STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salemtowne	**1550 Babcock Drive , Winston-Salem, North Carolina, 27106**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/08/25 through 12/11/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DD628-H1.	E0000		
F0000	INITIAL COMMENTS The survey team entered the facility on 12/08/25 to conduct a recertification and complaint survey and exited on 12/11/25. Additional information was obtained on 12/12/25 and 12/19/25. Therefore, the exit date was changed to 12/19/25. Event ID# 1DD628-H1. The following intake was investigated 886523. 1 of 1 complaint allegation did not result in a deficiency.	F0000		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the	F0607		

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 reverse for further 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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F0607 SS = D	Continued from page 1 following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to immediately report an allegation of abuse to the Administrator and failed to implement their abuse policies and procedures in the area of protection for 1 of 3 sampled residents (Resident #17). The findings included: Review of the facility policy titled “Resident Abuse, Neglect, Exploitation, Misappropriation Prevention” with a review dated 2/26/2024 revealed procedures that included, during the investigation, the resident(s) involved would be protected from further potential abuse, and team members involved in the allegation would be suspended until the investigation was completed. The policy did not include reporting an alleged violation involving abuse immediately to the Administrator of the facility. Resident #17 was admitted to the facility on 1/9/2025 with a diagnosis that included Parkinson’s disease, vascular dementia and anxiety disorder. An interview with Nursing Assistant (NA) #1 on 12/10/2025 at 5:00 PM revealed that on 5/20/2025 he was bathing Resident #17 when Resident #17 became anxious and uncomfortable. NA #1 called NA #3 into the room to assist with providing incontinence care. While providing incontinence care Resident #17 was yelling for his wife and wanting to go to the hospital. NA #1 requested that Nurse # 1 come to the room as Resident #17 was stating he wanted to die and he did not want to be here. On 5/20/2025 during second shift, a Police Officer questioned NA #1 and asked, “at any point did you place your finger up his bottom?” NA #1 indicated he told the police the process for providing incontinent care to include cleaning the rectal area. NA #1 further stated he told the police he did not stick his finger in Resident #17’s bottom. After speaking with the police, NA #1 filled out a witness	F0607		

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F0607 SS = D	Continued from page 2 statement and his assignment changed to another hall by Nurse #1. NA #1 stated he continued to work the remainder of his shift. The review of NA #1 timecard revealed NA #1 clocked in on 5/20/2025 at 5:59 PM and clocked out at 11:44 PM, on 5/21/2025 NA #1 clocked in at 5:30 PM and clocked out at 11:00 PM. An interview conducted with NA #3 on 12/11/2025 at 12:55 PM revealed on 5/20/2025 she was called to Resident #17's room by NA #1 to assist with incontinence care. Prior to assisting with incontinent care, NA #1 was attempting to give Resident #17 a bed bath. While assisting NA #1 with incontinence care, Resident #17 was stating he wanted to kill himself and go to heaven. NA #3 and NA #1 told Nurse #1 about Resident #17's behaviors during incontinence care and the resident was assessed by Nurse #1 for suicidal ideations. Emergency Medical Services (EMS) arrived at the facility to transport Resident #17 to the emergency room (ER). The Police Officer arrived after EMS left the facility and interviewed NA #3. NA #3 recalled the police asking if Resident #17 was touched sexually by staff on 5/20/2025. NA #3 indicated after speaking with the police she filled out a witness statement and her resident assignment was switched by Nurse#1 with NA #1's resident assignment for the rest of her shift. NA #3 revealed she did not observe NA #1 touch Resident #17 sexually. An interview with Nurse #1 on 12/10/2025 at 5:40 PM revealed on 5/20/2025 she attempted to give Resident #17 his medication. Resident #17 refused stating Nurse #1 was trying to poison him, and he wanted to go to the hospital. Nurse #1 indicated she contacted the on-call provider who provided directions to send Resident #17 to the ER. When EMS entered Resident #17's room, Resident #17 stated he did not feel safe with Nurse #1 in the room and she left the room. Nurse #1 stated within 30 minutes of EMS leaving with Resident #17, a Police Officer came to the facility and stated Resident #17 stated he was sexually assaulted by a male NA who stuck something up his rectum. Nurse #1 revealed the facilities policy was to report allegations of abuse to the Nurse Supervisor (Nurse #3). Nurse #1 contacted the previous Assistant Director of Nursing (ADON) immediately after she was questioned by the Police Officer (time unknown) and was instructed to provide a witness statement for the Director of Nursing (DON) regarding the allegation of sexual assault. She was further instructed not to go into Resident #17's room. An interview was attempted with the previous ADON, and	F0607		

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F0607 SS = D	Continued from page 3 she was unavailable for interview. Record review of the EMS report indicated that they arrived at the facility to transport Resident #17 to the emergency room (ER) on 5/20/2025 at 9:01 PM. The report indicated Resident #17 reported there was a man and a female who were going to give him a washcloth bath. Resident #17 reported he refused the bath and stated he did not want to be washed. The report continued with Resident #17 revealed he was forced to take a washcloth bath and during the process he was sexually assaulted. Resident #17 stated the male employee did some penetration to his anus with his fingers and fist. Resident #17 reported this happened around 7:00 PM on 5/20/2025. EMS contacted the Police Department and waited with Resident #17 in the ambulance for police to arrive. Review of the incident/investigation report dated 5/20/2025 by the Police Department revealed the police investigated an incident regarding Resident #17 on 5/20/2025 at 9:41 PM. The incident/investigation report contained no details of the incident. A telephone interview was conducted on 12/11/2025 at 9:29 AM with the prior DON. She revealed she was made aware by phone on 5/20/2025 by a nurse (unknown) Resident #17 was going to the hospital for suicidal ideations and on the way to the hospital Resident #17 told EMS he was sodomized (the act of engaging in anal intercourse). She stated that typically the person that was accused would be suspended pending an investigation. The prior DON stated NA #1 was suspended for 3 days beginning on 5/20/25. When the prior DON was informed that a review of NA #1's timecard revealed NA #1 had worked the remainder of his shift on 5/20/25 and worked from 5:30 PM until 11:00 PM on 5/21/25 she stated she was unaware NA #1 continued to work. Review of Nurse #3 (night supervisor) email to the prior DON dated 5/21/2025 at 7:04 AM revealed a Police Officer came to the facility and asked who was taking care of Resident #17. Nurse #3 asked what happened and the Police Officer stated Resident #17 reported to EMS that he was sexually assaulted during his shower. An interview was attempted with Nurse #3. Nurse #3 was unavailable to be interviewed. Initial Allegation Report dated 5/21/2025 identified an Allegation of Resident Abuse. The report stated the alleged abuse took place on 5/20/2025 and the facility became aware on 5/21/2025 at 8:15 AM. The allegation details revealed, per the Police Officer Resident #17	F0607		

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F0607 SS = D	Continued from page 4 told (EMS) while being transported to the emergency room for suicidal ideation, that he was assaulted in the shower on 5/20/2025 by NA's. The initial allegation report was signed by the previous Director of Nursing (DON). Review of the Investigation report dated 5/27/25 revealed there was an allegation of abuse to Resident #17 by NA #1. The report indicated additions to the description of the allegations included an EMS report that indicated Resident #17 was sexually assaulted by a male staff. Resident #17 had a male and female NA that provided care on 5/20/2025. The investigation summary details included on 5/20/2025 at approximately 7:30 PM Resident #17 expressed statements indicating suicidal ideation. The Nurse immediately contacted the on-call physician and EMS. During transport, the resident communicated to EMS personnel that he had been sexually assaulted in the shower by a NA. EMS personnel reported the information to the local police. The local police came to the facility on 5/20/25, and interviewed NA #1, NA #3, Nurse #1, and Nurse #3 who all provided care to the Resident #17 prior to leaving the facility with EMS. Upon leaving the facility, the police did not communicate any suspicions or findings of sexual assault to Resident #17. The immediate action taken by the facility, revealed staff would ensure Resident #17 remained safe and free of harm after indicating suicidal ideations and remained with Resident #17 until EMS arrived. The DON was notified of the police investigation and allegation, and an investigation was initiated per abuse reporting protocol. Witness statements were obtained from NA#1, NA #3, Nurse #1 and Nurse #3. The investigation did not include protection provided for other residents during the investigation. The investigation report was signed by the Administrator. An interview was conducted with the Administrator on 12/11/2025 at 2:53 PM. She revealed on 5/21/2025 she was notified by an email dated 5/21/2025 at 7:04 AM from the previous DON concerning the allegations regarding sexual abuse to Resident #17. Resident #17 was sent out for suicidal ideation, and he alleged an allegation of abuse. She stated she should have been made aware of Resident #17's allegation of sexual abuse immediately and was not. The Administrator stated the Police Officer did not come until the end of NA #1's shift which was why NA #1 was not sent home pending the investigation. The Police Officer did not have findings and did not proceed with his investigation. The Administrator stated based on Nurse #3 indicating the Police Officer did not feel Resident #17 was in immediate harm and the initial investigation was	F0607		

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F0607 SS = D	Continued from page 5 completed, NA #1 was not removed from shift during the investigation.	F0607		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff interviews, and manufacturer's recommendations, the facility failed to remove an expired insulin lispro kwikpen (an insulin pen) and failed to label the insulin lispro kwikpen with resident information for 1 of 5 medication carts reviewed for medication storage (Mill Place medication cart). The findings included: The manufacturer's 2023 storage recommendation for Insulin Lispro KwikPen stated that the pen should be discarded 28 days after opening. During an observation of the Mill Place medication cart on 12/10/25 at 11:45 a.m., Nurse #4 confirmed that a multidose Insulin Lispro KwikPen, opened on 10/16/25,	F0761		

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F0761 SS = D	Continued from page 6 remained in the cart for use. The pen was not labeled, and no information identified the resident's name or room number. In an interview at 11:54 a.m. on 12/10/25, Nurse #4 acknowledged that the insulin should have been discarded 28 days after opening. She stated that all nurses using the cart were responsible for checking and removing expired medications. In a follow-up interview at 12:06 p.m., Nurse #4 identified the insulin as belonging to Resident #36 and stated that both the KwikPen and its storage box should have been labeled with the resident's name and room number. During an interview on 12/11/25 at 10:57 a.m., the interim Director of Nursing (DON) stated that nurses assigned to the medication cart were responsible for identifying and removing expired medications. She added that the third shift (11 p.m. to 7 a.m.) was designated to check one cart per week. The DON also stated the kwikpen should have the pharmacy label with resident's name and the room number. In an interview on 12/11/25 at 12:58 p.m., the Administrator emphasized that nursing staff must follow the manufacturer's guidelines and audit both the medication cart and the medication room during their shifts.	F0761		