STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING _____ B. WING _____	10/22/2015

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for pressure ulcer (Resident #25) and for hydration (Resident #42) for 2 of 23 sampled residents reviewed. Findings included: 1. Resident #42 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident # 42 had severe cognitive impairment and was dehydrated. The doctor's progress notes were reviewed. The last notes dated 9/4/15 did not address dehydration. The nurse's notes were reviewed. The notes dated 9/18/15 at 3:08 AM indicated that Resident #42 was treated with Tylenol (fever reducer) for temperature of 101.2 degrees Fahrenheit (F) and at 5:52 PM, the resident was treated with [MEDICATION NAME] (antibiotic) for increased congestion and coughing. The notes dated 9/19/15 at 1:00 PM and 7:00 PM indicated that the resident's food and liquid intake were adequate. The notes dated 9/20/15 at 8:00 PM indicated that the resident's food and liquid intake were adequate. On 10/21/15 at 4:15 PM, the MDS Nurse was interviewed. She stated that she had not seen any documentation in the records to indicate that Resident #42 had dehydration. She added that the nurse's notes indicated that the resident had adequate food and liquid intake so the MDS Nurse acknowledged that the coding for hydration was inaccurate. 2. Resident #25 was readmitted to the facility on [DATE] status [REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated that Resident #25's cognition was intact and she had an unstageable pressure ulcer that was present on admission. The nursing admission assessment dated [DATE] indicated that the resident was admitted with skin impairment on the buttock/sacrum and right stump. The records indicated that Resident #25 was admitted with a stage II pressure ulcer on the buttock/sacrum and the pressure ulcer healed up on 9/27/15. The nurse's notes were reviewed. The notes dated 9/15/15 at 11 AM indicated that an area was noted to the right inner knee and it appeared to be from the stump brace. On 9/18/15, the skin integrity report indicated that an unstageable pressure ulcer was first identified on the right medial knee. The ulcer had 90% slough and 10% granulation measuring 1.5 centimeter (cm) x (by) 5.3 cm. On 9/19/15, there was a physician's orders [REDACTED]. On 10/21/15 at 11:05 AM, the MDS Nurse was interviewed. After reviewing the records, the MDS Nurse stated that the pressure ulcer was coded incorrectly. The unstageable pressure ulcer had developed in house and was not present on admission.
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to correctly transcribe a medication as ordered by the physician, to the Medication Administration Record [REDACTED]. Findings included: Resident # 30 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#30 had severe cognitive impairment. The physician's orders [REDACTED].#30 had an order for [REDACTED]. Review of the resident's MARs for August, September and October, 2015 revealed that Senna Plus was transcribed as Senna Lax (a laxative) to the MAR. On 10/21/15 at 2:20 PM, administrative staff #1 was interviewed. After reviewing the records, administrative staff #1 indicated that Nurse #1 incorrectly transcribed the Senna Plus to the MAR. She added that the incorrect transcription started in March, 2015 when the order was written. Administrative staff #1 confirmed that Resident #30 incorrectly received Senna Laxative instead of Senna Plus from 03/02/15 to 10/20/15. On 10/21/15 at 2:40 PM, Nurse #1 was interviewed. She acknowledged that she made a mistake in transcribing the Senna Plus to the resident's March 2015 MAR.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and staff and resident interview, the facility failed to closely monitor the skin and protect the skin from rubbing against a knee brace which resulted in the development of an unstageable pressure ulcer to the right medial knee for 1 (Resident #25) of 2 sampled residents with pressure ulcers. Findings included: Resident #25 was re-admitted to the facility on [DATE] status [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #25's cognition was intact and she had an unstageable pressure ulcer. The nursing admission assessment dated [DATE] indicated that the resident was admitted with skin impairment to the right stump. The resident's nurse's notes from 9/7/15 through 9/18/15 were reviewed. There were no documentation that Resident #25 was wearing a brace to her right leg or the skin surrounding the brace was closely monitored for skin breakdown except for the notes dated 9/15/15. The notes dated 9/15/15 at 11:00 AM indicated that an area was noted to the right inner knee and it appeared to be from the resident's stump brace. The resident's weekly skin checks were reviewed. The weekly skin checks were conducted on the 7: 00 AM to 3:00 PM shift every Monday. The skin checks completed on 9/14/15, 9/21/15 and 9/28/15 indicated that the resident had previously noted skin injury/wound. The checks did not indicate that the resident had a new skin breakdown. The resident's weekly skin integrity reports were reviewed. The report indicated that on 9/18/15, Resident #25 was noted to have an unstageable pressure ulcer on the right medial knee. The ulcer had 90% slough and 10% granulation measuring 1.5 centimeter (cm) x (by) 5.3 cm. On 10/16/15, the report indicated that the ulcer on the resident's right medial knee had 80% slough and 20% granulation measuring 1 cm x 5 cm. On 10/14/15, there was a physician's orders [REDACTED].

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

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 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) On 10/20/15 at 2:15 PM, interview with administrative staff #1 was conducted. She stated that Resident #25 had developed an unstageable pressure ulcer on the right medial knee. She indicated that the pressure ulcer was from the resident's knee brace. Administrative staff #1 stated that Resident #25 was re-admitted to the facility on [DATE] with a brace to her right leg to support the stump. On 10/21/15 at 9:40 AM, observation of a dressing change to Resident #25's right knee was conducted. Nurse #1 performed the dressing change. The pressure ulcer on the resident's right medial knee had slough in the center. The ulcer was cleaned with wound cleaner, calcium alginate was applied to the wound bed, covered with a foam dressing and secured with kerlix. On 10/21/15 at 9:50 AM, Nurse #1 was interviewed. She indicated that Resident #25 was re-admitted on [DATE] status [REDACTED]. The resident was admitted with a brace on her right leg to support the stump. The resident had to wear the brace at all times. She added that she noticed the redness on the resident's right knee and she thought that the dressing to the stump was too tight that caused the redness. Later on, she realized that the redness was from the resident's knee brace rubbing against the skin so she removed the brace from the resident's leg. Nurse #1 described the brace as a hard plastic material. On 10/22/15 at 9:50 AM, Resident #25 was interviewed. She stated that her knee brace was made of a clear white, hard plastic material. She added that the end of the brace was rubbing the back of her knee but she didn't know that there was an open area at the back of her knee. On 10/22/15 at 10:15 AM, administrative staff #1 was interviewed. She stated that the skin breakdown that Resident #25 experienced on her knee from the use of the knee brace could have been avoided. She indicated that when the resident was admitted , the nurse should have called the physician and obtained an order for [REDACTED]. records. On 10/22/15 at 10:35 AM, the resident's knee brace was observed. The brace was white and made of a hard plastic material. The front part of the brace that was protecting the resident's stump was padded but the rest of the brace had no padding on it. On 10/22/15 at 10:50 AM, Nurse #1 was interviewed. She stated that a doctor's order should have been obtained for Resident #25 on admission for the use of the brace including the instruction on how and when to apply it. She also stated that the application and observation of the resident's skin to prevent the skin from breakdown should have been completed by staff and documented in the resident's medical records.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, staff interviews and observations, the facility failed to follow the policy on smoking for one of three residents (Resident #133) reviewed for smoking. The findings included: The Smoking Policy revised 4/1/15 stated Patients will not be allowed to maintain their own lighter fluid or matches. The Siler City Center Smoking List included Resident #133. Resident #133 was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. A review of the annual Minimum (MDS) data set [DATE] revealed the resident was assessed as being cognitively intact. The resident was assessed with [REDACTED]. The Plan of Care dated 10/8/15 indicated the resident may smoke independently per smoking assessment. The interventions included the resident will dispose of smoking materials in a safe manner. The Smoking Evaluation dated 10/17/15 indicated that independent smoking was allowed for Resident #133. An interview was conducted on 10/20/15 at 11:01 AM with Resident #133. He stated that he has smoked in the courtyard. He stated that he kept his cigarettes in his bedside table. He stated that he had his own lighter and he lit his own cigarettes. An observation was made on 10/20/15 at 11:01 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted on 10/22/15 at 10:17 AM with Resident #133. He stated that he has smoked about four times a day. He stated that he has kept his lighter on his bedside table at night. An observation was made on 10/22/15 at 10:17 AM of Resident #133 removing a lighter from his pant pocket and placing the lighter back into the pocket. An interview was conducted with Administrative Staff #1 on 10/22/15 at 10:38AM. She stated she was not aware that Resident #133 kept his own lighter to use for smoking. She stated she thought the resident ' s lighter was kept in a locked drawer at the nurses ' station when not in use. Administrative Staff #1 stated the nurse assigned to 400 Hall was responsible for retrieving the resident ' s lighter upon request and securing it in a locked drawer after use. An interview was conducted with Nurse #1 on 10/22/15 at 12:58PM. The nurse stated she was assigned to 400 Hall where Resident #133 resided. Nurse #1 stated she was aware that the resident was a smoker. She stated she was not aware that the resident kept his lighter in his possession. She stated that Resident #133 had not asked her to retrieve his lighter from the nurses ' station.
F 0334 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop policies and procedures for influenza and pneumococcal immunizations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the facility failed to obtain informed consent when offering the influenza vaccine for the 2014 - 2015 influenza vaccine season for 3 of 5 Residents (Resident #98, #41 and #41). Findings included: 1. Resident #98 was admitted [DATE]. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #98 was cognitively impaired. Review of the Influenza Immunization Informed Consent form revealed it was signed by a family member of Resident #98 on 9/5/13. The section that read hereby give the center permission to administer an influenza vaccination annually, in the fall was checked. An Influenza Immunization Informed Consent form for the 2014 - 2015 influenza immunization season could not be located within the medical record. Review of the Influenza Vaccine Administration Record revealed Resident #98 was administered the vaccine on 10/3/14 for the 2014 - 2015 influenza vaccination season. On 10/22/15 at 12:05 PM interview with Nurse #4 revealed that she had just taken over the Immunization Coordinator role. She stated that she had been unaware that once a consent for Influenza Vaccine had been obtained in a given year that it still needed to be obtained in subsequent years, even thou the facility form indicated an ongoing annual consent. She added that residents who could speak for themselves could be asked for their informed consent at the time of administration but acknowledged that cognitively intact residents could not. In addition, Nurse #4 stated she had been looking through medical records to locate documentation of informed consent and had not been able to find any other documentation other than the above. Nurse #4 acknowledged that there was no documentation to show that prior to Resident #98 receiving the influenza vaccine in 2014 that the family/Responsible party was asked to consent for that year, or that the family/Responsible Party, or other residents, received the appropriate Vaccine Information Statement to make an informed choice. 2. Resident #4 was admitted [DATE]. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively impaired. Review of the Influenza Immunization Informed Consent form revealed it was signed by a family member of Resident #4 on 9/16/13. The section that read hereby give the center permission to administer an influenza vaccination annually, in the fall was checked. An Influenza Immunization Informed Consent form for the 2014 - 2015 influenza immunization season could not be located within the medical record. Review of the Influenza Vaccine Administration Record revealed Resident #4 was administered the vaccine on 10/3/14 for the 2014 - 2015 influenza vaccination season. On 10/22/15 at 12:05 PM interview with Nurse #4 revealed that she had just taken over the Immunization Coordinator role. She stated that she had been unaware that once a consent for Influenza Vaccine had been obtained in a given year that it still needed to be obtained in subsequent years, even thou the facility form indicated an ongoing annual consent. She added that residents who could speak for themselves could be asked for their informed consent at the time of administration but acknowledged that cognitively intact residents could not. In addition, Nurse #4 stated she had been looking through medical

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F 0334 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) records to locate documentation of informed consent and had not been able to find any other documentation other than the above. Nurse #4 acknowledged that there was no documentation to show that prior to Resident #4 receiving the influenza vaccine in 2014 that the family/Responsible party was asked to consent for that year, or that the family/Responsible Party, or other residents, received the appropriate Vaccine Information Statement to make an informed choice. 3. Resident #41 was readmitted [DATE]. The Quarterly Minimum Data Set (MDS) revealed Resident #41 was moderately cognitively impaired. Review of the Influenza Immunization Informed Consent form revealed it was signed by a family member of Resident #41 on 8/27/13. The section that read hereby give the center permission to administer an influenza vaccination annually, in the fall was checked. An Influenza Immunization Informed Consent form for the 2014 - 2015 influenza immunization season could not be located within the medical record. Review of the Influenza Vaccine Administration Record revealed Resident #41 was administered the vaccine on 10/21/14 for the 2014 - 2015 influenza vaccination season. On 10/22/15 at 12:05 PM interview with Nurse #4 revealed that she had just taken over the Immunization Coordinator role. She stated that she had been unaware that once a consent for Influenza Vaccine had been obtained in a given year that it still needed to be obtained in subsequent years, even thou the facility form indicated an ongoing annual consent. She added that residents who could speak for themselves could be asked for their informed consent at the time of administration but acknowledged that cognitively intact residents could not. In addition, Nurse #4 stated she had been looking through medical records to locate documentation of informed consent and had not been able to find any other documentation other than the above. Nurse #4 acknowledged that there was no documentation to show that prior to Resident #41 receiving the influenza vaccine in 2014 that the family/Responsible party was asked to consent for that year, or that Resident #41, the family/Responsible Party, or other residents, received the appropriate Vaccine Information Statement to make an informed choice.
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on record review, observations, resident interviews, and staff interviews the facility ' s Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed for the 10/30/14 recertification survey in order to achieve and sustain compliance in the areas of accuracy of assessment (F278) and accidents (F323) . These deficiencies were cited again on the current recertification survey of 10/22/15. The findings included: This tag is cross referenced to: F278 - Accuracy of assessment: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for pressure ulcer (Resident #25) and for hydration (Resident #42) for 2 of 23 sampled residents reviewed. During the recertification survey of 10/30/14 the facility was cited F278 for failing to accurately code the MDS to reflect Level II Preadmission Screening and Resident Review determination. F323 - Accidents: Based on record review, resident interview, staff interviews, and observations, the facility failed to follow the policy on smoking for 1 of 3 residents (Resident #133) reviewed for smoking. During the recertification survey of 10/30/14 the facility was cited F323 for failing to identify potentially hazardous conditions of pipe access portals. On 10/22/15 at 12:35PM an interview with the Administrator was conducted. She stated that she is the head of the facility ' s QAA Committee. She stated that the QAA Committee consisted of the medical director, the pharmacist and all department heads, including the director of nursing and the assistant director of nursing. The committee had met monthly without the pharmacist and quarterly with all participants. The Administrator indicated that she was aware that accuracy of assessments was a repeat deficiency from the previous recertification survey. She stated that the action plan that was put into place from the previous recertification survey was monitored by herself, the Director of Nursing (DON), and Administrative Staff #3. She stated that Administrative Staff #3 was responsible for the coding the MDS. She stated she believed the accuracy errors that resulted from miscoding was caused by human error of Administrative Staff #3. The Administrator stated that to her knowledge no one audited Administrative Staff #3 for accuracy. The Administrator also indicated that she was aware that accidents was a repeat deficiency from the previous recertification survey. She stated that the action plan that was put into place from the previous recertification survey was monitored by herself and by housekeeping staff. She indicated that residents ' lighters were to be kept locked in the nurse ' s station when not in use. She revealed that she did not know that Resident #133 kept his own lighter.