STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0458	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Bluff Inc	**100 Silver Bluff Drive , Canton, North Carolina, 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
L0000	INITIAL COMMENTS An onsite state licensure complaint investigation was conducted on 08/27/25 through 08/29/25. Event ID: 1D576C-H1. The following complaint allegations were investigated: 2587062, 2564768, 884216. 1 of 4 complaint allegations resulted in deficiency.	L0000		08/29/2025
L0039	SAFETY CFR(s): .2208(E) 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Type B Violation Based on record review and staff, Nurse Practitioner and Medical Director interviews, the facility failed to provide care in a safe manner for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). On 7/11/25 Nurse Aide (NA) #1 and Nurse #1 were on the right side of Resident #1's bed with NA #2 on the left side when initiating incontinence care for Resident #1. Resident #1 was lying on the left side of her bed with her body positioned on her right side facing NA #1 and Nurse #2 when NA #2 left the bed to obtain supplies leaving no staff on the left side of the bed where Resident #1 was positioned. Resident #1	L0039	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Corrective action for resident(s) affected by the alleged deficient practice. On 7/11/2025, while nurse#1 with the assistance of nurse aide #1 and nurse aide #2 was attempting to administer an injection to resident, it was noted that resident was having an incontinent episode and with emesis noted on gown. Nurse#1 and Nurse aide #1 were on left side of bed and nurse aide #2 was on right side of bed. Nurse aide #2 stepped away to retrieve supplies. As nurse aide #1 was walking around head of bed to right side of bed resident air mattress inflated on right side and resident slid to floor. On 7/11/2025, resident was assessed by nurse with no complaint of pain or discomfort or visible injuries noted. Medical Director and family notified. On 7/11/2025, air mattress was inspected and reset to not be in lateral rotation position by nurse to prevent resident from sliding from bed during care. On 7/12/2025, resident noted to grimace with pain during care when right lower leg was touched, Medical Director notified, and order given for two view x-rays to right tibia and fibula. On 7/12/2025, Director of Nursing verbally reeducated staff assisting resident with care during incident regarding Falls from Beds, positioning a resident and Air Mattress Policy to include settings and what to do	08/30/2025

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

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L0039	Continued from page 1 rolled off the left side of the bed and fell to the floor resulting in the resident sustaining a mildly displaced acute fracture of the right lateral malleolus (a break in the outer part of the ankle bone). The findings included: Resident #1 was admitted to the facility on 3/17/2015 with diagnoses that included cerebral palsy and epilepsy. A care plan dated 11/04/25 revealed Resident #1 had impaired cognitive function and had an Activities of Daily Living self-care performance deficit. A review of physician's orders revealed an order dated 5/20/25 for a pressure reduction mattress in place on bed at all times. The mattress that was placed on Resident #1's bed was provided by her family and was referred to as an air mattress by staff. The mattress has 2 settings. The static setting would keep the mattress firm, and the lateral rotation setting would inflate one side of the mattress while simultaneously deflating the other side. A review of Resident #1's orders revealed a Nurse Practitioner order dated 7/11/25 for gentamicin sulfate injection solution 40 milligrams/milliliter one time for one day for a urinary tract infection. An interview on 8/27/25 at 12:24 PM with Nurse Aide (NA) #1 revealed she and NA #2 were called into Resident #1's room on 7/11/25 by Nurse #1 to help change Resident #1. NA #1 indicated Resident #1 was positioned lying on the left side of the bed and she was standing on the right side of the bed with Nurse #1 when NA #2 walked away from the left side of the bed to get washcloths from the bathroom. NA #1 revealed she saw Resident #1 was sliding off the left side of the bed. She explained it happened so fast she did could not grab Resident #1 to keep her from falling off the bed. She yelled out that Resident #1 was falling and indicated by the time she got around to the left side of the bed Resident #1 had landed on the floor mat. She could not recall what position Resident #1 landed in. NA #1 reported she had not touched Resident #1 the entire time she was in the room. She revealed Resident #1 had very limited bed mobility and could not roll over by herself. NA #1 indicated she recalled the bed was lower than hip height, did not recall if there were side rails on the bed, and she had no knowledge of the settings for Resident #1's air mattress. She stated she had never touched the air mattress controls and knew nothing about the firmness of the mattress when	L0039	Continued from page 1 if noted in lateral rotation setting. On 7/13/2025, x-ray results positive for mildly displaced acute fracture of the right lateral malleolus. Medical Director notified and order given for resident to follow up with orthopedic doctor. Continue pain medication as ordered. On 7/13/2025, order placed for winged air mattress without lateral rotation function for resident safety from facility medical equipment supplier and family declined placement of air mattress due to billing. On 7/13/2025, order was placed on Medication Administration Record to monitor air mattress settings every shift to ensure air mattress was not in lateral rotation position to ensure resident safety. On 7/14/2025, resident seen by facility Nurse Practitioner with no new orders. On 7/16/2025, resident seen by Western Carolina Orthopedic Specialist and returned with order for walking boot and follow up with an orthopedic ankle specialist. On 7/17/2025, facility received orders from Western Carolina Orthopedic Specialist for three view x-ray of right and left ankle and two view x-rays of right femur. On 7/18/2025, x-ray results revealed subtle fractures of the left and right lateral malleolus and right distal femur fracture with bony formation representing an old fracture. On 7/23/2025, resident was seen by Southeastern Orthopedic and Spine and x-rays from 7/18/2025 were reviewed with no recommendation for surgery and plan for resident to have follow up visit in five weeks on 8/25/2025, repeat three view x-rays to left and right ankle in one month on 8/18/2025 at facility and pain control per facility protocol. Corrective action for residents with the potential to be affected by the deficient practice On 7/14/2025 the Director of Nursing identified residents that were potentially impacted by this practice by completing falls review audit for last 14 days and air mattress audits on all current residents. These audits were completed on 7/15/2025. The results included: No other resident had fall from air mattress or while care was being provided. Additionally, all air mattresses were inspected to ensure proper setting for residents. No other air mattresses identified with incorrect setting. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/13/2025, the Director of Nursing in serviced all full-time, part-time, and as needed direct care staff	

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L0039	Continued from page 2 Resident #1 fell out of the bed. She indicated there was no protocol in place for checking the mattress settings before providing care. An interview on 8/27/25 at 2:20 PM with Nurse Aide #2 revealed she and NA #1 were called into Resident #1's room on 7/11/25 by Nurse #1 to help change Resident #1. NA #2 indicated she was standing on the left side of the bed and went into the bathroom to get some washcloths. She revealed when she stepped away from the bed Resident #1 was lying on her right side facing Nurse #1 and NA #1 in the middle of the bed. NA #2 indicated when she was in the bathroom she heard NA #1 yelling that Resident #1 was falling, and when she exited the bathroom she saw Resident #1 lying on her back on the floor mat on the left side of her bed. She revealed Nurse #1 assessed Resident #1 and they placed her back in bed. NA #2 voiced Resident #1 showed no signs of pain and no signs of altered behavior after they got her back into bed. NA #2 revealed she then provided incontinence care and Resident #1 fell asleep. She indicated she had cared for Resident #1 for several years and Resident #1 was dependent for bed mobility and never rolled over in bed before on her own. NA #2 voiced this was the reason she felt it was safe to leave Resident #1's bedside to retrieve supplies. She indicated the bed was lower than hip level at the time of her fall. NA #2 did not recall having issues with Resident #1's air mattress before and she stated she checked the settings every shift to make sure it was set to static. She revealed she had checked the air mattress setting the morning of Resident #1's fall and recalled it was set to static. NA #2 did not know the setting at the time of the fall. There was no protocol in place for checking the mattress settings before providing care. An interview with Nurse #1 on 8/28/25 at 9:52 AM revealed she went into Resident #1's room to give her an injection on the day of the fall on 7/11/25. She indicated Resident #1 had vomited and needed incontinence care, so she asked NA #1 and NA #2 to come and help her. Nurse #1 revealed she and NA #1 were standing on the right side of the bed and NA #2 was standing on the left side of the bed when NA #2 went into the resident's bathroom to get some washcloths. Nurse #1 indicated when NA #2 went into the bathroom she looked down at the syringe she was holding and then heard NA #1 yelling that Resident #1 was falling out of the bed. She revealed that Resident #1 had side rails on the top 1/3 of her bed but they only extended about 3 or 4 inches above the mattress and they were up at	L0039	Continued from page 2 (including agency) on Fall from Bed, Falls Prevention and Response, Positioning a Resident, Air Mattress Policies. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 7/20/2025 will not be allowed to work until the training is completed. Root cause analysis completed, and it was determined that fall was due to air mattress setting being out of normal position and staff did not observe air mattress setting prior to rendering care resulting in resident sliding from bed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 7/18/2025, Quality Assurance Meeting was held to discuss findings and plan for monitoring for compliance. Beginning the week of 7/20/2025, The Director of Nursing will monitor Falls with Injury to include monitoring air mattress settings utilizing the Quality Assurance Tool for Falls with Injury. On 8/28/2025, The Quality Assurance Nurse Consultant held a Quality Assurance Meeting with the Administrator, Director of Nursing and Assistant Director of Nursing to discuss plan to initiate additional monitoring to include Activities of Daily Living care observations utilizing the Quality Assurance Tool for Activities of Daily Living Care Observations beginning 8/28/2025. These audits will be completed weekly for 4 weeks and monthly for 2 months to ensure falls prevention measures are in place, plan of care is followed related falls and to ensure resident safety when providing Activities of Daily Living care. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate and ongoing compliance. The weekly Quality Assurance Meeting may be attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Therapy, Staff Development Coordinator, Health Information Manager, and the Dietary Manager. Date of Compliance: 8/30/2025	

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L0039	Continued from page 3 the time of her fall. Nurse #1 indicated she went around to the left side of the bed and Resident #1 was sitting on the fall mat with her feet in the air. She assessed Resident #1 and found no abnormalities or areas of concern so she and NA #2 placed Resident #1 back in bed. Nurse #1 revealed the bed was lower than hip level. She did not know which setting the air mattress was on but indicated the bed was firm. She reported there was no protocol in place for checking the mattress setting before providing care. A review of Resident #1's electronic health record revealed a physician's order dated 7/12/25 for an x-ray of her right tibia-fibula (the two long bones of the lower leg located between the knee and the ankle). The results, dated 7/13/25, showed a mildly displaced acute fracture of the right lateral malleolus. An interview with the Nurse Practitioner (NP) on 8/27/25 at 1:26 PM revealed she was asked by staff to see Resident #1 after she fell out of bed on 7/11/25. She indicated she assessed Resident #1 just after she was placed back in bed and she saw no bruising, redness, skin irritation, signs or symptoms of pain or altered behavior. The NP voiced she had seen Resident #1 earlier on the day of the fall because of rigors (involuntary shaking or trembling of the body) and prescribed an intramuscular injection of antibiotics to be administered. She believed the rigors were caused by a urinary tract infection. She indicated bruising and swelling was observed on Resident #1's right ankle on 7/12/25 and an x-ray was performed with the results showing a mildly displaced right lateral malleolus. An interview with the Director of Nursing (DON) on 8/28/25 at 8:41 AM revealed the air mattress on Resident #1's bed was brought in by her family soon after she was admitted and not provided by the facility. She indicated the air mattress would inflate on one side and simultaneously deflate on the other side when it was not on the static setting and indicated it should have always been set on the static setting. The DON did not know for sure if the setting had been set on static when Resident #1 fell out of bed but speculated the incorrect setting could have been the reason for her falling out of bed. She revealed staff should keep their hands on a resident when providing care especially when one staff member steps away. She indicated there was no protocol in place for checking the mattress before providing care.	L0039		

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L0039	Continued from page 4 An interview on 8/28/25 at 12:12 PM with the Medical Director revealed Resident #1 was immobile and non-weight bearing for most of her life which would increase her risk for injury from a fall. He indicated staff should have kept their hands on Resident #1 while providing care. An interview with the Administrator on 8/28/25 at 3:48 PM revealed staff should always keep their hands on a resident when providing care to prevent a fall. She indicated staff received training after the incident on fall prevention and post care, and proper bed positioning for residents. The facility provided the following written plan regarding how the facility will immediately remove the Type B Violation in order to protect residents from further risk or additional harm. Corrective action for resident(s) affected by the alleged deficient practice. On 7/11/2025, while Nurse #1 with the assistance of Nurse Aide (NA) #1 and NA #2 were attempting to administer an injection to the resident and it was noted that the resident was having an incontinent episode and with emesis noted on gown. Nurse #1 and NA #1 were on left side of bed and NA #2 was on right side of bed. Nurse Aide #2 stepped away to retrieve supplies. As NA #1 was walking around head of bed to right side of bed resident air mattress inflated on right side and resident slid to floor. On 7/11/2025, the resident was assessed by Nurse #1 with no complaint of pain or discomfort or visible injuries noted. The Medical Director and family were notified. On 7/11/2025, the air mattress was inspected by the Director of Nursing (DON) and reset to not be in the lateral rotation setting to prevent the resident from sliding from bed during care. On 7/12/2025, the resident was noted to grimace with pain during care when her right lower leg was touched. The Medical Director was notified and an order was given for two view x-rays to right tibia and fibula. On 7/12/2025, the DON verbally reeducated the staff who assisted the resident with care during the incident regarding Falls from Beds, Positioning a Resident and Air Mattress Policy to include settings and what to do if noted in lateral rotation setting. On 7/13/2025, the x-ray results were positive for a mildly displaced acute fracture of the right lateral malleolus. The Medical Director was notified and an order was given for the resident to follow up with an orthopedic doctor, and continue pain medication as ordered. On 7/13/2025, an order was placed for winged air mattress without	L0039		

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L0039	Continued from page 5 lateral rotation function for resident safety from the facility medical equipment supplier and the resident's family declined placement of this air mattress due to billing. On 7/13/2025, an order was placed on the resident's Medication Administration Record to monitor air mattress settings every shift to ensure the air mattress was not in the lateral rotation position to ensure resident safety. On 7/14/2025, the resident was seen by the facility Nurse Practitioner with no new orders. On 7/16/2025, the resident was seen by Western Carolina Orthopedic Specialist and returned with an order for a walking boot to her right leg and to follow up with an orthopedic ankle specialist. On 7/17/2025,the facility received orders from Western Carolina Orthopedic Specialist for a three view x-ray of the resident's right and the left ankle and two view x-rays of the right femur. On 7/18/2025, x-ray results revealed subtle fractures of the left and right lateral malleolus and a right distal femur fracture with bony formation representing an old fracture. On 7/23/2025, the resident was seen by Southeastern Orthopedic and Spine and x-rays from 7/18/2025 were reviewed with no recommendation for surgery and a plan for the resident to have a follow up visit in five weeks on 8/25/2025, repeat three view x-rays to the left and right ankle in one month on 8/18/2025 at the facility, and pain control per facility protocol. Corrective action for residents with the potential to be affected by the deficient practice On 7/14/2025 the Director of Nursing identified residents who were potentially impacted by this practice by completing fall review audits for the last 14 days and air mattress audits on all current residents. The audits were completed on 7/15/2025. The results included: No other resident had fall from air mattress or while care was being provided. Additionally, all air mattresses were inspected to ensure the proper settings for residents. No other air mattresses were identified with an incorrect setting. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/13/2025, the Director of Nursing in-serviced all full-time, part-time, and as needed direct care staff (including agency) on: Fall from Bed, Falls Prevention and Response, and Positioning a Resident and Air Mattress Policies. The DON will ensure that any of the above identified staff who did not complete the in-service training by 7/20/2025 would not be allowed to work until the training is completed. A root cause analysis was completed and it was determined that the	L0039		

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L0039	Continued from page 6 fall was due to the air mattress setting being out of normal position (static) and staff did not observe the air mattress setting prior to rendering care, resulting in the resident sliding from her bed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 7/18/2025, a Quality Assurance Meeting was held to discuss findings and plan for monitoring for compliance. Beginning the week of 7/20/2025, the DON will monitor falls with injury to include monitoring air mattress settings utilizing the Quality Assurance Tool for falls with injury. On 8/28/2025, the Quality Assurance Nurse Consultant held a Quality Assurance Meeting with the Administrator, DON and Assistant Director of Nursing to discuss a plan to initiate additional monitoring to include Activities of Daily Living care observations utilizing the Quality Assurance Tool for Activities of Daily Living Care Observations beginning on 8/28/2025. These audits will be completed weekly for 4 weeks and monthly for 2 months to ensure falls prevention measures are in place, and the plan of care is followed related to falls and to ensure resident safety when providing Activities of Daily Living care. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or DON to ensure corrective action initiated is appropriate and ongoing compliance. The weekly Quality Assurance Meeting may be attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Therapy, Staff Development Coordinator, Health Information Manager, and the Dietary Manager. Date of compliance: 08/29/25	L0039		