STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siler City Center	900 W Dolphin Street Siler City, NC 27344

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review, observations, and resident and staff interviews the facility failed to maintain the resident's dignity by not emptying urinals prior to lunch and as needed. This was evident for 1 of 4 residents (Resident #41) reviewed for dignity. Findings include: Resident #41 was admitted on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #41's cognition was moderately impaired. He required moderate assistance with toileting and dressing and minimal assistance with transfers. He was occasionally incontinent of bowel and bladder. Resident #41 had range of motion impairment to both sides of his upper extremities. An observation and interview were conducted with Resident #41 in his room on 11/04/24 at 10:39 AM. Resident #41 was observed laying on his bed watching TV. Two urinals were noted on the nightstand with urine in them. One with approximately 400 milliliters (ml) of yellow urine and one with approximately 250 ml of yellow urine. He stated the staff emptied them when they got a chance but sometimes the urinals sat there with urine in them for a while. An observation and interview were conducted on 11/04/24 at 11:34 AM revealed the urinals with the same amount of urine were still on the nightstand. Resident #41 stated the urinals had not yet been emptied. An observation and interview were conducted on 11/04/24 at 1:05 PM. An observation was made of Nursing Assistant #1 bringing Resident #41's lunch tray into his room and then exiting the room. She did not empty the urinals on the nightstand which still had urine in two of them. Nursing Assistant #1 indicated she did not see the urinals therefore she did not empty them. An interview was conducted on 11/04/24 at 1:06 PM with Resident #41. He stated he would like for the urinals to be emptied more often. At least before he eats his meals because he felt it was unsanitary. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nursing Assistant #2 on 11/04/24 at 1:15 PM. She verified she was the direct care Nursing Assistant for Resident #41. She stated she emptied Resident #41's urinals an hour ago. When Nursing Assistant #2 was asked to observe the urinals on the nightstand which were in the same place and had the same amount of urine in them as they did in the earlier observations, Nursing Assistant #2 walked away and refused to respond to the surveyor. An observation on 11/06/24 at 10:25 AM in Resident #41's room revealed a urinal sitting on the nightstand that had approximately 300ml of yellow urine in it. An observation and interview were conducted on 11/06/24 at 12:45 PM. Resident #41 was observed sitting in his wheelchair eating lunch in his room. There was a urinal sitting on the nightstand with approximately 300ml or yellow urine in it. An observation and interview were conducted on 11/06/24 at 12:51 PM with Resident #41 in his room. He stated his urinal had not been emptied since that morning. He also stated it's nasty for the urinals to be sitting there so long and that they should at least be emptied before meals so it's not sitting there when he ate his meals. He further commented, it won't do any good to say anything because as soon as you and I turn our backs it'll happen again. An interview was conducted with Nursing Assistant #3 on 11/06/24 at 12:59 PM. She verified she was the direct care Nursing Assistant for Resident #41. When asked about when the last time she emptied the urinals she quickly turned away and entered Resident #41's room. She did not respond to the question. Nurse #2 was present at that time. An interview was conducted with Nurse #2 on 11/06/24 at 1:02 PM. He stated earlier in the shift he instructed Nursing Assistant #3 to make sure she kept Resident #41's urinals empty throughout her shift. He explained that Resident #41 requested the urinals to be emptied more often especially prior to his meals because he did not want to smell the urine while he ate. He indicated he had not looked at the urinals when he was in the room. An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 1:12 PM. She stated she had reminded staff to make sure rounds were done to make sure Resident's urinals were empty. She explained she expected staff to empty urinals prior to meals being served and as needed. She indicated residents should not have to look at or smell urine in their rooms.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, observations, and interviews with resident and staff, the facility failed to assess and obtain a physician's order for the self-administration of medications found at bedside for 1 of 1 resident (Resident #58). The findings included: Resident #58 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), diabetes type 2, and hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #58 was cognitively intact and displayed no behaviors or rejection of care. A review of Resident #58's medical record did not reveal an order to self-administer medications. On 11/4/24 at 10:30 AM, an observation was made of medications in a medication cup sitting on Resident #58's over the bed table. Resident #58 stated that the medication had been sitting there since his breakfast was delivered and that staff did not normally leave his medication sitting on the over the bed table. Resident #58's breakfast plate sitting on the over the bed table and Resident #58 stated he had completed his breakfast meal. He did not indicate he was going to take the medications. An interview was conducted with Nurse #3 on 11/4/24 at 10:40 AM. She verified she was the nurse that left Resident #58's morning medication on the over the bed table for him to take. She stated, He had them in his hand when I was in there. She returned to the room, Resident #58 stated he didn't want to take them at that time, Nurse #3 retrieved the medications and marked them as refused by Resident #58 on the Medication Administration Record (MAR). Nurse #3 further stated the medications should be secured and Resident #58 did not have an order to self-administer medications. The medications left in the medication cup on the over the bed table included the following: Amlodipine 10 milligrams (mg) 1 tablet, Cefdinir 300mg 1 tablet, Coreg 25mg 1 tablet, Divalproex 500mg 2 tablets, Entresto 49-51mg 1 tablet, Finasteride 5mg 1 tablet, Furosemide 20mg 1 tablet, Gabapentin 300mg 2 capsules, Levothyroxine 50 micrograms (mcg) 1 tablet, Metformin 500mg 1 tablet, Multivitamin 1 tablet, Senna Docusate 8.6-50mg 1 tablet and Sertraline 50mg 1 tablet. The Director of Nursing was interviewed on 11/4/24 at 12:37 PM and stated that medications should not be left at bedside unsecured unless the resident had an order for self-administration. She added that Resident #58 did not have an order for self-administration.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on resident and staff interviews, the facility failed to deliver resident mail unopened for 3 of 7 residents reviewed for mail delivery (Resident #29, Resident #91, and Resident #100). The findings included: a. Resident #29 was admitted to the facility on [DATE]. Resident #29's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was cognitively intact. An interview on 11/05/24 at 10:24 AM with Resident #29 revealed that he had received opened mail that was addressed to him. He stated that it had happened on more than one occasion but was unable to give specific dates. Resident #29 stated the mail that was opened was related to his financial status. b. Resident #91 was admitted to the facility on [DATE]. Resident #91's annual MDS assessment dated [DATE] revealed Resident #91 was cognitively intact. An interview on 11/05/24 at 10:26 AM with Resident #91 revealed that she had received opened mail that was addressed to her. She stated that it had happened on more than one occasion but was unable to give specific dates. Resident #91 stated the mail that was opened was related to her financial status. c. Resident #100 was admitted to the facility on [DATE]. Resident #100's quarterly MDS assessment dated [DATE] revealed Resident #100 was cognitively intact. An interview on 11/05/24 at 10:28 AM with Resident #100 revealed that she had received opened mail that was addressed to her. She stated that it had happened on more than one occasion but was unable to give specific dates. She also stated for staff to open her mail without her consent was against her rights. Resident #100 stated the mail that was opened was related to her financial status. During an interview on 11/05/24 at 3:02 PM with the Activity Director she revealed she delivered mail to the residents Monday through Friday. She explained that there had been times when she delivered mail that had been taped closed due to previously being opened. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 3:22 PM with the Business Office Manager (BOM), she verified that she handled mail that related to resident's financial aspects. She indicated mail that came to the business office was put in a box that was attached to her office door. She explained that she grabbed the stack of mail and opened all envelopes prior to looking at who the mail was addressed to. She stated if a resident's cognition was impaired, she opened their mail. If they were cognitively intact, she was not supposed to open their mail. When she opened mail in error, she taped it back closed, and had it delivered to the resident. She agreed she should not open any mail without verifying who it was addressed to. During an interview on 11/06/24 at 1:15 PM with the Administrator he stated he was unaware the mail addressed to cognitively intact residents had been opened prior to them receiving it and the mail should not be opened. He explained that the only time mail should be opened was if the mail was addressed to the facility or if the resident was cognitively impaired. He then indicated that employees should always follow the mail handling process.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review and staff interviews, the facility failed to provide the resident or Responsible Party (RP) written notification of the reason for a hospital transfer for 4 of 4 residents reviewed for hospitalization (Residents #22, #58, #111 and #132). The findings included: 1. Resident #22 was admitted to the facility on [DATE]. Resident #22's medical record revealed she was transferred to the hospital on 4/15/24 and readmitted to the facility on [DATE] and transferred again to the hospital on 5/18/24 and readmitted to the facility on [DATE]. There was no documentation that written notices of transfers were provided to the RP for the reasons for the transfers. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #22 had severely impaired cognition. An interview occurred with Nurse #2 on 11/6/24 at 1:00 PM and explained when a resident was transferred to the hospital a copy of the face sheet, physician orders, medication list, DNR information and bed hold policy were sent with them. He was unaware of a written notice of transfer that was provided to the resident or RP. On 11/5/24 at 3:10 PM, the Director of Nursing (DON) was interviewed and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #22's RP. The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed. 2. Resident #58 was admitted to the facility on [DATE]. Resident #58's medical record revealed he was transferred to the hospital on 11/16/23 and readmitted to the facility on [DATE] and transferred again to the hospital on 3/24/24 and readmitted to the facility on [DATE]. There was no documentation that written notices of transfers were provided to the resident or RP for the reasons of the transfers. A quarterly MDS assessment dated [DATE] indicated Resident #58 was cognitively intact. An interview occurred with Nurse #2 on 11/6/24 at 1:00 PM and explained when a resident was transferred to the hospital a copy of the face sheet, physician orders, medication list, DNR information and bed hold policy were sent with them. He was unaware of a written notice of transfer that was provided to the resident or RP. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 11/5/24 at 3:10 PM, the DON was interviewed and stated a copy of the face sheet, any DNR information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #58's RP. The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed. 3. Resident #111 was admitted to the facility on [DATE]. Resident #111's medical record revealed he was transferred to the hospital on 12/5/23 and readmitted to the facility on [DATE], transferred to the hospital on 2/22/24 and readmitted to the facility on [DATE], and transferred again to the hospital on 5/7/24 and readmitted to the facility on [DATE]. There was no documentation that written notices of transfers were provided to the resident or RP for the reasons of the transfers. A quarterly MDS assessment dated [DATE] indicated Resident #111 had moderately impaired cognition. An interview occurred with Nurse #2 on 11/6/24 at 1:00 PM and explained when a resident was transferred to the hospital a copy of the face sheet, physician orders, medication list, DNR information and bed hold policy were sent with them. He was unaware of a written notice of transfer that was provided to the resident or RP. On 11/5/24 at 3:10 PM, the DON was interviewed and stated a copy of the face sheet, any DNR information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #111's RP. The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed. 46095 4. Resident #132 was admitted to the facility on [DATE]. Resident #132's medical record revealed he was transferred to the hospital on 10/28/24. There was no documentation that written notices of transfers were provided to the RP for the reasons for the transfers. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #132's Resident #132 was cognitively intact. An interview was conducted with Nurse #6 on 11/07/24 at 4:23 PM. She indicated Resident #132 called 911 himself for transport to the hospital due to him not feeling well. He did not notify staff he was calling 911. She stated emergency medical services (EMS) arrived, took face sheet, list of medications, and DNR form and transported Resident #132 to the hospital per his request. She notified his power of attorney (POA), Hospice, and the Director of Nursing (DON) of the transfer. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 11/5/24 at 3:10 PM, the Director of Nursing (DON) was interviewed and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The responsible party (RP) would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #132's RP. The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, observations and staff interviews, the facility failed to administer water flushes via a feeding tube at the physician ordered flow rate for 1 of 2 residents reviewed with tube feedings (Resident #22). The findings included: Resident #22 was originally admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and presence of a feeding tube. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #22 rarely made herself understood and had severely impaired decision-making skills. She was coded as receiving 51% or more of her total calories through a tube feeding and an average fluid intake of 501 cubic centimeters (cc) per day or more by tube feeding. A review of Resident #22's active physician orders included an order dated 10/17/24 to flush the feeding tube with 110 milliliters (ml) of water every 3 hours during continuous feedings. Resident #22's active care plan, last reviewed 10/25/24, revealed a focus area for an enteral feeding tube to meet nutritional needs. The interventions included to provide water as ordered. An observation of Resident #22 on 11/5/24 at 8:35 AM, revealed her feeding tube was connected to a continuous bottle of formula with a standby bag of water. The water flush was observed to be running at 110 cc and the setting on the pump for frequency of the water flush was set at every 4 hours. Resident #22's lips were not dry or cracked in appearance. An observation was made with Nurse #1 on 11/5/24 at 2:05 PM, of Resident #22's water flush setting on the tube feed pump. He acknowledged the settings for the water flush were set at a rate was at 110 ml and the frequency of the water flush was set at every 4 hours. After reviewing the physician orders, he verified the water flush order was for 110 ml every 3 hours. He was unable to state why the rate was different than the physician's order but would correct it on the feeding tube pump. The Director of Nursing was interviewed on 11/5/24 at 3:10 PM and stated she expected water flushes to be at the prescribed rate.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, and Medical Director and staff interviews, the facility failed to hold blood pressure medication as ordered by the physician for 1 of 6 residents reviewed for unnecessary medications (Resident #95). The findings included: Resident #95 was admitted to the facility on [DATE] with diagnoses that included low blood pressure (hypotension). A review of Resident #95's active physician orders included an order dated 10/7/24 for Midodrine (a blood pressure medication) 10 milligrams (mg) one tablet by mouth three times a day for low blood pressure- take if systolic blood pressure is less than 120. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #95 was cognitively intact. The October 2024 and November 2024 Medication Administration Records (MARs) were reviewed and revealed Resident #95 had received Midodrine despite the systolic blood pressure (SBP) being greater than 120. - 10/9/24 at 1:00 PM the SBP was 122 and at 5:00 PM the SBP was 124. - 10/21/24 at 9:00 AM the SBP was 122, at 1:00 PM the SBP was 122 and at 5:00 PM the SBP was 122. - 10/24/24 at 9:00 AM the SBP was 122. - 11/1/24 at 9:00 AM the SBP was 121, at 1:00 PM the SBP was 121 and at 5:00 PM the SBP was 121. - 1/2/24 at 9:00 AM the SBP was 122 and the 5:00 PM SBP was 122. - 11/3/24 at 9:00 AM the SBP was 122, the 1:00 PM SBP was 122 and the 5:00 PM SBP was 122. - 11/5/24 at 9:00 AM the SBP was 134, the 1:00 PM SBP was 134 and the 5:00 PM SBP was 130. An interview was conducted with Nurse #5 on 11/6/24 at 12:56 PM. She was the nurse assigned to Resident #95 on 10/24/24, 11/1/24 and 11/3/24. The October 2024 and November 2024 MARs were reviewed with Nurse #5 who stated the medication should have been held per the parameter and felt it was an oversight. A phone interview was held with Nurse #3 on 11/6/24 at 3:30 PM, who was assigned to Resident #95 on 10/21/24. The October 2024 MAR was reviewed with Nurse #3 who stated the medication should have been held per the order and felt it was an oversight. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts to contact Nurse #1 were made without success. He was assigned to Resident #95 on 11/5/24. Attempts to contact Nurse #4 were made without success. She was assigned to Resident #95 on 10/9/24 and 11/2/24. The Director of Nursing was interviewed on 11/7/24 at 8:52 AM who reviewed the October 2024 and November 2024 MARs. She stated she would expect the medication to be given as ordered. A phone interview occurred with the Medical Director on 11/7/24 at 10:03 AM and stated if Resident #95 had received a few dosages of Midodrine outside the parameter it would not have caused any serious harm. The Medical Director added he would expect the nurses to follow the orders for the Midodrine as written.