DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. BUILDING ______ B. WING ______	C **08/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITHFIELD MANOR INC	**POST OFFICE BOX 1940** **SMITHFIELD, NC 27577**

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		8/28/14

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

Electronically Signed | 08/28/2014

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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This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and records review, the facility failed to report within 24 hours and investigate an injury of unknown origin to the state agency for 1 (Resident #1) of 3 residents reviewed for injury. Findings included:

Resident #1 was admitted 11/13/07 with cumulative diagnoses of Parkinson Disease. The quarterly Minimum Data Set dated 7/8/14 indicated Resident #1 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs).

A review of a nursing note dated 8/10/14 and an incident report dated 8/10/14 indicated at 10:00 AM, a bruise was noted to Resident #1 ' s left eye. The physician and the responsible party (RP) were notified.

A grievance report was started by the Director of Clinical Services (DOCS) on 8/11/14 at the request of the RP questioning the cause of the bruise. The grievance was dated and signed as completed with staff interviewed on 8/13/14 by the DON and a follow up call was made to the RP. The grievance indicated the cause was not determined but a new intervention was implemented by padding the one side rail. The grievance also indicated that staff education with bed mobility was done. A review of the interviews done by the DOCS indicated the bruise was not observed at 5:30 AM Sunday morning and first identified on 8/10/14 at 9:30 AM by the assigned nursing assistant (NA).

In an observation on 8/14/14 at 10:30 AM, Resident #1 was observed lying on the left side

For Resident #1, a 24-Hour Initial Report and a 5-Working Day Report were completed within 24 hours of complaint survey exit. The 24-Hour Initial and 5-Working Day reports were completed per guidance of Judith Jackson, Johnston County investigator for the North Carolina Department of Health & Human Services Health Care Personnel Registry.

Facility policy entitled "Resident Abuse and Prohibition Policy and Procedures," revised to reflect reporting of allegations of abuse, neglect and/or misappropriation of property to the Health Care Personnel Registry Of Division Of Facility Services within 24 hours and removing clause "or as soon as practicable."

Facility policy entitled "Resident Abuse and Prohibition Policy and Procedures," revised to reflect the definition of "injuries of unknown source" to include conditions in which they are classified by, per the interpretive guidelines of state regulation 483.13.

Disciplinary warning notice completed 8/25/14 for Director of Clinical Services (DOCS) regarding non-compliance of policy entitled "Resident Abuse Prohibition Policy and Procedures," and her failure to notify the administrator.
Acknowledgement of understanding and future compliance obtained.

The Staff Development Coordinator shall

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F 225 — Summary Statement of Deficiencies (continued):

with a nebulizer mask covering the nose and face. NA #1 removed to mask to reveal a linier bruise under the left eye that was covered by the elastic strap where the nebulizer was placed. Yellowish discoloration surrounded the left eye. There were numerous areas of scabbing and discolorations to Resident #1's skin due to a disorder called Bullous Pemphigoid which results in blisters on the skin. The only observed side rail was on the right side of the bed and it was padded. NA #1 stated Resident #1 was not able to turn or reposition in bed independently.

A review of Resident #1's most recent labs dated 6/9/14 indicated she was anemic and a review of the mediation administration record for August revealed Resident #1 was prescribed Prednisone daily for the inflammation associated with Bullous Pemphigoid. A common side effect of prolonged Prednisone use results in bruising easily.

In an interview on 8/14/14 at 12:02 PM, the DOCS recalled the RP approaching her on Monday 8/11/14 inquiring about the bruise discovered on 8/10/14. The DOCS stated she was unaware of the bruise but a grievance form was started because the DON was off Monday and she knew it would need to be investigated since the origin was unknown. The DOCS stated she began calling the staff who worked with Resident #1 on Saturday and Sunday. The DOCS stated she did not speak to the nurse #1 who completed the incident report but she felt that it may have occurred during care when a staff member rolled her over and she bumped her eye on the unpadded side rail. She had the side rail padded on 8/11/4.The RP returned to the facility on Wednesday 8/13/14 and again inquired about the outcome of the investigation. She

F 225 — Provider's Plan of Correction (continued):

conduct facility wide in-services of all departments to include, but not limited to, the revised policy entitled "Resident Abuse Prohibition Policy and Procedures." The Staff Development Coordinator will provide education related to all components of the policy to include screening, training, prevention, investigation and reporting/response and include emphasis of the timely reporting of allegations within 24 hours and the definition and understanding of "injuries of unknown source." In-services to all departments will be utilized to establish facility expectations. Continued yearly in-services and all new hires will receive this training conducted by the Staff Development Coordinator.

Bi-weekly audits entitled "Abuse Notification Audit" are to be completed by the Quality Assurance coordinator or his/her designee X 1 quarter, and quarterly thereafter. These audits shall include all departments and encompass questioning to ensure facility employees are knowledgeable and compliant in regards to the policy entitled "Resident Abuse Prohibition Policy and Procedures," in relation to timely reporting of allegations within 24 hours. These audits shall be included in the agenda of the quarterly Quality Assurance Committee meeting and be monitored for correction, achievement and sustainment of the revised policy.

Date of completion of corrective action is August 29, 2014.

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stated she had not had an opportunity to contact nurse #1 who completed the incident report but she had spoken to the other staff working with Resident #1 and no cause for the source of the bruise had been identified. It was at this time, the RP requested the DON take over the investigation. The DOCS stated she did not inform the SDC or the DON of the bruise or the grievance she was working on behalf of the RP until Wednesday 8/13/14.

In a telephone interview on 8/13/14 at 1:05 PM, nurse #1 stated on Sunday the NA notified her of a bruise to Resident #1's left eye. She assessed the bruise and notified the physician and the RP. She stated Resident #1 had a habit of lying on the left side and resting her face on her fist. Nurse #1 completed an incident report and left the report for the DOCS to do an investigation. She stated nobody from the facility had contacted her to date regarding the incident.

In an interview on 1:22 PM, the DON stated nurse #1 was an administrative nurse therefore his expectation was she not be interviewed part of the investigation. The DON stated based on the grievance and the interviewing done by the DOCS with the staff involved, he did not feel any form on intential injury had been done to Resident #1.

In an interview on 8/14/14 at 2:32 PM, the SDC stated she became aware of the incident on 8/13/14 when the DON asked her to start staff education on bed mobility with Resident #1. She stated when an injury of unknown origin was identified the facility typically completes a grievance then does an investigation. The SDC confirmed she was the abuse coordinator but the

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F 225	Continued From page 4 DOCS handled this incident without her knowledge. In and interview on 8/14/14 at 2:00 PM with the administrator and the DON, the administrator stated the RP asked him about the bruise on 8/13/14. The DON was also unaware of the incident at this time. It was at that point the DON became involved and spoke with the RP about the possibility she was turned and her face bumped the side rail. The administrator stated his expectation was that when an incident or injury of unknown origin was identified, it would be reported using the 24 hour report and 5 day report to the state agency and the investigation be started immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews and records review the facility failed to develop a policy and procedures to identify and investigation an injury of unknown origin for 1 of 3 residents reviewed for injury. Findings included: The facility provided their policy titled "Resident Abuse Prohibition Policy and Procedures" with date revised of 2009. A review of the facility policy made no mention of the identification of	F 226	Facility policy entitled "Resident Abuse and Prohibition Policy and Procedures," revised to reflect reporting of allegations of abuse, neglect and/or misappropriation of property to the Health Care Personnel Registry Of Division Of Facility Services within 24 hours and removing clause "or as soon as practicable." Facility policy entitled "Resident Abuse	8/28/14

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F 226	Continued From page 5 events suspicious in nature or injuries of unknown origin. The policy also read that the facility should ensure that the state agency would be notified within 24 hours or as soon as practicable of the allegation which appear to a reasonable person to be related to abuse, neglect or misappropriation of resident property. On 8/14/14 at 9:33 AM, administrator and the Director of Nursing (DON) identified the Staff Development Coordinator (SDC) and the DON as the Abuse Coordinators for the facility. Resident #1 was admitted 11/13/07 with cumulative diagnoses of Parkinson Disease. The quarterly Minimum Data Set dated 7/8/14 indicated Resident #1 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). A review of a nursing note dated 8/10/14 and an incident report dated 8/10/14 indicated at 10:00 AM, a bruise was noted to Resident #1's left eye. The physician and the responsible party (RP) were notified. A grievance report was started by the Director of Clinical Services (DOCS) on 8/11/14 at the request of the RP questioning the cause of the bruise. The grievance was dated and signed as completed with staff interviewed on 8/13/14 by the DON and a follow up call was made to the RP. The grievance indicated the cause was not determined but a new intervention was implemented by padding the one side rail. The grievance also indicated that staff education with bed mobility was done. A review of the interviews done by the DOCS indicated the bruise was not observed at 5:30 AM Sunday morning and first	F 226	and Prohibition Policy and Procedures," revised to reflect the definition of "injuries of unknown source" to include conditions in which they are classified by, per the interpretive guidelines of state regulation 483.13. The Staff Development Coordinator shall conduct facility wide in-services of all departments to include, but not limited to, the revised policy entitled "Resident Abuse Prohibition Policy and Procedures." The Staff Development Coordinator will provide education related to all components of the policy to include screening, training, prevention, investigation, reporting/response and emphasis of the timely reporting of allegations within 24 hours and the definition and understanding of "injuries of unknown source. In-services to all departments will be utilized to establish facility expectations. Continued yearly in-services and all new hires will receive this training conducted by the Staff Development Coordinator. Bi-weekly audits entitled "Abuse Notification Audit" are to be completed by the Quality Assurance coordinator or his/her designee X 1 quarter, and quarterly thereafter. These audits shall include all departments and encompass questioning to ensure facility employees are knowledgeable and compliant in regards to the policy entitled "Resident Abuse Prohibition Policy and Procedures," in relation to timely reporting of allegations within 24 hours. These audits shall be	

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F 226	Continued From page 6 identified on 8/10/14 at 9:30 AM by the assigned nursing assistant (NA). In an interview on 8/14/14 at 12:02 PM, the DOCS recalled the RP approaching her on Monday 8/11/14 inquiring about the bruise discovered on 8/10/14. The DOCS stated she was unaware of the bruise but a grievance form was started because the DON was off Monday and she knew it would need to be investigated since the origin was unknown. In a telephone interview on 8/13/14 at 1:05 PM, nurse #1 stated on Sunday the NA notified her of a bruise to Resident #1's left eye. She assessed the bruise and notified the physician and the RP. Nurse #1 completed an incident report and left the report for the DOCS to do an investigation. She stated nobody from the facility had contacted her to date regarding the incident. In an interview on 1:22 PM, the DON stated his interruption of the federal guideline was the facility could include incidents of unknown origin but it was not mandated if no malicious intent was identified. In an interview on 8/14/14 at 2:32 PM, the SDC stated she became aware of the incident on 8/13/14 when the DON asked her to start staff education on bed mobility with Resident #1. She stated when an injury of unknown origin was identified the facility typically completes a grievance then does an investigation. She stated that if abuse was suspected, they facility had 24 hours or as soon as practicable to report the incident. In and interview on 8/14/14 at 2:00 PM with the	F 226	included in the agenda of the quarterly Quality Assurance Committee meeting and be monitored for correction, achievement and sustainment of the revised policy. Date of completion of corrective action is August 29, 2014.	

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F 226	Continued From page 7 administrator and the DON, the administrator stated he was not aware that the facility policy did not include the reporting and investigation of incidents of suspicious in nature or incidents of unknown origin and unaware that the policy indicated reporting as soon as practicable. The administrator stated his expectation was that when an suspect incident or injury of unknown origin was identified, it was to be reported using the 24 hour report and 5 day report to the state agency and the investigation be started immediately.	F 226		