STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING ______ B. WING ______	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT SPRUCE PINES	**218 LAUREL CREEK COURT SPRUCE PINE, NC 28777**

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F 000	INITIAL COMMENTS The surveyor entered the facility on 10/22/24 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 10/23/24. Therefore, the exit date was 10/23/24. Intake NC00222674 was investigated. One (1) of the three allegations resulted in a deficiency. Event ID #WBQ311.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a hazard-free environment by leaving a pair of blunt tipped scissors unsecured in the dining room of the locked memory care unit, resulting in a resident obtaining the scissors and making multiple superficial cuts to his penis. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility 08/15/24 with a diagnosis including non-Alzheimer's dementia. The admission Minimum Data Set (MDS)	F 689	Criteria #1 Resident #1 no longer resides in the facility. Criteria #2 All residents on the locked and secured memory unit and all residents with a decreased level of cognition have the potential to be affected. On 10/24/24, all resident rooms and common areas in the facility were audited by the Director of Nursing(DON)/designee to ensure no sharp items such as scissors had been left unsecured. Any item found was removed and placed in locked box or	10/25/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/04/2024

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 689	Continued From page 1 assessment dated 08/21/24 revealed Resident #1 was moderately cognitively impaired and did not have behaviors during the look back period. An interview with Nurse Aide (NA) #1 on 10/22/24 at 11:00 AM revealed she was caring for Resident #1 on 09/02/24 on the 7:00 AM to 3:00 PM shift. She stated she and NA #2 went into Resident #1's room the morning of 09/02/24 to assist him out of bed when she noticed blood on his bed sheet. NA #1 stated she thought Resident #1 had scratched himself in his private area and she assisted him to the bathroom to help clean him up. She stated when she checked Resident #1's private area she saw multiple lacerations to his penis that were bleeding a small amount. NA #1 stated she notified the Administrator and Nurse #1 immediately and Nurse #1 assessed Resident #1. An interview with NA #2 on 10/22/24 at 11:10 AM revealed she was caring for Resident #1 on 09/02/24 on the 7:00 AM to 3:00 PM shift. NA #2 stated she and NA #1 went into Resident #1's room the morning of 09/02/24 to assist him out of bed. She stated as they entered the room, she and NA #1 saw a small amount of blood on Resident #1's bottom sheet. NA #2 stated NA #1 assisted Resident #1 to the bathroom to help him get cleaned up and she left the room to get clean linen. She stated when she returned to Resident #1's room, she saw a pair of yellow blunt tipped scissors with what appeared to be blood on them, lying on the unoccupied bed in Resident #1's semi-private room. NA #2 stated she placed the scissors in the sharps (puncture resistant) container. She stated she had never seen scissors like the pair in Resident #1's room on the unit before and was not sure where they came	F 689	secure area. On 10/24/24, skin checks were completed by a licensed nurse on all residents with a BIMS of 9 or below to ensure there had been no new skin injuries resulting from sharp items such as scissors. No new concerns were identified. Criteria #3 On or before 10/24/24, all staff were educated by the DON/designee regarding the safety of residents with a decreased level of cognition. Education included that no sharp items such as scissors can be left unsecure in resident rooms or common areas. If a sharp object such as scissors is found, it must be removed and secured immediately. All staff, including agency staff, will be educated by the DON/designee prior to working a shift in the facility. Criteria #4 Beginning on 10/25/24, DON/designee will complete checks of 5 rooms and 1 common area 3x per week for 4 weeks, then 2x per week for 4 weeks to ensure that there are no sharp objects such as scissors unsecure in resident rooms or common areas. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly. Monitoring to determine ongoing compliance will continue at the discretion of the QAPI Committee.	

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F 689	Continued From page 2 from. A telephone interview with Nurse #1 on 10/22/24 at 12:57 PM revealed he was caring for Resident #1 on 09/02/24 on the day shift. He stated he was passing medications the morning of 09/02/24 when a NA notified him Resident #1 was bleeding. Nurse #1 stated he immediately went to Resident #1's room and noted some superficial cuts to Resident #1's penis. He stated he cleaned the lacerations and notified the NP of the incident. Nurse #1 stated when he asked Resident #1 what happened, Resident #1 explained he had wrecked on his motorcycle and had to cut himself out of barbed wire. He stated the entire unit was searched for scissors and no other scissors were found. Nurse #1 stated he had never seen blunt tipped scissors on the unit before and he did not know how Resident #1 obtained the scissors. A telephone interview with NA #3 on 10/22/24 at 3:37 PM revealed she cared for Resident #1 on 09/01/24 on the 11:00 PM to 7:00 AM shift. She stated she noticed a pair of yellow scissors with blunt tips sitting behind the sink in the day room/dining room when she began her shift on 09/01/24. NA #3 stated she had never seen the scissors on the unit before that shift and did not think about storing the scissors in the locked closet in the day room/dining room because residents were never in the room without supervision. She stated when she worked on the locked memory care unit, she usually sat in a chair in the doorway of the day room/dining room to monitor residents because she could visualize all resident rooms to see if residents exited their rooms. NA #3 stated Resident #1 did not leave his room during her shift on 09/01/24 and no	F 689	Date of compliance 10/25/24	

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other resident came in the day room/dining room the entire night. She stated Resident #1 seemed his usual self when she did her last round before her shift ended and she would have notified the nurse immediately if she had seen Resident #1 with scissors or noted any blood on his sheets.

An interview with the Activities Director on 10/22/24 at 11:53 AM revealed the activities department did have some blunt tipped scissors, but they were never allowed on the locked memory care unit. She stated when crafts were done on the memory care unit the activities department pre-cut any items that needed to be cut and she did not know how or why scissors would be on the unit.

A telephone interview with the Nurse Practitioner (NP) on 10/22/24 at 12:42 PM revealed she was asked to evaluate Resident #1 on 09/02/24 due to cuts on his penis. She stated nursing staff reported to her that Resident #1 had a pair of blunt tipped scissors and it was presumed he used the scissors to cut multiple areas on his penis. The NP stated the lacerations were superficial and she ordered antibiotic ointment and gauze to the area twice a day. She stated prior to this incident Resident #1 had not demonstrated any behaviors which indicated he might cause himself harm.

An interview with the Physician on 10/22/24 at 1:42 PM revealed she evaluated Resident #1 on 09/03/24 for lacerations on his penis. She stated the lacerations were superficial and did not show any signs or symptoms of infection. The Physician stated she asked Resident #1 why he had cuts on his penis, and he explained to her that he had gotten stuck in some barbed wire,

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F 689	Continued From page 4	F 689		

and he removed the barbed wire from his person. She stated Resident #1 had not routinely been having hallucinations prior to this incident and there was no indication he would harm himself. The Physician stated Resident #1 was very mobile and he could have obtained the scissors from another resident's room, and it was not possible to police every item that came in and out of the unit. She stated it was never determined how or where the scissors came from because they were not similar to any scissors kept in the facility.

An interview with the Director of Nursing (DON) on 10/22/24 at 2:37 PM revealed she was on vacation when Resident #1 cut himself with scissors, but the facility was unable to identify where the scissors came from or how he obtained the scissors. She stated scissors should not be on the memory care unit.

An interview with the Administrator on 10/22/24 at 2:42 PM revealed she was notified NAs went into Resident #1's room the morning of 09/02/24 to provide incontinence care, noted blood on his bedsheets, saw lacerations on his penis, and a pair of yellow blunt tipped scissors were found in Resident #1's room. The Administrator stated she did not visualize the areas but was told the lacerations were more like abrasions. She stated it was determined that sometime the morning of 09/02/24 Resident #1 had obtained a pair of scissors and cut his penis and scrotum. The Administrator stated she did not observe the scissors Resident #1 used because they had been placed in the sharps container before she could observe them, but their description did not match any scissors that kept in the facility. The Administrator stated she was never able to

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F 689	Continued From page 5 identify how Resident #1 was able to obtain the scissors or where the scissors came from, and the scissors should not have been on the memory care unit.	F 689		