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	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Bluff Inc	100 Silver Bluff Drive Canton, NC 28716

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on observations, record review, and staff interviews the facility failed to protect a resident's right to be free from physical restraint when Nurse Aide (NA) #2 held Resident #61's wrists/hands in front of her chest during incontinence care when Resident #61 started swinging her arms and kicking her legs. In addition, NA #1 and NA Student #1 observed NA #2 smacking Resident #61 with an open hand on the wrist following the completion of incontinence care. This was for 1 of 3 residents reviewed for physical restraint (Resident #61). The findings included: Resident #61 was admitted to the facility on [DATE]. Her diagnoses included dementia with behavioral disturbances. The annual Minimum Data Assessment (MDS) dated [DATE] revealed Resident #61 had severe cognitive impairment. The MDS documented she had physical behaviors directed toward others 1 to 3 days and verbal behaviors directed toward others daily. She was not documented for rejection of care. Resident #61 was documented as being incontinent of bowel/ bladder and dependent on staff for toileting hygiene, personal hygiene, and lower body dressing. Resident #61 had the following care plans in place: A behavior care plan related to dementia with behavioral disturbance revised on 9/3/24. Consisting of behaviors that can be disruptive including, verbally/ physically aggressive behaviors, has displayed yelling/ screaming, tapping/ hitting walls, cursing, and combativeness with staff. The care plan interventions included: -Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Stop and allow time to calm down if excessive physical aggression occurs during care. Resident frequently displays physical aggression/combativeness towards staff members during care and does not always understand that staff members are attempting to assist her. During aggression episodes, resident will often exclaim that something is occurring to her, but it is instead what she is doing to others. For example, when resident hits staff members she then yells that she has been hit. This primarily occurs during high contact care with resident. Staff to continue to explain all procedures to the resident before and during provision of care assistance. -Monitor behavior episodes and attempt to identify underlying cause. The Director of Nursing completed the Initial Allegation Report on 9/18/24 regarding an allegation of staff to resident abuse involving Resident #61. The report stated the facility had been made aware that a NA (NA #2) swatted at Resident #61's hand when Resident #61 attempted to hit the NA following incontinence care. Following the incident Resident #61 was assessed by a nurse and did not have any visible marks or injury. The accused employee was suspended pending investigation. The facility reported the allegation of abuse to the police and adult protective services on 9/18/24. There were two witnesses to the alleged abuse incident. A facility investigation of the incident was completed by the Director of Nursing. Through their investigation the facility concluded the abuse allegation was un-substantiated. A typed staff interview form dated 9/18/24 for NA #2 read in part: NA #2 stated while attempting to assist with incontinence care for Resident #61, she became combative after care was completed. I told everyone to step back. I attempted to hold resident's hand and talk to her calmly and she attempted to swing at me and I threw up my hand in defense to protect myself. Me and the other aides backed away and did not touch the resident anymore and left the room. About 30 minutes later I was told to leave because the student said I had swatted the resident on the hand. At no time during the care did I intend to cause the resident harm or hit her. An interview with NA #2 was conducted on 11/6/24 at 1:31 PM. NA #2 said she remembered the incident with Resident #61 which had occurred a little over a month ago. NA #2 explained she had gone with two other staff members to Resident #61's room to provide care. She did not remember the names of the other staff members. NA #2 said Resident #61 was in bed while incontinence care was being provided. She said two of the staff members (NA #1 and NA Student #1) were positioned at Resident #61's legs/ feet toward the bottom of the bed and she had been positioned at the head of the bed during the care. NA #2 stated Resident #61 started swinging her arms and kicking. NA #2 said they walked away and tried to let Resident #61 calm down for 3 to 5 minutes before proceeding with care. NA #2 said after the 3-to-5-minute break she and the other two NAs proceeded to provide incontinence care to Resident #61. She stated Resident #61 started swinging her arms and kicking again. NA #2 stated she was protecting Resident #61's hands from getting hit by holding them and doing defensive moves in a patty cake action while the other NAs completed incontinence care. She described patty cake as smacking hands with the resident. She described defensive moves as putting her arm up to block Resident #61's arm swing. NA #2 indicated no one had told her to hold Resident #61's hands. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed staff interview form dated 9/18/24 for NA #1 read in part: NA #1 stated while attempting to provide incontinence care for resident (Resident #61) with assistance from nurse aide (NA #2) and student (NA student #1) Resident #61 became combative by swinging arms and kicking and she (NA #1) told everyone to step back and give her (Resident #61) a minute to calm down. After care was completed and we were cleaning up and preparing to leave the room, resident (Resident #61) started swinging her arms and kicking and NA #2 went closer to the resident (Resident #61) and NA #2's arm went up and her hand swatted the back of Resident #61's hand. We finished gathering our supplies and trash and left the room. As we were leaving NA #2 asked if resident (Resident #61) was always that way?. An interview was conducted with NA #1 on 11/6/24 at 1:53 PM. NA #1 stated she remembered the incident of alleged abuse on 9/18/24 involving Resident #61. NA #1 stated she had been training NA #2 on 9/18/24. NA #1 explained she had asked NA student #1 to help with Resident #61's care because she could be feisty during care. She explained feisty as Resident #61 would sometimes try to hit during care. NA #1 said it typically required 2 to 3 NAs to provide care for Resident #61. She explained she had asked another NA to come in to help with care because she was pregnant and knew Resident #61 had behaviors that included kicking. NA #1 said she, NA #2, and NA Student #1 had entered Resident #61's room around 8:30 PM to provide care. She explained the care provided was changing Resident #61 into a gown, changing her brief, and assisting her to bed for the night. She stated Resident #61 became upset during care and she told NA #2 and NA student #1 to take a step back and give Resident #61 a minute to calm down. NA #1 explained everyone stepped back and gave Resident #61 three to five minutes to calm down before reapproaching her for care. When they resumed care with Resident #61 it was herself and NA Student #1 who performed incontinence care for Resident #61 and changed her brief. NA #1 stated NA #2 was sitting on the bedside table located at the head of Resident #61's bed watching the care and initially was not actively participating in the care. Resident #61 started swinging her arms in the air and NA #2 proceeded to hold the lower part of both of Resident #61's hands around her wrists. NA #1 stated after the incontinence care for Resident #61 was completed she and NA student #1 were cleaning up. She said NA #2 was still standing close to Resident #61 holding the resident's hands/wrists. NA #1 further stated Resident #61 swung her arms and NA #2 smacked Resident #61 on the arm near her right wrist. NA #1 recalled Resident #61 did not appear startled, scared, or cry out during the incident. NA #1 stated Resident #61 had not swung her arms in the direction of NA #2 and that she had been swinging her arms in the air. NA #1 recalled after NA #2 swatted Resident #61 on the arm NA #2 walked out of the room and said, is she always like that. She stated the contact NA #2 had with Resident #61 was not defensive or a defensive block. NA #1 said the care was over and NA #2 could have stepped back away from Resident #61 instead of swatting her arm. NA #1 stated NA #2 had smacked Resident #61 with an open hand, and she had not seen a visible mark on Resident #61 where NA #2 had smacked her. The interview further revealed NA #2 had not been asked to hold Resident #61's hands/wrists during care. NA #1 explained Resident #61 did not need to be held down or restrained during care. NA #1 stated NA #2 was not holding Resident #61 down, she was just holding her hands. NA #1 indicated the situation had made her feel uncomfortable. NA #1 said everyone exited the room around 9:00 PM and after exiting Resident #61's room she and NA #2 went to the nurse's station. NA #1 recalled NA #2 did not go into any other resident rooms to provide care. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed staff interview dated 9/24/24 for NA student #1 read in part: NA student #1, NA #1, and NA #2 were providing care to Resident #61. She (Resident #61) became combative, and we all stepped back. We allowed her some time and then explained everything we were going to do to make her feel more comfortable. She appeared to calm down and we proceeded to continue to provide care. Once we were done providing incontinence care I was collecting the trash from the floor but still standing in the same spot. NA #2 was standing at bedside. Resident (Resident #61) took both hands and pushed at/ towards NA #2. Resident's (Resident #61) hands were balled up. NA #2 brought her hand up in a defensive manner to block the blow, she made contact with Resident #61's hands with her arm and hand. Her (NA #2) hand was open. We all backed away and left the room. An interview was conducted with NA Student #1 on 11/6/24 at 3:41 PM. She stated she remembered the incident on 9/18/24 with Resident #61. NA Student #1 said she went to Resident #61's room with NA #1 and NA #2 around 8:30 PM to assist with getting Resident #61 ready for bed and changing her brief. She explained Resident #61 was usually feisty and was sometimes combative during care. NA Student #1 said during care when they were removing her clothes Resident #61 said no your not doing that. NA Student #1 explained if you talked to Resident #61 during care it distracted her and then she was usually agreeable with care. NA Student #1 stated she and NA #1 transferred Resident #61 to the bed, laid her down on the bed to change her brief, and Resident #61 started to hit and kick. NA Student #1 recalled when Resident #61 started to hit NA #1 said, lets back away and let her cool down. She said they backed away for about 5 minutes and let Resident #61 calm down. NA Student #1 said Resident #61 calmed down a lot and then she and NA #1 resumed care. NA #2 was sitting on the nightstand located at the head of Resident #61's bed watching the care. NA Student #1 further explained once they were almost done changing Resident #61's brief she started trying to hit again. NA Student #1 revealed when Resident #61 started trying to hit NA #2, NA #2 started holding Resident #61 around both of her wrists to keep her from hitting. NA Student #1 explained NA #2 was positioned at the head of Resident #61's bed and was holding her arms away by the wrists while they provided care. She said Resident #61 was not trying to hit or swat at NA #2 at the time. NA student #1 said, she (NA #2) hit her (Resident #61) it was not a defensive block. NA Student #1 said what she witnessed was abuse and she felt it was done aggressively by NA #2. She said there was no change in Resident #61's behavior after the incident and that she did not yell out, or act like she was hurt or scared when the incident occurred. NA student #1 stated she knew what defense was and NA #2's action was not defensive. NA Student #1 recalled everyone exited Resident #61's room around 9:00 PM and NA #2 went to the nurse's station with NA #1 and she did not see NA #2 go into any other resident rooms. The written statement provided by NA Student #1 was reviewed by NA Student #1. NA Student #1 confirmed she had not typed the statement and that the statement had been read to her. NA Student #1 noted she had not re-read the statement and missed that the statement said NA #2 brought her hand up in a defensive manner. NA Student #1 again stated, NA #2's action was intentional and not defensive. During the interview NA Student #1 demonstrated how NA #2 had held Resident #61. She demonstrated Resident #61 had both her arms bent at the elbow and positioned in front of her chest. NA Student #1 showed the placement of NA #2's hands holding Resident #61 around both of her wrists and the base of the hands in front of Resident #61's chest. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Charge Nurse on 11/6/24 at 4:56 PM revealed she had been the supervisor on 9/18/24 for the 7:00 PM to 7:00 AM shift. She stated NA #1 reported NA #2 had smacked Resident #61 while helping with care. The Charge Nurse stated she could not remember what time NA #1 had reported the incident to her and she could not remember exactly where NA #1 had reported NA #2 had smacked Resident #61, except she knew it was not on the face or head. The Charge Nurse indicated when NA #1 reported the incident she immediately called the Director of Nursing (DON). The Charge Nurse stated she checked on Resident #61 after the incident. She explained she checked Resident #61's skin all over and did not see any visible marks. The Charge Nurse recalled Resident #61 was unable to tell her what had occurred and Resident #61 did not have any changes in behavior or appear upset or fearful after the incident. A typed interview document for the DON dated 9/18/24 read in part: I received a call at approximately 9:50 PM from the Charge Nurse. She stated she had a report of abuse. NA #1 was placed on the phone and described the incident. She stated while providing care to Resident #61, NA #2 and NA Student #1 were assisting. NA #1 said that while NA Student #1 and her were providing incontinence care NA #2 had been holding residents' (Resident #61) hands to prevent her from striking staff. She said that when they were about finished NA #2 let go of residents (Resident #61) hands and Resident #61 attempted to swing at NA #2. She stated that NA #2 then swatted at residents (Resident #61) hands. I (DON) asked if action was intentional and NA #1 responded yes, that she did feel it was intentional. I spoke with NA #2 who stated she had assisted with resident (Resident #61) care. She stated resident (Resident #61 was combative and she held her hands to prevent resident (Resident #61 from hitting her and other staff. NA #2 stated that when she let go of residents (Resident #61) hands that the resident went to swing at her and she threw out her hand/ arm in defense to block her swing. An interview was conducted with the DON on 11/7/24 at 12:26 PM. The DON stated the Charge Nurse had called her on 9/18/24 around 9:40 PM and reported an allegation of abuse. The DON further stated she spoke on the phone with NA #1 who reported to her NA #2 had swatted Resident #61 during care. The DON spoke with NA #2 and told her there was an allegation of abuse that was going to be investigated, and she needed to leave the facility immediately. The DON reported each NA was spoken to separately about the incident and a reenactment of the incident was conducted with NA #1 and NA Student #1. The DON explained based on the interviews and reenactment of the incident with NA #1 and NA Student #1, the facility determined NA #2's actions had been defensive and that NA #2's contact with Resident #61 had been a defensive block. The DON stated the facility had unsubstantiated the abuse allegation. The DON could not say why NA #1 and NA Student #1 reported during surveyor interviews, they did not feel NA #2's actions were a defensive block and that NA #2's actions were intentional. An interview was conducted with the Administrator on 11/7/24 at 3:10 PM. The Administrator stated the DON had made him aware of the incident on 9/18/24 when it occurred. The Administrator explained the DON had conducted the investigation and reported the findings to him. He stated he had agreed based on what was described that it was not abuse and that it appeared to have been a defensive reaction by NA #1. The Administrator stated the abuse allegation was not substantiated by the facility. The facility provided the following Corrective Action Plan with a correction date of 9/26/24: Corrective action for resident(s) affected by the alleged deficient practice: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/18/2024 approximately thirty minutes following incident around 8:50pm, the Nurse Aide #1 and Nurse Aide Student #1 reported to charge nurse #1 that nurse aid #2 had swatted resident # 61's hand following incontinent care after resident attempted to hit staff. -At approximately 9:40pm, Charge Nurse #1 immediately notified Director of Nursing and suspended nurse aide#1, nurse aide #2 and nurse aide student #1 pending investigation and assessed resident # 61 with no concerns noted. -Resident #61 denied any pain or discomfort. -On 9/18/2024, Resident #61 RP notified. On 9/18/2024 MD was notified with no new orders. -On 9/18/2024 the Director of Nursing immediately reported incident to Administrator and initiated investigation, notified police and Adult Protective Services and sent initial allegation report to state reporting agency. -On 9/18/2024, Director of Nursing interviewed resident #61 and completed body audit with no concerns noted. Director of Nursing spoke with resident #61 family and discussed investigation process. -On (9/18/2024) resident #61 Care Plan updated. -On 9/19/2024, the Director of Nursing interviewed nurse aide #1 and nurse aide #2 separately to get details of the alleged abuse. -On 9/24/2024, the Director of Nursing interviewed nurse aide student #1 and completed reenactment of event. During the interviews, each nurse aide also completed a reenactment of the event. -On 9/25/2024, the Administrator and Director of Nursing concluded the alleged abuse investigation and based on investigation findings unsubstantiated alleged abuse of Resident #61. On 9/25/2024, the Director of Nursing submitted the Investigation Report to the State Survey Agency with findings. Corrective action for residents with the potential to be affected by the deficient practice: -Beginning 9/19/2024 full body audit completed for current residents with BIMS 12 and below with no new skin issues noted. -Safe Check interviews completed for all current residents with BIMS 13 and higher with no issues noted. Staff who worked on the 300 hall were interviewed. Staff not aware of any issues involving any other residents. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/18/2024, the Director of Nursing began in servicing all full-time, part-time, and PRN (as needed) staff (including agency) on ABUSE (preventing, recognizing and reporting) and Dealing with Challenging Behaviors policies. This training included: Abuse Types, reporting abuse allegations immediately to nurse/DON/Administrator, what to do if abuse observed or suspected, assuring resident safety, zero tolerance of retaliation of reporting allegations of abuse, along with notification of local law enforcement, Adult Protective Services, and State Survey Agency. Staff were also asked if they were aware of any abuse occurring to any resident in the facility and what to do if observed or suspected. No staff were aware of any other abuse occurring in facility. The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 9/21/2024 will not be allowed to work until the training is completed. This training will be included in new hire orientation for any newly hired staff. -Investigation findings were reviewed in Quality Assurance Meeting on 9/20/2024 with Administrator, Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator with no additional findings. 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: -Beginning the week of 9/23/2024, the Director of Nursing or designee will monitor ABUSE/CARE CONCERNS using the QA Tool for ABUSE and ADL Care Observations by observing staff perform incontinence care for 5 residents to ensure staff are adhering to Abuse Policy. This will be completed weekly for 4 weeks and monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. Date of Compliance: 9/26/2024 On 11/7/24, the facility's corrective action plan effective 9/26/24 was validated by the following: The facility held a quality assurance (QA) meeting on 9/20/24 and discussed the abuse allegation related to Resident #61. Review of records revealed the facility had completed body audits for all resident with a BIMS of 12 or below and had completed safe check interviews for all residents with a BIMS of 13 or higher with no issues identified. The facility audit tools for activity of daily living (ADL) observations and quality assurance (QA) recognizing/ reporting abuse audit tools were reviewed. The facility had completed ADL and abuse audits weekly. The facility had held weekly QA meetings to review the audits. Review of training in-service-logs revealed all staff received education on abuse, prevention, recognizing and reporting and dealing with challenging behaviors. Interviews were conducted with licensed nurses, nursing assistants (NAs), and non-nursing department staff. The staff were able to verbalize the different types of abuse and actions to take for reporting abuse. The staff were able to verbalize techniques to manage and deal with challenging behaviors. The education included new staff and contract/agency staff. New staff and contract/ agency staff were not allowed to work until education had been received. The completion date of 9/26/24 for the correctvie action plan was validated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, staff interviews and record reviews, the facility failed to secure an unopened vial of inhaler and an opened tube of ointment in the medication cart for 1 of 1 room (room [ROOM NUMBER]), failed to date an opened bottle of eye medication and 7 opened pens of insulin for 3 of 6 medication carts (200 halls, 300 halls, and 400 halls), and failed to lock 1 of 6 medication carts during observations for medication storage audits (300 halls). The findings included: a. During a medication storage audit conducted on 11/04/24 at 10:51 AM, 1 vial of unopened ipratropium-albuterol (DuoNeb) solution and an opened tube of zinc oxide ointment were found sitting on Resident #73's bedside table and ready to be used. An attempt to interview Resident #73 on 11/04/24 at 10:52 AM was unsuccessful. She was unable to answer questions. During an interview conducted on 11/04/24 at 10:54 AM, Unit Manager #1 acknowledged that the vial of DuoNeb solution and the tube of zinc oxide ointment should not be left unattended in Resident #73's room. She added Resident #73 had never been assessed for self-administration of medication. She was not the nurse who passed medications in 500 halls in the morning and did not know why both medications were left unattended in Resident #73's room. An interview was conducted with the Staff Development Coordinator on 11/04/24 at 11:21 AM. She explained she did not work in 500 halls on a regular basis. When she passed medication in the morning, she did not notice that 2 medications were left unattended in Resident #73's room. She acknowledged that both medications should be kept in the medication cart. b. The manufacturer's package inserts for latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between the temperature of 36 to 46 Fahrenheit (F) and protected from light. Once it was opened, latanoprost could be stored at room temperature up to 77 F for up to six weeks. A review of manufacturer's package inserts for insulin glargine, Humalog KwikPen, insulin lispro KwikPen, and Levemir FlexPen revealed an unopened pen should be stored under refrigeration between 36 to 46 F and protected from light. Once they were opened, the above insulins could be stored in the refrigerator or at room temperature up to 86 F for up to 28 days, and up to 42 days for Levemir FlexPen. During a medication storage audit conducted on 11/05/24 at 2:03 PM for the medication cart of 300 halls in the presence of Nurse #1, an opened bottle of latanoprost eye drops and an opened pen of insulin glargine were found in the medication cart without an opening date, and they were ready to be used. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse #1 on 11/05/24 at 2:28 PM. She stated she worked the first shift most of the time and explained the latanoprost eye drops and the insulin glargine were scheduled to be administered on the evening shift. She did not notice the eye drops and insulin were opened without an opening date when she passed medication in the morning. c. A medication storage check was conducted on 11/05/24 at 3:22 PM for the medication cart of 200 halls in the presence of Medication Aide #1 (MA #1). The following insulins were found in the medication cart without an opening date and ready to be used: 1. 1 opened pen of insulin glargine 100 unit/milliliter (ml), with manufacturer's expiration date of 04/30/26. 2. 1 opened pen of Humalog KwikPen 100 unit/ml, with manufacturer's expiration date of 05/31/25. 3. 1 opened pen of Levemir FlexPen 100 unit/ml, with manufacturer's expiration date of 09/30/25. 4. 1 opened pen of insulin lispro 100 unit/ml, with manufacturer's expiration date of 10/31/25. During an interview conducted on 11/05/24 at 3:29 PM, MA #1could not determine how long the insulins had been opened and stored in the medication cart. She explained she was not authorized to administer insulin and therefore rarely checked the insulins to ensure they were dated properly. d. During a medication storage audit conducted on 11/05/24 at 3:42 PM in the presence of MA #2, 2 opened pens of insulin glargine for 2 different residents were found in medication cart for 400 halls without an opening date and ready to be used. An interview was conducted on 11/05/24 at 3:45 PM with MA #2. She stated she did not know who had opened the insulins and acknowledged that all insulins should be dated after they were opened and stored in the medication cart. She explained she was not authorized to administer insulin and therefore she never checked the insulins in her medication cart. During an interview conducted on 11/05/24 at 4:18 PM with the Assistant Director of Nursing (ADON), she stated all the hall nurses were instructed to date medications such as insulins and latanoprost when they were opened. It was her expectation for all the nurses to date latanoprost and insulins when they were opened and stored in the medication cart. She added even though the MAs was not authorized to administer insulin, it was her expectation for the MAs to check the insulins and communicated with the nurse as indicated and as needed. e. A medication storage check was conducted on 11/06/24 at 8:40 AM for the medication cart of 300 halls. Nurse #1 was seen leaving the medication cart interacting with several nurse students about 30 feet away in the hallways. The medication cart was parked unattended in the hallways next to the door of room [ROOM NUMBER]. A bunch of keys were seen sitting on the countertop of the medication cart. At the same time, the medication cart was unlocked as the locking knob was in the up position. Nurse #1 returned to the medication cart approximately 3 minutes later at 8:43 AM. None of the staff or residents were seen standing near the medication cart during the observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Silver Bluff Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Silver Bluff Drive Canton, NC 28716	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 11/06/24 at 8:43 AM, Nurse #1 confirmed that the bunch of keys were for the medication cart and medication storage rooms. She stated that she usually locked the medication cart before leaving it unattended. However, she was constantly disrupted by the nursing students in the morning as they asked questions repeatedly. She acknowledged that the keys for the medication cart and medication storage room should be in her possession at all times and the medication cart should be locked before leaving it unattended. An interview was conducted with the Director of Nursing (DON) on 11/07/24 at 1:55 PM. She stated the incidents could be avoided if nursing staff paid attention when dealing with time or temperature sensitive medications in the facility. It was her expectation for all the nurses or MAs to date insulin pen and latanoprost eye drops when opened a new pen or bottle, and kept residents' room free of unattended medication all the time. An interview was conducted with the Administrator on 11/07/24 at 2:11 PM. He stated it was his expectation for the nursing staff to follow manufacturer's guidelines when handling insulin and latanoprost and kept the facility free of unattended medications in residents' room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on observations, record review, test tray, and resident, resident representative, and staff interviews, the facility failed to provide palatable food that was appetizing in temperature for 3 of 3 residents reviewed with food concerns (Resident #42, Resident #59, and Resident #103). Findings included: a. Resident #59 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #59 had severely impaired cognition and required set up assistance with eating. An interview on 11/04/24 at 10:15 AM with Resident #59's resident representative revealed the food was often cold at lunch and dinner. b. Resident #103 was admitted to the facility on [DATE]. The annual Minimum Data Set, dated dated dated [DATE] revealed Resident #103 was cognitively intact and required set up assistance with eating. An interview on 11/04/24 at 11:08 AM with Resident #103 revealed he said the food was cold about half the time. c. Resident #42 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, dated dated dated [DATE] revealed Resident #42 was cognitively intact and required set up assistance with eating. An interview on 11/04/24 at 11:42 AM with Resident #42 revealed the food was cold sometimes. An observation of the lunch tray line was conducted on 11/05/24 at 12:45 PM. The test tray was the last tray plated and delivered to the dining room. It was sampled with the Corporate Dietary Manager, facility Dietary Manager, and another facility Dietary Manager at 12:52 PM. The observation revealed the following: the meal plate had no plate warmer under the plate and after the lid was removed, there was no visible steam from the food. When tasted, the pork chop was cold, the beets were cold, and the stuffing was warm. The dessert was pears, and they were not tasted. The overall appearance of the plate was mostly brown. An interview with Corporate Dietary Manager and facility Dietary Manager on 11/05/24 at 12:55 PM confirmed that the food was cold and did not taste appealing. The Corporate Dietary Manager stated she thought the cold food plate was due to the steam table temperature not being set high enough, the lack of food plate warmers, and the lack of insulated meal tray carts. An interview on 11/06/24 at 8:19 AM with the Administrator revealed he was not aware of any concerns related to cold food until yesterday when he talked to the Corporate Dietary Manager.