STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DR CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility records, and staff interviews, the facility failed to position two (2) of fifty-three (53) resident beds away from baseboard heaters when the heaters were operating. (Rooms 205 and 409) The findings are: A review of undated manufacturer's documentation revealed the bedspreads provided to residents by the facility met the qualifications for fire retardant properties. A review of staff development records dated 10/12/11 and 11/01/11 revealed documentation of facility staff education which included fire safety. Part of the fire safety in-service required staff to list fuel sources which included bedding, furniture, clothing, and linens. An observation on 02/27/12 at 1:30 PM revealed an unoccupied resident bed in Room 409 was covered with a facility bedspread. The bed was positioned so that the bedspread was lying on top of a baseboard heater casing. The heater was on	F 323	All beds and linens were moved away from the heaters within 2 hours of the issue being brought to our attention. Staff were re-inserviced immediately regarding this issue. The following day while the survey team was still in our building, we contacted Startec, our electrical contractors, and directed them to disconnect all electric baseboard heaters at the panel box that service the living areas inside our skilled nursing building. See attached documentation. Because the baseboards are no longer functioning, this will never be an issue again. We have continued monitoring temperatures inside the building to ensure that the central heating and cooling units are maintaining temperatures comfortable for our residents and within the required ranges.	2/27/12 2/28/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bobby N Leathers

TITLE: Administrator

(X6) DATE: 3-21-12

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 323	Continued From page 1 and was warm to touch. Observations on 02/27/12 beginning at 2:50 PM with the Director of Nursing (DON) and Maintenance Supervisor (MS) revealed the baseboard heater in room 205 was turned on. An unoccupied resident bed was observed covered with a facility bedspread. The bedspread was lying on top of the heater casing. The DON stated the bed was located too close to the baseboard heater. She was observed unlocking the bed and repositioning it away from the heater. In room 409 an unoccupied resident bed was observed covered with a facility bedspread which was touching the top of the baseboard heater casing. The heater was turned on and was warm to touch. The DON stated the bed was too close to the heater and was observed repositioning the bed away from the heater. She stated she expected no bedding should be resting on the heaters. The DON added the baseboard heaters were utilized for individual resident needs and were not the primary source of heat in residents' rooms. She stated the nursing assistants turn the heaters on and off as needed. The DON added the facility has never had a problem with the heaters. During the observations, the MS demonstrated how the heaters were turned on and off using knobs located at the end of each heating unit. An interview with Nursing Assistant (NA) #1 on 02/27/12 at 3:00 PM revealed she worked the 200 hall and was unaware of any adjustments that might be required regarding the position of the resident's bed when the baseboard heat was turned on.	F 323		

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F 323	Continued From page 2 An interview with NA #2 on 02/27/12 at 3:05 PM revealed she worked on the 300 hall. She stated if a resident required the use of baseboard heaters, the bed and blankets should be away from the heater. An interview with NA #3 on 02/27/12 at 3:25 PM revealed she worked on all halls in the facility. She was unaware of any repositioning requirements that might be required for the resident's bed if the baseboard heater was turned on. On 02/28/12 at 11:14 AM an interview with the baseboard heater manufacturer representative was conducted via phone with the DON present. The representative stated he was the technical support manager. He stated the instructions in the manual should be followed in regards to safe distances for bedding and furniture. In a continued interview with the DON on 02/28/12 at 11:20 AM, the DON stated the facility tries to keep bedding off the baseboard heaters. An interview with NA #4 on 02/29/12 at 9:30 AM revealed she worked on the 300 hall. She stated residents' beds should have bedding tucked in and be away from the baseboard heaters when they are in use.	F 323		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		

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F 463	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews the facility failed to provide a functioning call bell in one (1) of one (1) bathrooms utilized by residents and located in hallway by the nurses' station. The findings are: An observation on 02/28/12 at 3:20 PM revealed Resident # 201 entered the unlocked bathroom off the hallway by the nurses' station. Resident #201 closed the door then exited the bathroom a few minutes later. An interview with Nursing Assistant (NA) #6 on 03/01/12 at 1:17 PM revealed residents who were able to ambulate on their own used the bathroom located by the nurses' station. NA #6 stated Resident #119 was one of the residents who frequently used this bathroom. An interview with Resident #119 on 03/01/12 at 1:28 PM revealed he utilized the unlocked bathroom located off the hallway by the nurses' station. He stated it was convenient. An interview with the Maintenance Supervisor on 03/01/12 at 2:00 PM revealed the bathroom off the hallway by the nurses' station was not for resident use. He stated it did not contain a functioning call bell. When asked how do residents' know not to use it, he replied he did not know. At 2:27 PM on 03/01/12 Resident # 201 was	F 463	The bathroom to the right of the central nurses' station does not meet ADA requirements and therefore cannot have a nurse call pull installed. This bathroom has traditionally been a staff only bathroom. It has now been re-labeled "Employees Only" and locked, with the key maintained securely behind the desk at the nurses' station. Because the door now remains locked, it is no longer possible for any resident to access it. Staff have been instructed to re-direct residents to an appropriate bathroom.	3/15/12

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F 463	Continued From page 4 observed entering the bathroom by the nurses' station and closing the door. A few minutes later he exited the bathroom. An interview with the Director of Nursing (DON) on 03/01/12 at 2:30 PM revealed the bathroom off the hallway by the nurses' station was designated for staff use, although she was aware residents sometimes used it. The DON stated the bathroom did not contain a functioning call bell and should be inaccessible to residents.	F 463		