23/17 at 9:05 AM, Nurse #2 stated Resident #10 was known to have episodes of crying in the evenings but it was not often. Nurse #2 stated Resident #10 was easily comforted with a brief visit. Nurse #2 stated she

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 08/24/2017

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

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F 329	Continued From page 14	F 329		

wrote a nursing note if Resident #10 exhibited any of her targeted behaviors.

In an interview on 8/23/17 at 4:20 PM. Nurse #4 stated she was not aware of Resident #10 having any episodes of crying. She stated she had only observed Resident #10 wandering in the hallways. She stated nobody had reported any behaviors to her about Resident #10. Nurse #4 stated she documented any resident behaviors in a general nursing note when they occur but Resident #10 was known to wander about the facility.

In an interview on 8/23/17 at 3:30 PM, the Social Worker (SW) confirmed she completed section regarding behaviors on Resident #10 ' s MDS. She stated there had been concerns for several months about the lack of behavior monitoring for all the residents taking psychotropic medications. The SW stated the concern was discussed in the July 2017 Quality Assurance (QA) meeting. The decided intervention was to have the nursing supervisors monitor the behavior monitoring documentation.

In an interview on 8/23/17 at 3:47 PM, Nurse Supervisor #1 stated she was aware of concerns about the nurses not completing the behavior monitoring documentation. She stated it has been an ongoing problem. She confirmed the nursing supervisors were doing audits for the behavior monitoring documentation. She stated if a nursing note was created in the electronic medical record, she would check to make sure the nurse documented also on the behavior monitoring sheets. Nurse Supervisor #1 stated she was instructed to ensure the documentation was in both places. She also confirmed it problem was

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 08/24/2017

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 15	F 329		

discussed in a recent QA meeting and the auditing had been ongoing for a few weeks.

In a telephone interview on 8/23/17 at 3:55 PM, the behavioral health nurse practitioner stated it was her practice to talk to the nursing staff and validate what they said using the behavior documentation. She recalled the staff reporting mood instability in Resident #10 last month.

In an interview on 8/23/17 at 4:25 PM, Nurse Supervisor #3 stated she was told about two weeks ago, to begin auditing nursing notes and reviewing behavior monitoring sheets.

In an interview on 8/23/17 at 4:50 PM, the Director of Nursing (DON) stated it was her expectation that the nurse document and behaviors for residents on psychotropic medications in both the nursing notes and on the behavior monitoring sheets. She stated the SW brought it to her attention about 5-6 months ago, that there was a lack of behavior monitoring documentation. The DON stated the corporate consultant was going to see if behavior monitoring piece could be added to the electronic medical record but she was told a few months ago, that it was not an option to add it to the computer software. The DON stated that was when she started having the Nurse Supervisors look at the behavior monitoring sheets more closely and the reviewed the nursing notes. The DON stated about one month ago, the corporate consultant recommended that the nurses improve on documenting resident behaviors.

In an observation on 8/24/17 at 10:10 AM, Resident #10 was self-propelling her wheelchair in the hallway. She did not appear agitated or

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 08/24/2017

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 16 tearful. In an interview on 8/24/17 at 10:40 AM, the Administrator stated it was her expectation that the nurses document targeted behaviors for all residents on psychotropic medications. In an interview on 8/24/17 at 11:00 AM, Nursing Assistant (NA) # 1 stated she had worked at the facility for over twenty years and she worked all shifts. NA #1 stated Resident #10 experienced behaviors across all shifts. She stated Resident #10 ' s behaviors included wandering into other resident rooms, combativeness, rejection of care, hitting and trying to bite staff. She stated when she worked on night shift, Resident #10 would not go to bed until two-three in the morning. NA #1 stated when Resident #10 displayed the behaviors stated, she reported the behaviors to her charge nurse. In an interview on 8/24/17 at 11:05 AM, NA #2 stated Resident #10 was more cooperative on first shift but she displayed cursing and rejection of care on second shift. NA #2 stated when Resident #10 had behaviors, she would report those behaviors to her charge nurse.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371		9/21/17

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 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 371	Continued From page 17 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to hold cold food (Cobb Salads) at 41 degrees Fahrenheit (F) prior to serving and failed to ensure all fans used in the kitchen for cooling were free of dust. The facility also failed to ensure the sprinkler heads suspended over the stove top were free from grease and dust. Findings included: 1. During the initial tour of the kitchen on 8/20/17 at 4:30 PM, the walk-in cooler temperature was observed at 46 degrees F. A review of the August temperature log revealed the temperature of the walk-in cooler ranged from 36 to 40 degrees F. During a second observation on 8/21/17 at 9:00 AM, the walk-in cooler temperature was 48 degrees F. During a third observation on 8/23/17 at 12:00	F 371	Fans and sprinklers were cleaned on Monday, August 21, 2017 by the Food & Nutrition Director. The fans and sprinklers in dietary were inspected for cleanliness the week of September 11, 2017 by the Regional Director of Dining Services and cleaned as needed. The week of September 18, 2017,the Regional Food and Nutrition Director re-educated the Dietary staff on maintaining cooler temperatures, food holding temperatures, and reporting high cooler temperatures to the Maintenance Department. Education included the process for foods that did not maintain the correct holding temperatures and cleaning of fans and sprinklers.	

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 08/24/2017

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 371	Continued From page 18 PM, the walk-in cooler was empty except for a tray cart with a large trash bag covering Cobb salads. The Dietary Manager (DM) stated all items were moved from the walk-in cooler to a refrigeration truck last night because the compressor was "popping off and may go at any time." During the temperature checks of the lunch meal, the Cobb Salads were recorded at a temperature of 50.9 degrees F. Items in the salad included cheese, boiled eggs and bacon. The DM then moved the tray cart holding the Cobb salads to the walk-in freezer. After 10 minutes, the Cobb salads were rechecked after being stored in the freezer. The temperature was 49 degrees F. A dietary aide retrieved the Cobb salads from the freezer and proceed to place them at the serving line. The DM stated it was his understanding that if the food was "palatable", it was acceptable to serve. The DM stated the cheese was stored in the reach-in refrigerator last night, the eggs and bacon were prepared last night and stored in the reach-in refrigerator overnight. He stated the salads were assembled this morning then placed in the walk-in cooler. In another interview on 8/23/17 at 12:30 PM, the DM stated dairy items should be held prior to serving at 41 degrees, hard boiled eggs should be held at 41 degrees and cured cooked meats should be held at 41 degrees prior to serving and confirmed the Cobb salads were served today to the residents. In an interview on 8/23/17 at 2:40 PM, the Registered Dietician (RD) stated the Cobb salads should be held at 41 degrees prior to serving. In a telephone interview on 8/23/17 at 2:45 PM, the lead cook stated the Cobb salads should be	F 371	Registered Dietitian (RD) will complete sanitation audits weekly for one month, every 2 weeks for one month, and monthly there after. Morning and evening cook on duty will check and record temperatures of cooler and food, three times daily for one month, then two times daily thereafter. Regional Food and Nutrition Director will complete sanitation audit every 2 weeks for one month, then monthly for two months Registered Dietitian/Food and Nutrition Director will report findings of the audits to the Performance Improvement Committee monthly for 3 months	

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 08/24/2017

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 371	Continued From page 19	F 371		

held at 41 degrees prior to serving.

In an interview on 8/24/17 at 10:40 AM, the Administrator stated it was her expectation the cold foods be held at 41 degrees prior to serving and if the Cobb salads were held above 41 degrees, they should be discarded.

2. During the initial tour of the kitchen on 8/20/17 at 4:30 PM, on entry to the kitchen there was a black "Air Mover" fan sitting on a metal cart blowing toward the kitchen serving area. A thick layer of dust was observed where the air blew out of the bottom of the fan. There was a large "Global" fan mounted on the wall near the reach-in refrigerator blowing air directly toward the food preparation table and serving line. Dust was observed on the fan. At the same location was another smaller black fan sitting on a small metal cart blowing air toward the food preparation table and serving line. Dust was observed on the fan. During this observation, there was no food on the preparation table and there was no food being served from the serving line. There was another large fan mounted on the wall that blew down on the clean dishes as they came out of the dishwasher. A dietary aide was removing the clean dishes from the dish machine during the time of this observation. Dust was observed on the fan.

In another observation on 8/22/17 at 9:00 AM, the DM stated the "Air Mover" fan was removed from the kitchen for cleaning. The large "Global" fan mounted on the wall near the reach-in refrigerator was turned from blowing air directly toward the food preparation table and serving line. There was no observed dust on the fan. At the same location was another smaller black fan sitting on a

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 08/24/2017

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 371	Continued From page 20	F 371		

small metal cart blowing air not directed toward the food preparation table and serving line. There was no observed dust on the fan. The large fan mounted on the wall where the dishes came out of the dishwasher had no observed dust. There were no dishes observed in the dishwashing area. The DM stated the fans had been cleaned and it was his expectation that his staff were to keep the fans clean and free of dust.

In an interview on 8/22/17 at 10:55 AM, the RD stated she was at the facility 32 hours each week and part of her role was to do monthly sanitation rounds.

A review of the Food Safety and Sanitation Audit for August 2017 was completed by the RD. The audit did not have a date but the RD confirmed she completed the August audit around the 9th. The check list item number 4, under the sanitation, read "Vents, fans clean and free of debris" was marked yes to indicate the fans were clean.

In an interview on 8/24/17 at 9:20 AM, the Maintenance Director stated he was responsible for taking the wall mounted fans down but it was the responsibility of the dietary department to ensure the fans are free of dust.

In a telephone interview on 8/23/17 at 2:45 PM, the lead cook stated she was under the impression that Maintenance was responsible for cleaning the fans.

In an interview on 8/24/17 at 10:40 AM, the Administrator stated it was her expectation that the Maintenance Director took the wall fans down and the dietary staff were to clean all fans to

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 08/24/2017

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 371	Continued From page 21	F 371		

ensure they were free of dust and not blowing directly on the preparation and serving areas.

3. A review of the subcontractor invoice dated 6/14/17 revealed a complete kitchen exhaust cleaning was done to include the hood, ducts, fans and filters. There was no mention that the suspended sprinklers were cleaned.

A review of a service request completed by the Maintenance Director dated 6/26/17 requested a visible inspection of sprinkler heads for correct position, dirt, dust and grease. The request read to clean and repair as needed.

The facility provided no evidence of when the suspended sprinklers above the stove top were last cleaned.

During the initial tour of the kitchen on 8/20/17 at 4:30 PM, the suspended sprinkler heads above the stove were observed covered in a thick layer of grease and a large amount of visible dust.

During a second observation on 8/21/17 at 9:00 AM, the sprinkler heads over stove had been cleaned but dust and grease build up were still observed. The DM stated he and the Maintenance
Director cleaned the sprinkler heads 8/20/17.

In an interview on 8/22/17 at 10:55 AM, the RD stated she was at the facility 32 hours each week and part of her role was to do monthly sanitation rounds.

A review of the Food Safety and Sanitation Audit for August 2017 revealed the audit was

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 08/24/2017

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 371	Continued From page 22 completed by the RD. The audit did not have a date but the RD confirmed she completed the August audit around the 9th. The check list item number 4, under the sanitation, read "hood clean to touch, free of dust and debris" and was marked yes to indicate the hood over the stove top was clean. There was no mention of an observation of the suspended sprinklers over the stove top. In an interview on 8/24/17 at 9:20 AM, the Maintenance Director stated he completed the service request for the sprinklers over the stove top on 6/26/17 but apparently, the provider did not clean the sprinklers as requested. In an interview on 8/24/17 at 10:40 AM, the Administrator stated it was her expectation the suspended sprinklers above the stove be free of grease and dust at all times.	F 371		
F 456 SS=E	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to have an operating walk-in cooler in the kitchen to hold food at 41 degrees Fahrenheit (F). Findings included:	F 456	Greensboro Refrigeration Company replaced the compressor, filter drier, and low pressure control on the walk-in cooler on September 7, 2017. Raw food items requiring refrigeration were moved from the refrigeration truck back to the cooler	9/21/17

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 08/24/2017

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 456	Continued From page 23 A review of an invoice dated 3/2/17 indicated the facility requested a service call on the walk-in cooler and found the condenser fan locked up. The fan motor was replaced. During the initial tour of the kitchen on 8/20/17 at 4:30 PM, the walk-in cooler temperature was observed at 46 degrees F. A review of the August temperature log revealed the temperature of the walk-in cooler ranged from 36 to 40 degrees F. During a second observation on 8/21/17 at 9:00 AM, the walk-in cooler temperature was 48 degrees F. A review of an invoice dated 8/22/17 read the walk-in cooler condenser coils were dirty and the compressor was overheating. A quote was to be provided to the facility for a replacement cooler system. During a third observation on 8/23/17 at 12:00 PM, the walk-in cooler was empty except for a tray cart with a large trash bag covering Cobb salads. The temperature of the Cobb Salads was 50.9 degrees F. The Dietary Manager (DM) stated all items were moved from the walk-in cooler to a refrigeration truck last night because the compressor was "popping off and may go at any time." The DM stated part of the walk-in cooler compressor was replaced last year. In a telephone interview on 8/23/17 at 2:45 PM, the lead cook stated "every summer, the walk-in cooler goes out." She stated on 8/22/17 when she arrived at work early morning the walk-in cooler compressor was off and she had to go outside and restart it. She stated she reported it to the	F 456	on September 7, 2017 Maintenance Department to be re-educated by Regional Property Manager on preventive maintenance on walk-in cooler and logging results in preventive maintenance log by 9/21/17. The Dietary Department will be re-educated by the Regional Food & Nutrition Director on recording temperatures of walk-in cooler and reporting abnormal temperatures to the Maintenance the week of 9/18/2017. The cook will record the temperature of walk in cooler 3 times daily for one month, then 2 times daily thereafter. The Maintenance Director will present the results of the preventive maintenance on the walk in cooler to the Performance Improvement Committee monthly for three months. The Registered Dietician will present the results of the daily temperatures to the Performance Improvement Committee monthly for three months.	

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 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 456	Continued From page 24	F 456		

Maintenance Director and the DM 8/22/17. The lead cook stated a someone came to look at the walk-in cooler compressor on the afternoon of 8/22/17 but when she arrived at work on 8/23/17, she saw a refrigerator truck outside. She stated the DM and Administrator decided the food needed to be moved since the walk-in cooler compressor could go at any time.

In an interview on 8/24/17 at 9:20 AM, the Maintenance Director stated he was at the facility on Saturday 8/19/17 because he received a call from the facility that the ice cream was thawed. He stated he watched the walk-in cooler and freezer temperature for several hours and noted no concerns. The Maintenance Director stated he was not aware that the kitchen staff had to restart the walk-in cooler compressor on 8/22/17. He stated he and DM started to notice a problem with the walk-in cooler on 8/22/17. The Administrator decided to have a refrigerator service representative to look at the walk-in cooler compressor. The service representative stated the system was old but he could get the walk-in cooler to hold temperature below 41 degrees F but stated the system it could go out at any time. The Administrator decided to have a refrigerator truck come and store the walk-in cooler items and stay for the duration until the whole system could be replaced.

In an interview on 8/24/17 at 9:55 AM, the Maintenance Assistant stated he had worked at the facility for 17 years and every summer there was a problem with the walk in cooler compressor. He stated when he arrived at work on 8/22/17 he noticed the cover was off the walk-in cooler compressor. He stated the Maintenance Director reported he had to restart

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 08/24/2017

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

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F 456	Continued From page 25 the walk-in cooler compressor the morning of 8/22/17. Later in the day on 8/22/17, the walk-in cooler compressor started acting up and that was when the Administrator decided to call a refrigeration service representative to come at look at the walk-in cooler compressor. The service representative reported that the he did everything he could but the system could go out at any time. That was when the Administrator opted to have the items in the walk-in cooler moved to a refrigeration truck until the whole cooler system was replaced. In an interview on 8/24/17 at 10:40 AM, the Administrator stated it was her expectation that the facility always has a functioning walk-in cooler to hold refrigerated items at a maximum of 41 degrees F.	F 456		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance	F 520		9/21/17

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 08/24/2017

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F 520	Continued From page 26 committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observation, staff interviews, and record review, 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 8/19/16 recertification survey. This was for two recited deficiencies in the areas of Assessment Accuracy (F278) and Unnecessary Medications (F329). These deficiencies were cited again on the current recertification survey of 8/24/17. 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 Assessment and Assurance program. The findings included:	F 520	F 278 Modifications were made to the Minimum Data Set (MDS) for resident #28, #90, and #121 on 9/13/2017 by the Clinical Reimbursement Coordinator(CRC). They were resubmitted and transmitted on 9/13/17 The week of September 18, 2017 audit to be completed by Assistant Director of Nurses (ADNS) on residents' last MDS to ensure that behaviors coded in Section E had supporting documentation during the look back period. ADNS reviewed the last MDS of residents receiving Hospice Services to ensure that	

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F 520	Continued From page 27 This tag is cross-referenced to: 1. F278 - Assessment Accuracy: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of behaviors for 2 of 3 residents (Residents #121 and #28) reviewed for behavioral and emotional status and in the area of life expectancy/prognosis for 1 of 1 residents (Resident #90) reviewed for hospice. During the recertification survey of 8/19/16 the facility was cited F278 for failing to code the MDS accurately in the areas of medications and dental. On the current recertification survey of 8/24/17 the facility was cited for failure to code the MDS accurately in the areas of behaviors and life expectancy/prognosis. 2. F329: Unnecessary Medications: Based on observations, staff interviews and record review, the facility failed to provide evidence of behavior monitoring for 1 of 5 (Resident #10) prescribed multiple psychotropic medications reviewed for unnecessary medications. During the recertification survey of 8/19/16 the facility was cited F329 for failing to monitor the effectiveness of antianxiety medication. On the current recertification survey of 8/24/17 the facility was cited for failure to provide evidence of behavior monitoring. An interview was conducted with the Administrator on 8/24/17 at 11:05 AM. She stated she was the head of the facility ' s QAA Committee. She indicated the committee consisted of the Medical Director, Director of	F 520	Section J1400 was coded correctly the week of September 18, 2017. Modifications will be completed by the CRC of any residents that had errors in coding in Section E or Section J1400 the week of September 18th. On September 14, 2017 the Director of Nurses re-educated the CRC and Social Service Department on coding Section E and Section J1400 to ensure, that if coded, there was supporting documentation during the look back period. ADNS to audit Section E to ensure that behavior coding has the appropriate supporting documentation 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 then 10% of resident quarterly thereafter. ADNS will audit the area of life expectancy/progress in Section J1400 to ensure appropriate coding 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. F 329 Resident # 10 has had no observed behaviors. Last MDS modified to reflect no behaviors observed. MDS was resubmitted and transmitted on 9/13/2017 100 % of residents' medication orders were reviewed to identify any use of psychotropic medication by the Assistant Director of Nursing and Unit Managers the	

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	345143	A. BUILDING ______ B. WING ______	C 08/24/2017

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F 520

Continued From page 28

Nursing (DON), Assistant Director of Nursing (ADON), MDS Coordinator, Social Services Director, Business Office Manager, Dietary Manager, Registered Dietician, Therapy Manager, Housekeeping Manager, Maintenance Director, Activities Director, and Pharmacy Consultant. She stated the committee met monthly with the exception of the Pharmacy Consultant who attended quarterly.

The Administrator indicated she was aware F278 was a repeat citation from the 8/19/16 recertification survey. She stated their plan of correction included audits of all sections of the MDS assessments. She indicated these audits were ongoing and were now being conducted on a random sample of 10% of all MDS assessments. She reported the ADON and MDS Coordinator collaboratively audited the assessments. She stated at the time of the last recertification survey the facility had 2 MDS Coordinators, but since October 2016 they had only one MDS Coordinator completing all of the assessments. The Administrator stated the facility was working on hiring another MDS Coordinator to assist with completion of the assessments.

The Administrator indicated she was aware F329 was a repeat citation from the 8/19/16 recertification survey. She revealed the facility was aware of an ongoing problem with behavior documentation being completed accurately and consistently by the nursing staff. She indicated a Performance Improvement Plan was in process for this concern, but she was aware the problem had not yet been resolved. She stated the facility was looking into converting to electronic medical record behavior documentation that required the

F 520

week of September 18, 2017. Residents that were identified to be receiving psychotropic medications, will have an order for behavioral monitoring questions added to electronic medical record: 1) Is resident free of behaviors document Yes or No. If No a nurses note to be added to describe type of behaviors, interventions used to redirect, and outcomes. These orders to be completed the week of September 18, 2017 by the Unit Managers.

Licensed nurses, including full-time, part-time, and PRN were re-educated on documenting behaviors as behaviors are exhibited. Education provided by Nurse Educator the week of September 11, 2017. Residents that receive psychotropic medication will have an order entered into Point Click Care which will require a response on the medication administration record whether the resident is exhibiting behaviors the week of September 11, 2017 by the Supervisors. If behaviors are exhibited the nurse will be required to write a progress note addressing type of behavior and intervention to redirect behavior. The licensed nurses were educated on the new process on the week of September 11, 2017 by the Nurse Educator. The Assistant Director and the Supervisors will audit the residents on psychotropic medication for behavior documentation 5 days per week to included one day during the weekend and alternating all three shifts for one month; 3 times a week to include one day during the weekend and

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F 520	Continued From page 29 nurses to document behaviors for all residents on psychotropic medications.	F 520	alternating all three shifts for one month; and once weekly to include all three shifts for one month. Newly admitted residents with psychotropic medications orders will be reviewed at Clinical Stand-up daily indefinitely. Center Nurse Executive will audit weekly for any trends and report the findings of audits to the Performance Improvement Committee every two weeks x 2 months, then monthly x 2. ADNS will report the findings of the audits to the Performance Improvement Committee (PI) every 2 weeks for two months then monthly x 2 months	
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC	F 526		9/21/17

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 08/24/2017

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F 526	Continued From page 30	F 526		

facility must meet the following requirements:

(i) Ensure that the hospice services meet professional standards and principles that apply to
individuals providing services in the facility, and to the timeliness of the services.

(ii) Have a written agreement with the hospice that is signed by an authorized representative of the
hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

(A) The services the hospice will provide.

(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.

(C) The services the LTC facility will continue to provide based on each resident's plan of care.

(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

(E) A provision that the LTC facility immediately notifies the hospice about the following:

(1) A significant change in the resident's physical, mental, social, or emotional status.

(2) Clinical complications that suggest a need to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 526	Continued From page 31	F 526		

alter the plan of care.

(3) A need to transfer the resident from the facility for any condition.

(4) The resident’s death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility’s responsibility to furnish 24-hour room and board care, meet the resident’s personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident’s needs.

(H) A delineation of the hospice’s responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 526	Continued From page 32	F 526		

facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

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F 526	Continued From page 33 (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient.	F 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 526	Continued From page 34 (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to coordinate care with the hospice provider for one of one residents (Resident #90) reviewed for hospice. The findings included: Resident #90 was admitted to the facility 8/16/12. Cumulative diagnoses included: end stage heart disease. A review of the medical record revealed a hospice form that indicated Resident #90 was admitted to hospice services on 8/29/16. A further review of the medical record (hard copy and electronic copy) revealed there was not a current hospice plan of care. The last hospice plan of care certification period was from 11/27/16 through 2/24/16. On 8/23/17 at 4:41 PM, an interview was conducted with the Director of Nursing. She said she expected a current hospice plan of care to be in the medical record. The Director of Nursing	F 526	Resident # 90 had a current hospice plan of care placed on medical record by Health Information Manager on August 24, 2017 The week of September 18, 2017 the medical records of residents receiving Hospice Services were reviewed by Health Information Manager(HIM) for current hospice plan of care certification. The residents that did not have a current hospice plan of care certification one was obtained and placed on the medical record by the HIM. The HIM will be responsible for ensuring the Hospice plan of care certifications are filed in the medical record. The week of September 18, 2017, the HIM was educated by the Director of Nurses on auditing and maintaining a log of current residents receiving hospice services. HIM will ensures that residents	

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 08/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 526	Continued From page 35 stated she was not responsible for checking for hospice documentation. She was not sure who was responsible for coordinating care with hospice and who would make sure a current hospice plan of care was on the medical record. On 8/23/17 at 5:03 PM, an interview was conducted with the MDS Coordinator who stated she was unsure of who was responsible for ensuring that a current hospice plan of care was on the medical record. On 8/23/2017 5:14 PM, an interview was conducted with the Social Worker who stated she arranged for hospice services but, once that had been done, nursing staff were responsible to make sure hospice documentation and the current hospice plan of care was on the chart. On 8/23/17 at 5:29 PM, the Director of Nursing stated there was no one designated as a responsible person to collaborate and co-ordinate care with hospice. On 8/24/17 at 8:34 AM, the Administrator stated they had contacted hospice that morning and the hospice agency had faxed the facility a copy of the hospice plan of care to be placed on the chart. The hospice plan of care certification period was 7/4/17 through 9/1/17. She said they did not have anyone designated as a responsible person to collaborate and co-ordinate care with hospice.	F 526	newly admitted to hospice have a current plan of care. The HIM will be responsible to maintain a log of residents on hospice services with the dates of the last plan of care certification. If plan of care not current the hospice company will be called and plan of care requested by the HIM. The HIM will place a copy of the current Hospice plan of care certification in medical record. HIM will also give copy to social worker assigned to each resident under hospice services. The social worker will review hospice plan of care with the Interdisciplinary team. The social worker will review the hospice plan of care with the Interdisciplinary team quarterly. The HIM will present the log of hospice plan of care certifications to the PI committee monthly for three months.	