STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	C 02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted a complaint investigation on 02/16/15, 02/19/15, and 02/23/15 with an exit conference via telephone on 02/24/15. The complaint investigation was inititated by the Forsyth County Department of Social Services on 02/11/15.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled residents (Resident #1) in accordance with the resident's assessed needs and current symptoms, which resulted in the physical assault and subsequent death of another resident. The findings are: Review of Resident #1's hospital-generated FL-2 dated 02/03/15 revealed: -Diagnoses included Lewy body dementia and recurrent falls. -The resident was not designated as physically or verbally abusive or dangerous to self or others. Review of hospital discharge information dated	D 270		

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02/01/15 revealed:
-Lewy body dementia with agitation and "violent outbursts".
-Recent physical assault by resident of three family members prior to hospitalization.
-Attempted to swing at the hospital Certified Nursing Assistant (CNA).

Review of the facility's New Admission Notice revealed Resident #1 was admitted on 02/03/15 at 3:00 pm.

Review of facility care notes, behavior reports, and incident reports revealed:
-On 02/03/15 at 6:30 pm, Resident #1 wandered into another resident's room and an unwitnessed physical altercation occurred.
-On 02/04/15 evening shift, Resident #1 was "running in the hallways" for 30 minutes.
-On 02/05/15 at 6:30 am, Resident #1 wandered into a female resident's room and pushed her down.
-On 02/06/15 day shift, Resident #1 was "not as combative" as he had been the "past couple of days".
-On 02/06/15 evening shift, Resident #1 was running in the hallways chasing staff.
-On 02/06/15 at 10:00 pm, Resident #1 was swinging at staff.
-On 02/06/15 at 10:50 pm, Resident #1 bit a staff person.
-On 02/06/15 at 11:00 pm, Resident #1 wandered into another male resident's room and punched him in the left eye.
-On 02/07/15 at 6:30 am, Resident #1 lifted a 93-year-old female resident out of her wheelchair, punched her in the face, and hit her across the legs with a belt. Both residents were discharged to the hospital.

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D 270	Continued From page 2 Review of documentation from the local hospice facility revealed the female resident expired on 02/09/15 at 7:20 am. Review of facility care notes revealed there was no documentation of increased supervision of Resident #1 in response to aggressive or violent behaviors exhibited toward staff and other residents. Review of flowsheets provided by the facility revealed: -Staff documented Resident #1 was placed on 30-minute checks on 02/05/15 at 3:00 pm which continued through 02/06/15 at 5:30 am. -Staff documented Resident #1 was checked every 30 minutes from 02/06/15 at 7:00 am through 3:00 pm and again from 11:30 pm through 5:30 am. Interview on 02/19/15 at 2:23 pm with the Dementia Care Coordinator (DCC) revealed: -The DCC initiated the 30-minute checks on 02/05/15 before she went home for the day because she "just had a feeling". -Resident #1 was not agitated that day. -Resident #1 was pleasant, but moving furniture and wandering, so she decided to implement 30-minute supervisory checks. -She was not aware the checks were not being done consistently. -She routinely reviews the checks weekly on Mondays. Interview on 02/19/15 at 3:45 pm with an evening shift Medication Aide (MA) revealed: -Resident #1 "got into it" with another resident on his first day in the facility, on 02/03/15. -Both residents were hitting each other and both had bruising.	D 270		

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D 270	Continued From page 3 -Resident #1 also had a "couple" of episodes of swinging at staff during that shift on day of admission. -Staff "figured" Resident #1 was adjusting to being in a new place. -There was no increase in supervision of Resident #1 in response to his behaviors. Interview on 02/23/15 at 6:45 am with a second night shift PCA revealed: -When she arrived for duty on 02/03/15 at 11:00 pm, the second shift staff reported Resident #1, admitted earlier that day, was combative and to "be careful around him". -The PCA was never instructed to increase supervision of Resident #1. -Staff were instructed to "keep an eye on him". Interview on 02/23/15 at 6:27 am with a night shift PCA revealed: -When staff tried to guide Resident #1, he would get "kinda violent". -The resident balled his fists and tried to swing at the PCA on one occasion. -The PCA walked about 10 feet away from the resident when he was violent to "let him calm down". -On one occasion, the PCA heard a female resident calling for help. When he entered her room, Resident #1 was present and she reported that Resident #1 had pushed her down to the floor. -The PCA was instructed to "keep a close eye" on Resident #1 to keep him out of other residents' rooms, but the staff routinely did that for all residents anyway. -The PCA stated he thought he signed a 30-minute supervision list that was implemented so staff would watch Resident #1 closer to prevent wandering.	D 270		

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D 270	Continued From page 4 Interview on 02/23/15 at 11:09 am with an evening shift Personal Care Aide (PCA) revealed: -On 02/06/15 at about 10:00 pm, she attempted to give incontinent care to Resident #1 when he "got violent" and grabbed her arms and would not let go of her. -When he finally let her go, she "panicked and left rapidly" and the resident began chasing her. -The resident was "charging" after all visible staff and swinging at them. -After a few minutes, the resident appeared calm, so she approached him and motioned with her hand for him to follow her so she could continue his incontinent care. -The resident appeared calm and was talking with the PCA about his family and previous career. -The PCA asked the resident if he needed a hug and he grabbed her wrist and bit her on the arm at the elbow, breaking the skin and bruising her arm. -The incident was witnessed by the MA on duty. Telephone interview on 02/24/15 at 8:30 am with a second evening shift MA revealed: -She was the MA on duty the evening of 02/06/15. -At about 10:40 pm, Resident #1 was swinging at staff in the hallway. The resident approached her like he was going to punch her, but she backed away. The resident kept going toward her and began chasing her and the other staff. -The MA "started running away looking for somewhere safe to go". -Resident #1 calmed down after about 11:00 pm "like turning off a light switch". -While the MA was preparing to take out the trash and laundry, she heard another staff person yelling, "Come back! He's swinging on (named resident)!" -The MA re-entered the unit and was informed	D 270		

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Resident #1 had hit another resident in the eye.
-The MA reported the incident to the oncoming shift for follow up and told them "if he gets any more agitated, he needs to be sent out to be evaluated".
-Resident #1 was not on any increased supervision "as far as (she) knew".
-The MA did not implement increased supervision of Resident #1 in response to the events.

Interview on 02/23/15 at 8:03 am with the night shift Supervisor revealed:
-She was the Supervisor on duty the night of 02/06/15.
-She worked on the assisted living side of the facility but was responsible for supervisory duties throughout the facility.
-When she reported to work that night, the evening shift staff reported to her that Resident #1 had become aggressive toward staff and was chasing them down the hallways.
-The Supervisor witnessed Resident #1 chasing staff, "running full force" behind them at 10:45 pm on 02/06/15 but did not intervene.
-The evening shift staff reported Resident #1 had "been like that since 10:00 pm" and he bit a staff member and had just punched another resident in the face.
-The Supervisor asked the previous shift what had been done about Resident #1's behavior and was told a behavior report had been started.
-The resident was not on any increased supervision as far as she was aware.
-As a Supervisor, she would have been notified by the previous shift if a resident was on increased supervisory checks and Resident #1 was not on increased checks.
-The Supervisor did not implement any increased supervision of Resident #1 in response to his violent behavior toward staff and residents on the

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evening and night of 02/06/15.
-The resident calmed down around 11:30 pm or 11:45 pm and the supervisor "kept watch" on him to look for any return of his previous behaviors.
-On the morning of 02/07/15, a PCA went to the assisted living side of the facility and reported to the Supervisor that Resident #1 had punched a female resident in her face and slapped her with a belt across her legs.
-When the Supervisor went to the SCU to see what happened, she observed Resident #1 walking calmly alone in the hallway, so she went back to the assisted living side of the facility to call the Resident Care Director (RCD) to see what to do.
-The supervisor was instructed to send both residents to the hospital for evaluation.
-The supervisor called 911 and requested two ambulances and law enforcement.

Interview on 02/23/15 at 9:40 am with a night shift PCA revealed:
-Shortly after reporting to work on the night of 02/06/15, she heard a staff member screaming for help.
-The staff member was trying to get Resident #1 out of another male resident's room and reported Resident #1 had just hit the other resident.
-Resident #1 was already on 30-minute supervisory checks because he had pushed another resident down to the floor the previous day.
-Resident #1 was on 30-minute checks throughout the night.
-Resident #1 woke up and got out of bed around 6:00 am on the morning of 02/07/15 and was "highly angry and agitated, banging on doors and marching like in the army up and down the halls, stomping".

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-While Resident #1 was banging on the doors and marching throughout the hallways independently, the staff were busy getting people up and dressed for the day.
-When the PCA emerged from a resident's room, she observed Resident #1 "yank" a female resident out of her wheelchair by her sweater, held her up and punched her in the face with his fist.
-The female resident was crying and saying, "Stop, please, stop".
-The PCA started screaming, "I need help! Put her down! He's hit her!" Resident #1 had a folded belt in his hand and hit the female resident across the thigh as the PCA was running toward the residents.
-When the PCA reached the residents, Resident #1 shoved the female resident into the PCA and took her wheelchair and left with it.
-The PCA asked a coworker to retrieve the resident's wheelchair, take the resident to her room, and notify the supervisor of the incident.
-The PCA then began to gather the other residents and put them into the TV room for safety because Resident #1 was still very agitated and hitting on doors with his hands and with his belt.
-The PCA observed Resident #1 enter another male resident's room and she followed. She observed Resident #1 had taken the leg off the resident's wheelchair and was standing over the resident with the wheelchair leg raised, about to strike the resident with the wheelchair leg while the resident lay in bed.
-The PCA grabbed the wheelchair leg from behind Resident #1's back and "moved back fast into the hallway".
-Resident #1 snatched the covers from off the resident and left the resident's room.
-Resident #1 continued to wander up and down

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the halls for about 30 minutes beating on doors while the PCA was trying to get other residents to safety.
-Another resident came out of his room and was upset, reporting to the PCA that Resident #1 entered his room and took his clothes while he was trying to get dressed.
-The PCA did not try to engage Resident #1, but was trying to remove other residents from the area.
-The PCA stated, "No one was really staying with him; I was trying to get the other residents to safety". The PCA stated she thought if she got the other residents off the hall and quiet, Resident #1 would calm down.
-Ambulances arrived around 7:15 am and transported both residents to the hospital for evaluation.

Interviews with 10 SCU staff members revealed:
-10 of 10 staff members were aware of Resident #1's history of combative, aggressive, and/or violent behavior toward others prior to the incident of 02/07/15.
-7 of 10 staff members interviewed had witnessed Resident #1 being aggressive and/or violent prior to the incident of 02/07/15.
-7 of 10 staff members interviewed were not aware of implementation of increased supervision of Resident #1.

Interview on 02/19/15 at 2:23 pm with the DCC revealed:
-Staff routinely made rounds every two hours for all residents.
-Supervision of Resident #1 was not increased on the day of admission (02/03/15) after the altercation with another male resident because the other resident initiated the altercation when Resident #1 wandered into his room.

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-Supervision of Resident #1 was not increased on 02/05/15 after he pushed the female resident to the floor because the incident was not witnessed so she did not know whether or not the female resident identified the correct person.
-The DCC initiated 30 minute checks on the evening of 02/05/15 because she "had a feeling".
-She did not increase supervision of Resident #1 in response to the combative behavior toward staff on 02/06/15 at 10:00 pm, the biting of a staff member at 10:50 pm, or the physical assault of another male resident at 11:00 pm because she was not on duty and unaware of the incidents.
-The Medication Aide (MA) on duty or the supervisor on duty could have increased the frequency of supervisory checks of Resident #1, assigned staff to provide 1:1 supervision of the resident, or called her or other management for instructions.

Review of Emergency Department (ED) notes from the local hospital for the female resident who was assaulted revealed:
-She was evaluated on 02/07/15 at 8:26 am.
-Her injuries included a superficial abrasion to the right ear canal with minimal bleeding and bilateral jaw fractures.
-She was discharged to a hospice facility on 02/07/15.

Review of hospice Clinical Notes revealed:
-The resident was admitted on 02/07/15 at 2:50 pm following an assault.
-The resident was unable to get aggressive treatment due to her age.
-The resident continued to complain of "severe pain" and had bruising and deformity on the chin, jaw, and neck areas.
-Nursing staff administered Dilaudid, Morphine, Ativan in response to multiple complaints of

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D 270	Continued From page 10 severe pain. (Dilaudid and morphine are narcotic pain relievers; Ativan is used to treat anxiety.) -The resident subsequently expired on 02/09/15 at 7:20 am. Interview on 02/19/15 at 12:15 pm with a hospice nurse revealed: -Hospice services were initiated on 07/15/14 for failure to thrive. -At the time of initiation of hospice services, the resident was very thin, frail, and consistently short of breath with an admission weight of 74; however, the resident showed significant improvement and was no longer "end of life" at the time of the incident on 02/07/15. Interview on 02/23/15 at 6:45 am with a PCA revealed prior to the incident of 02/07/15, the female resident was able to walk short distances, converse with staff, dress herself with minimal assistance, feed herself, propel herself in her wheelchair throughout the hallways, toilet herself, and shower herself with supervision only. _____ On 02/23/15, the Administrator submitted a Plan of Protection as follows: -All residents would be assessed immediately to determine the appropriate level of supervision required to maintain their safety and the safety of other residents. -Supervision would immediately be provided based on the above assessment. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 26, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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D 273	Continued From page 11 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to notify the physician and refer to mental health services for 1 of 1 sampled residents (Resident #1) with violent behavior resulting in the physical assault and subsequent death of another resident. The findings are: Review of Resident #1's hospital-generated FL-2 dated 02/03/15 revealed: -Diagnoses included Lewy body dementia and recurrent falls. -The resident was not designated as physically or verbally abusive or dangerous to self or others. Review of hospital discharge information dated 02/01/15 revealed: -Lewy body dementia with agitation and "violent outbursts". -Recent physical assault by resident of three family members prior to hospitalization. -Attempted to swing at hospital Certified Nursing Assistant (CNA). Review of the facility's New Admission Notice revealed Resident #1 was admitted on 02/03/15 at 3:00 pm. Review of facility care notes, behavior reports, and incident reports revealed:	D 273		

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-On 02/03/15 at 6:30 pm, Resident #1 wandered into another resident's room and an unwitnessed physical altercation occurred.
-On 02/04/15 evening shift, Resident #1 was "running in the hallways" for 30 minutes.
-On 02/05/15 at 6:30 am, Resident #1 wandered into a female resident's room and pushed her down.
-On 02/06/15 day shift, Resident #1 was "not as combative" as he had been the "past couple of days".
-On 02/06/15 evening shift, Resident #1 was running in the hallways chasing staff.
-On 02/06/15 at 10:00 pm, Resident #1 was swinging at staff.
-On 02/06/15 at 10:50 pm, Resident #1 bit a staff person.
-On 02/06/15 at 11:00 pm, Resident #1 wandered into another male resident's room and punched him in the left eye.
-On 02/07/15 at 6:30 am, Resident #1 lifted a 93-year-old female resident out of her wheelchair, punched her in the face, and hit her across the legs with a belt. Both residents were discharged to the hospital.

Review of documentation from the local hospice facility revealed the female resident expired on 02/09/15 at 7:20 am.

Review of facility care notes revealed there was no documentation the physician was notified of Resident #1's aggressive or violent behaviors exhibited toward staff and other residents.

Review of facility incident reports revealed:
-The report for the incident occurring on 02/03/15 at 6:30 pm was faxed to a physician.
-There were no other incident reports completed for Resident #1's behavior.

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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 273	Continued From page 13 Telephone interviews on 02/19/15 at 2:15 pm and 3:52 pm with the nurse from the physician's office revealed: -Resident #1 was not their resident. -The physician's office did not have an active or inactive file on Resident #1. -Resident #1's name was unfamiliar. -All faxes received at the physician's office were filed under the appropriate resident's name and the facility did not have any record of having seen Resident #1 at any time. -The nurse called back to clarify that the facility sent an intake packet for Resident #1 on 02/03/15 but the packet was incomplete; it did not contain the FL-2, insurance card or Medication Administration Record (MAR). -The physician's office contacted the facility on 02/03/15, 02/05/15, and 02/09/15 to request the required information in order to accept the resident and provide services, but the information was never sent to them. -When the office contacted the facility on 02/09/15, they were told the resident was no longer at the facility. Interview on 02/19/15 at 2:23 pm with the Dementia Care Coordinator (DCC) revealed: -The house doctor was going to be Resident #1's doctor because most new admissions see him. -The Nurse Practitioner (NP) routinely visited the facility on Wednesdays and Fridays. -The NP was in the facility on 02/03/15 and 02/06/15 but did not see Resident #1 because the physician's office staff had not yet entered the resident's information into the computer system for him to receive services. -If a resident was in need of medical intervention before a physician was established, the resident should be sent to the local hospital Emergency	D 273		

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Room (ER).
-The DCC stated, "My rule of thumb is all residents with violent episodes be sent out (to ER)".
-The staff on duty during Resident #1's aggressive behavior and violent outbursts should have utilized the services of the ER or crisis center if initial interventions to calm the resident were ineffective.
-Even if attempts to calm the resident were effective, the staff on duty should have notified the crisis center and the physician to inform them of the issue and to give the doctor a chance to write orders or change the plan of care.
-It was the DCC's expectation that staff notify her of any incidents occurring during their shift, but she was not notified of any of the incidents which occurred on 02/06/15 or 02/07/15.
-The DCC stated if she had been notified of the incidents which occurred on the evening of 02/06/15, she would have instructed staff to send Resident #1 out to the ER for evaluation.

Interview on 02/19/15 at 3:45 pm with an evening shift Medication Aide (MA) revealed:
-When an incident occurred, it was the responsibility of the MA on duty to complete the incident report, fax it to the physician's office, and notify the DCC.
-She was working on 02/03/15 when the unwitnessed altercation occurred between Resident #1 and another male resident.
-The MA stated the physician was notified of the incident because she faxed the incident report to his office.

Interview on 02/23/15 at 11:09 am with an evening shift Personal Care Aide (PCA) revealed:
-At about 10:00 pm, she attempted to give incontinent care to Resident #1 when he "got

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violent" and grabbed her arms and would not let go of her.
-When he finally let her go, she "panicked and left rapidly" and the resident began chasing her.
-The resident was "charging" after all visible staff and swinging at them.
-After a few minutes, the resident appeared calm, so she approached him and motioned with her hand for him to follow her so she could continue his incontinent care.
-The resident appeared calm and was talking with the PCA about his family and previous career.
-The PCA asked the resident if he needed a hug and he grabbed her wrist and bit her on the arm at the elbow, breaking the skin and bruising her arm.
-The incident was witnessed by the MA on duty.

Telephone interview on 02/24/15 at 8:30 am with a second evening shift MA revealed:
-She was the MA on duty the evening of 02/06/15.
-At about 10:40 pm, Resident #1 was swinging at staff in the hallway. The resident approached her like he was going to punch her, but she backed away. The resident kept going toward her and began chasing her and the other staff.
-The MA "started running away looking for somewhere safe to go".
-Resident #1 calmed down after about 11:00 pm "like turning off a light switch".
-While the MA was preparing to take out the trash and laundry, she heard another staff person yelling, "Come back! He's swinging on (named resident)!"
-The MA re-entered the unit and was informed Resident #1 had hit another resident in the eye.
-The MA reported the incident to the oncoming shift for follow up and told them "if he gets any more agitated, he needs to be sent out to be evaluated".

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D 273	Continued From page 16 -The MA did not fill out an incident report or contact a physician or send the resident out for evaluation because the incident occurred at the beginning of the oncoming shift. -All MAs were supposed to notify the DCC at the end of their shift of any incidents occurring during the shift. -The MA stated she texted the DCC because it was "more convenient" for her and she preferred to text. She informed the DCC about Resident #1's agitation, swinging on staff, hitting of the other resident, and chasing staff. -The MA did not call the DCC for instructions or to ensure the text message was received. -The MA did not receive a call back from the DCC. -The MA did not notify any other member of management. Interview on 02/19/15 at 2:23 pm with the DCC revealed: -She did not receive a text message on the night of 02/06/15 because her phone was not working properly. -When her phone service was restored, there was no text message from the MA regarding the incidents of 02/06/15. -If a text message had been sent while her phone service was down, it would have been received when her service was restored. Interview on 02/23/15 at 8:03 am with a night shift Supervisor revealed: -She was the Supervisor on duty the night of 02/06/15 through the morning of 02/07/15. -When she arrived for her shift at around 10:45 pm, she observed Resident #1 being aggressive toward staff, chasing them down the hallway running "full-force" behind them. -The evening shift MA instructed the staff to stop	D 273		

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running from the resident.
-The evening shift MA reported to her that Resident #1 had "been like that since 10:00 pm".
-The MA asked what had been done about the resident's behavior and the evening shift MA told her she started a behavior report.
-The evening shift MA also reported Resident #1 had "just" hit another male resident in the face.
-The Supervisor completed an incident report for the resident who was hit by Resident #1 and faxed it to his physician, but did not complete an incident report for Resident #1 or contact a physician about him.
-By 11:30 pm to 11:45 pm, Resident #1 had "calmed himself down and the supervisor "kept watch" on him to look for any return of his previous behaviors.
-On the morning of 02/07/15, a PCA came to the assisted living side of the facility and reported to the supervisor that Resident #1 had punched a female resident in her face and slapped her with a belt across her legs.
-When the Supervisor went to the SCU about 6:45 am to see what happened, she observed Resident #1 walking calmly alone in the hallway, so she went back to the assisted living side of the facility to call the Resident Care Director (RCD) to see what to do.
-The Supervisor was instructed to send both residents to the hospital for evaluation.
-The Supervisor stated she should have sent Resident #1 out for evaluation earlier in the shift.

Interview on 02/23/15 at 9:40 am with a night shift PCA revealed:
-Shortly after reporting to work on the night of 02/06/15, she heard a staff member screaming for help.
-The staff member was trying to get Resident #1 out of another male resident's room and reported

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D 273	Continued From page 18 Resident #1 had just hit the other resident. -Resident #1 woke up and got out of bed around 6:00 am on the morning of 02/07/15 and was "highly angry and agitated, banging on doors and marching like in the army up and down the halls, stomping". -While Resident #1 was banging on the doors and marching throughout the hallways independently, the staff were busy getting people up and dressed for the day. -When the PCA emerged from a resident's room, she observed Resident #1 "yank" a female resident out of her wheelchair by her sweater, held her up and punched her in the face with his fist. -The female resident was crying and saying, "Stop, please, stop". -The PCA started screaming, "I need help! Put her down! He's hit her!" Resident #1 had a folded belt in his hand and hit the female resident across the thigh as the PCA was running toward the residents. -When the PCA reached the residents, Resident #1 shoved the female resident into the PCA and took her wheelchair and left with it. -The PCA asked a coworker to retrieve the resident's wheelchair, take the resident to her room, and notify the supervisor of the incident. -The PCA then began to gather the other residents and put them into the TV room for safety because Resident #1 was still very agitated and hitting on doors with his hands and with his belt. -The PCA observed Resident #1 enter another male resident's room and she followed. She observed Resident #1 had taken the leg off the resident's wheelchair and was standing over the resident with the wheelchair leg raised, about to strike the resident with the wheelchair leg while the resident lay in bed.	D 273		

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D 273	Continued From page 19 -The PCA grabbed the wheelchair leg from behind Resident #1's back and "moved back fast into the hallway". -Resident #1 snatched the covers from off the resident and left the resident's room. -Resident #1 continued to wander up and down the halls for about 30 minutes beating on doors while the PCA was trying to get other residents to safety. -Another resident came out of his room and was upset, reporting to the PCA that Resident #1 entered his room and took his clothes while he was trying to get dressed. -The PCA did not try to engage Resident #1, but was trying to remove other residents from the area. -The PCA stated, "No one was really staying with him; I was trying to get the other residents to safety". The PCA stated she thought if she got the other residents off the hall and quiet, Resident #1 would calm down. -Ambulances arrived around 7:15 am and transported both residents to the hospital for evaluation. Review of Emergency Medical Services (EMS) call logs revealed the facility called for two ambulances and the police at 7:11 am on 02/07/15. Review of Emergency Department (ED) notes from the local hospital for the female resident who was assaulted revealed: -She was evaluated on 02/07/15 at 8:26 am. -Her injuries included a superficial abrasion to the right ear canal with minimal bleeding and bilateral jaw fractures. -She was discharged to a hospice facility on 02/07/15.	D 273		

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D 273	Continued From page 20 Review of hospice Clinical Notes revealed: -The resident was admitted on 02/07/15 at 2:50 pm following an assault. -The resident was unable to get aggressive treatment due to her age. -The resident continued to complain of "severe pain" and had bruising and deformity on the chin, jaw, and neck areas. -Nursing staff administered Dilaudid, Morphine, Ativan in response to multiple complaints of severe pain. (Dilaudid and morphine are narcotic pain relievers; Ativan is used to treat anxiety.) -The resident subsequently expired on 02/09/15 at 7:20 am. Interview on 02/19/15 at 12:15 pm with a hospice nurse revealed: -Hospice services were initiated on 07/15/14 for failure to thrive. -At the time of initiation of hospice services, the resident was very thin, frail, and consistently short of breath with an admission weight of 74; however, the resident showed significant improvement and was no longer "end of life" at the time of the incident on 02/07/15. Interview on 02/23/15 at 6:45 am with a PCA revealed prior to the incident of 02/07/15, the female resident was able to walk short distances, converse with staff, dress herself with minimal assistance, feed herself, propel herself in her wheelchair throughout the hallways, toilet herself, and shower herself with supervision only. On 02/23/15, the Administrator submitted a Plan of Protection as follows: -All supervisors and medication aides would be inserviced prior to their next scheduled shift regarding proper procedure for reporting and following up incidents, including notification of the	D 273		

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D 273	Continued From page 21 appropriate manager and physician for further instructions. -The Director of Nursing (DON) will ensure all residents receive appropriate referral and follow up going forward. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 26, 2015.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure residents were free of neglect related to failure to provide safety and protection for residents by admitting a resident to the Special Care Unit with a history of violent outbursts who had physical altercations with residents resulting in injury to residents and the death of one resident. The findings are: Review of Resident #1's hospital-generated FL-2 dated 02/03/15 revealed: -Diagnoses included Lewy body dementia and recurrent falls. -The resident was not designated as physically or verbally abusive or dangerous to self or others.	D 338		

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D 338	Continued From page 22 Review of hospital discharge information dated 02/01/15 revealed: -Lewy body dementia with agitation and "violent outbursts". -Recent physical assault by resident of three family members prior to hospitalization. -Attempted to swing at the hospital Certified Nursing Assistant (CNA). Interview on 02/16/15 at 11:30 am with the Director of Nursing (DON) revealed: -It was her responsibility to assess potential residents to determine whether or not the resident would be appropriate for admission, but it was the Administrator's decision whether or not to accept the resident for admission. -Sometimes the DON's recommendations for admission were followed and sometimes they were not. -She reviewed Resident #1's hospital FL-2 and History and Physical, which included information regarding aggressive behavior and violence toward family members. -The DON sent an email to the Administrator stating the facility could meet the resident's health care needs, but she had concerns regarding the resident's diagnosis and tendency toward violence. -The DON stated she did not feel the resident should have been admitted to the facility and thought the email conveyed that information clearly. -The DON did not complete a documented preadmission screening because she did not think the facility was going to accept the resident for admission based on her review of the resident's information and recommendation. -On 02/03/15, the day of admission, the DON was informed by the Administrator that the resident	D 338		

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was being admitted, at which time the DON verbally expressed her concern regarding the facility's ability to manage the resident's behaviors.
-The Administrator told the DON if anything happened, they could discharge the resident back to the family.

Interview on 02/19/15 at 2:23 pm with the Dementia Care Coordinator (DCC) revealed:
-It was the DON and Administrator's responsibility to determine the appropriateness of admissions to the SCU.
-The DCC saw an email prior to the resident's admission indicating the DON's recommendation was not to accept the resident into the facility because of his diagnosis and prior history of aggressive behavior and violence.
-On 02/03/15, while off duty, the DCC received a text message informing her Resident #1 was being admitted.

Interview on 02/23/15 at 11:40 am with the Administrator revealed:
-The Director of Nursing (DON) was responsible for completing preadmission screening for all new residents to the Special Care Unit (SCU).
-The DON reviewed Resident #1's hospital information and verbally approved him for admission, though she had some concerns regarding his diagnosis and potential for aggressive behavior.
-The Administrator stated the email sent by the DON was sent after the bed offer had already been made; however, the email did not say the DON's recommendation was not to accept the resident but that she had concerns about the resident's behaviors.
-The Administrator stated to the best of her knowledge, she thought the DON was willing to

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"try him" (admit the residnet) and she would not override the DON's recommendations.

Review of the facility's New Admission Notice revealed Resident #1 was admitted on 02/03/15 at 3:00 pm.

Review of facility care notes, behavior reports, and incident reports revealed:
-On 02/03/15 at 6:30 pm, Resident #1 wandered into another resident's room and an unwitnessed physical altercation occurred.
-On 02/04/15 evening shift, Resident #1 was "running in the hallways" for 30 minutes.
-On 02/05/15 at 6:30 am, Resident #1 wandered into a female resident's room and pushed her down.
-On 02/06/15 day shift, Resident #1 was "not as combative" as he had been the "past couple of days".
-On 02/06/15 evening shift, Resident #1 was running in the hallways chasing staff.
-On 02/06/15 at 10:00 pm, Resident #1 was swinging at staff.
-On 02/06/15 at 10:50 pm, Resident #1 bit a staff person.
-On 02/06/15 at 11:00 pm, Resident #1 wandered into another male resident's room and punched him in the left eye.
-On 02/07/15 at 6:30 am, Resident #1 lifted a 93-year-old female resident out of her wheelchair, punched her in the face, and hit her across the legs with a belt. Both residents were discharged to the hospital.

Review of documentation from the local hospice home revealed the female resident expired on 02/09/15 at 7:20 am.

Interview on 02/19/15 at 3:45 pm with an evening

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shift Medication Aide (MA) revealed:
-Resident #1 "got into it" with another male resident on his first day in the facility, on 02/03/15.
-Both residents were hitting each other and both had bruising.
-Resident #1 also had a "couple" of episodes of swinging at staff during that shift on day of admission.

Interview on 02/23/15 at 6:45 am with a second night shift Personal Care Aide (PCA) revealed:
-When she arrived for duty on 02/03/15 at 11:00 pm, the second shift staff reported Resident #1, admitted earlier that day, was combative and to "be careful around him".

Interview on 02/23/15 at 6:27 am with a night shift PCA revealed:
-When staff tried to guide Resident #1, he would get "kinda violent".
-The resident balled his fists and tried to swing at the PCA on one occasion.
-The PCA walked about 10 feet away from the resident when he was violent to "let him calm down".
-On one occasion, the PCA heard a female resident calling for help. When he entered her room, Resident #1 was present and she reported that Resident #1 had pushed her down to the floor.

Interview on 02/23/15 at 11:09 am with an evening shift Personal Care Aide (PCA) revealed:
-On 02/06/15 at about 10:00 pm, she attempted to give incontinent care to Resident #1 when he "got violent" and grabbed her arms and would not let go of her.
-When he finally let her go, she "panicked and left rapidly" and the resident began chasing her.

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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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) COMPLETE DATE
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-The resident was "charging" after all visible staff and swinging at them.
-After a few minutes, the resident appeared calm, so she approached him and motioned with her hand for him to follow her so she could continue his incontinent care.
-The resident appeared calm and was talking with the PCA about his family and previous career.
-The PCA asked the resident if he needed a hug and he grabbed her wrist and bit her on the arm at the elbow, breaking the skin and bruising her arm.
-The incident was witnessed by the MA on duty.

Telephone interview on 02/24/15 at 8:30 am with a second evening shift MA revealed:
-She was the MA on duty the evening of 02/06/15.
-At about 10:40 pm, Resident #1 was swinging at staff in the hallway. The resident approached her like he was going to punch her, but she backed away. The resident kept going toward her and began chasing her and the other staff.
-The MA "started running away looking for somewhere safe to go".
-Resident #1 calmed down after about 11:00 pm "like turning off a light switch".
-While the MA was preparing to take out the trash and laundry, she heard another staff person yelling, "Come back! He's swinging on (named resident)!"
-The MA re-entered the unit and was informed Resident #1 had hit another resident in the eye.

Interview on 02/23/15 at 8:03 am with the night shift Supervisor revealed:
-She was the Supervisor on duty the night of 02/06/15.
-She worked on the assisted living side of the facility but was responsible for supervisory duties throughout the facility.

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-When she reported to work that night, the evening shift staff reported to her that Resident #1 had become aggressive toward staff and was chasing them down the hallways.
-The Supervisor witnessed Resident #1 chasing staff, "running full force" behind them at 10:45 pm on 02/06/15.
-The evening shift staff reported Resident #1 had "been like that since 10:00 pm" and he bit a staff member and had just punched another resident in the face.
-The resident calmed down around 11:30 pm or 11:45 pm and the Supervisor "kept watch" on him to look for any return of his previous behaviors.
-On the morning of 02/07/15, a PCA went to the assisted living side of the facility and reported to the Supervisor that Resident #1 had punched a female resident in her face and slapped her with a belt across her legs.
-Both residents were sent to the hospital for evaluation.

Interview on 02/23/15 at 9:40 am with a night shift PCA revealed:
-Shortly after reporting to work on the night of 02/06/15, she heard a staff member screaming for help.
-The staff member was trying to get Resident #1 out of another male resident's room and reported Resident #1 had just hit the other resident.
-Resident #1 woke up and got out of bed around 6:00 am on the morning of 02/07/15 and was "highly angry and agitated, banging on doors and marching like in the army up and down the halls, stomping".
-Resident #1 was banging on the doors and marching throughout the hallways.
-When the PCA emerged from a resident's room, she observed Resident #1 "yank" a female resident out of her wheelchair by her sweater,

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held her up and punched her in the face with his fist.
-The female resident was crying and saying, "Stop, please, stop".
-The PCA started screaming, "I need help! Put her down! He's hit her!" Resident #1 had a folded belt in his hand and hit the female resident across the thigh as the PCA was running toward the residents.
-When the PCA reached the residents, Resident #1 shoved the female resident into the PCA and took her wheelchair and left with it.
-The PCA asked a coworker to retrieve the resident's wheelchair, take the resident to her room, and notify the supervisor of the incident.
-The PCA then began to gather the other residents and put them into the TV room for safety because Resident #1 was still very agitated and hitting on doors with his hands and with his belt.
-The PCA observed Resident #1 enter another male resident's room and she followed. She observed Resident #1 had taken the leg off the resident's wheelchair and was standing over the resident with the wheelchair leg raised, about to strike the resident with the wheelchair leg while the resident lay in bed.
-The PCA grabbed the wheelchair leg from behind Resident #1's back and "moved back fast into the hallway".
-Resident #1 snatched the covers from off the resident and left the resident's room.
-Resident #1 continued to wander up and down the halls for about 30 minutes beating on doors while the PCA was trying to get other residents to safety.
-Another resident came out of his room and was upset, reporting to the PCA that Resident #1 entered his room and took his clothes while he was trying to get dressed.

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-The PCA did not try to engage Resident #1, but was trying to remove other residents from the area.
-The PCA stated, "No one was really staying with him; I was trying to get the other residents to safety". The PCA stated she thought if she got the other residents off the hall and quiet, Resident #1 would calm down.
-Ambulances arrived around 7:15 am and transported both residents to the hospital for evaluation.

Review of Emergency Department (ED) notes from the local hospital for the female resident who was assaulted revealed:
-She was evaluated on 02/07/15 at 8:26 am.
-Her injuries included a superficial abrasion to the right ear canal with minimal bleeding and bilateral jaw fractures.
-She was discharged to a hospice facility on 02/07/15.

Review of hospice Clinical Notes revealed:
-The resident was admitted on 02/07/15 at 2:50 pm following an assault.
-The resident was unable to get aggressive treatment due to her age.
-The resident continued to complain of "severe pain" and had bruising and deformity on the chin, jaw, and neck areas.
-Nursing staff administered Dilaudid, Morphine, Ativan in response to multiple complaints of severe pain. (Dilaudid and morphine are narcotic pain relievers; Ativan is used to treat anxiety.)
-The resident subsequently expired on 02/09/15 at 7:20 am.

Interview on 02/19/15 at 12:15 pm with a hospice nurse revealed:
-Hospice services were initiated on 07/15/14 for

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D 338	Continued From page 30 failure to thrive. -At the time of initiation of hospice services, the resident was very thin, frail, and consistently short of breath with an admission weight of 74; however, the resident showed significant improvement and was no longer "end of life" at the time of the incident on 02/07/15. Interview on 02/23/15 at 6:45 am with a PCA revealed prior to the incident of 02/07/15, the female resident was able to walk short distances, converse with staff, dress herself with minimal assistance, feed herself, propel herself in her wheelchair throughout the hallways, toilet herself, and shower herself with supervision only. On 02/23/15, the Administrator submitted a Plan of Protection as follows: -All residents involved in the incident have been discharged. -All residents who seek placement in the SCU will be screened prior to making a bed offer to ensure admission is appropriate. -A documented Preadmission Screening tool will be utilized to determine and confirm appropriate placement. -Administrator will ensure the preadmission screening is completed prior to any bed offers being made for admission to the SCU. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 26, 2015.	D 338		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse,	D914		

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neglect, and exploitation.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure residents were free of neglect related to the failure to provide safety and protection for residents by admitting a resident to the Special Care Unit with a history of violent outbursts, failure to provide supervision, and failure to notify a physician or obtain mental health services for a resident with violent and aggressive behaviors.

The findings are:

A. Based on interviews and record reviews, the facility failed to ensure residents were free of neglect related to failure to provide safety and protection for residents by admitting a resident to the Special Care Unit with a history of violent outbursts who had physical altercations with residents resulting in injury to residents and the death of one resident. [Refer to Tag 338, 10A NCAC 13F .0909 (Type A1 Violation).]

B. Based on interviews and record reviews, the facility failed to provide supervision of 1 of 1 sampled residents (Resident #1) in accordance with the resident's assessed needs and current symptoms, which resulted in the physical assault and subsequent death of another resident. [Refer to Tag 270, 10A NCAC 13F .0901(b) (Type A1 Violation).]

C. Based on record reviews and interviews, the facility failed to notify the physician and refer to mental health services for 1 of 1 sampled residents (Resident #1) with violent behavior resulting in the physical assault and subsequent death of another resident. [Refer to Tag 273, 10A

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D914	Continued From page 32 NCAC 13F .0902(b) (Type A1 Violation).]	D914		