Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SMOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 000 Initial Comments D 000 All potential residents for the SCU The Adult Care Licensure Section and the will be evaluated and assessed in Forsyth County Department of Social Services person following the Salem conducted a complaint investigation on 02/16/15, 02/19/15, and 02/23/15 with an exit conference Terrace's Special Care Unit via telephone on 02/24/15. The complaint Admission Policy & Procedure. investigation was inititated by the Forsyth County The Pre-admission will be Department of Social Services on 02/11/15. completed through the onsite D 270 D 270 10A NCAC 13F .0901(b) Personal Care and physical assessment. All available Supervision assessment documentation and interviews will be considered when 10A NCAC 13F .0901 Personal Care and Supervision deciding on making a bed offer. (b) Staff shall provide supervision of residents in (Attachment A for Policy & accordance with each resident's assessed needs, care plan and current symptoms. Attachment B for Assessment Tool) Upon admission, appropriate This Rule is not met as evidenced by: monitoring will be set up for 72 **TYPE A1 VIOLATION** hours for the new resident based on the needs and available history of Based on interviews and record reviews, the facility failed to provide supervision for 1 of 1 the resident. The Special Care Unit sampled residents (Resident #1) in accordance Admission Staff Rounds Policy & with the resident's assessed needs and current Procedure (Attachment C) will be symptoms, which resulted in the physical assault and subsequent death of another resident. used as a recommended guideline. More frequent monitoring for longer The findings are: periods of time can be put in place if Review of Resident #1's hospital-generated FL-2 indicated. Staff is required to dated 02/03/15 revealed: communicate needs to the Special -Diagnoses included Lewy body dementia and Care Coordinator, the Resident Care recurrent falls. -The resident was not designated as physically or Coordinator and/or the verbally abusive or dangerous to self or others. Administrator. Review of hospital discharge information dated Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPL

STATE FORM

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administrates

3-31-1

f continuation sheet 1 of 33

POC Approved

Per B. Moore \ Is

04-22-2015

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D 270	Continued From page	1 ,	D 270	W		
		with agitation and "violent				<u>.</u>
	family members prior -Attempted to swing a Nursing Assistant (CN Review of the facility' revealed Resident #1 at 3:00 pm. Review of facility care and incident reports r -On 02/03/15 at 6:30 into another resident's physical altercation of -On 02/04/15 evening "running in the hallwa -On 02/05/15 at 6:30 into a female resident downOn 02/06/15 day shift combative" as he had days"On 02/06/15 evening running in the hallway -On 02/06/15 at 10:00 swinging at staffOn 02/06/15 at 10:50 personOn 02/06/15 at 11:00 into another male resi him in the left eyeOn 02/07/15 at 6:30 a 93-year-old female respunched her in the face	at the hospital Certified NA). Is New Admission Notice was admitted on 02/03/15 Is notes, behavior reports, evealed: pm, Resident #1 wandered courred. Is shift, Resident #1 was ys" for 30 minutes. Is not as am, Resident #1 wandered is room and pushed her It, Resident #1 was "not as been the "past couple of shift, Resident #1 was		If the staff observes a resider change in status which result increase in agitation and/or aggression, it will be reported immediately to the Supervisor Charge and/or Resident Care Management who will impless schedule of increased supervisor following the Policy & Guide for Resident Increased Agitti (See attachment D). In the event of an aggressive violent behavior, the resident involved will be transferred be ambulance or police escort to appropriate healthcare center incident will be documented behavior reported to the attemphysician, the Special Care Coordinator, the Resident Car Coordinator and/or the Administrator. (See Attachment Special Care Coordinator and/or the Administrator.)	s in an d or in ment a ision elines on. and/or the . The and ding	2-10-15 M-50m

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 02/24/2015 HAL034098 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 270 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. In the event that a resident has an incident of aggressive or violent Review of facility care notes revealed there was no documentation of increased supervision of behaviors and the hospital is able to Resident #1 in response to aggressive or violent offer effective solutions and return behaviors exhibited toward staff and other residents. the resident to us, the Resident Care management and staff will follow Review of flowsheets provided by the facility the guidelines set forth in the Policy -Staff documented Resident #1 was placed on & Guidelines for Returning 30-minute checks on 02/05/15 at 3:00 pm which Residents back to Salem Terrace continued through 02/06/15 at 5:30 am. after Agitated Incidents. (See -Staff documented Resident #1 was checked every 30 minutes from 02/06/15 at 7:00 am Attachment H) 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.

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C HAL034098 B. WING 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 270 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.

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prevent wandering.

-The PCA stated he thought he signed a 30-minute supervision list that was implemented so staff would watch Resident #1 closer to

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
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D 270 C	ontinued From page	4	D 270		
ev-Coto "g le -V ra -T an -A so ha hi -T th -T an -S st liik a' -F -V a yo	vening shift Persona on 02/06/15 at about give incontinent car not violent" and grablet go of her. When he finally let he pidly" and the resident was "chand swinging at them. If the area few minutes, it is and for him to follow as incontinent care. The resident appeare to PCA about his fand he grabbed her was the elbow, breaking m. The incident was with the incident was with the helbow, breaking m. The incident was with the elbow, breaking m. The incident was with the helbow, breaking m. The was the MA on the second evening shifts the hallway. The was going to poway. The resident keepan chasing her and the MA "started runnomewhere safe to go Resident #1 calmed keepan chasing off a light While the MA was prind laundry, she heat elling, "Come back! esident)!"	the resident appeared calm, m and motioned with her her so she could continue ed calm and was talking with nily and previous career. esident if he needed a hug wrist and bit her on the arm of the skin and bruising her messed by the MA on duty. In 02/24/15 at 8:30 am with fit MA revealed: duty the evening of 02/06/15. Resident #1 was swinging at the resident approached her nunch her, but she backed ept going toward her and did the other staff. hing away looking for out.			

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supervision of Resident #1 in response to his violent behavior toward staff and residents on the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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D 270	evening and night of 0-The resident calmed 11:45 pm and the sup to look for any return -On the morning of 02 assisted living side of the Supervisor that R female resident in her a belt across her legs -When the Superviso what happened, she walking calmly alone back to the assisted I call the Resident Camwhat to doThe supervisor was residents to the hospi	down around 11:30 pm or pervisor "kept watch" on him of his previous behaviors. 2/07/15, a PCA went to the the facility and reported to esident #1 had punched a race and slapped her with the rewent to the SCU to see observed Resident #1 in the hallway, so she went living side of the facility to be Director (RCD) to see instructed to send both tital for evaluation.	D 270			
	PCA revealed: -Shortly after reportin 02/06/15, she heard a for helpThe staff member wa out of another male re Resident #1 had just -Resident #1 was alre supervisory checks b another resident dow dayResident #1 was on throughout the nightResident #1 woke up 6:00 am on the morni "highly angry and agi	eady on 30-minute ecause he had pushed n to the floor the previous				

PRINTED: 03/10/2015 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 270 Continued From page 7 D 270 -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 -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

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the resident lay in bed.

into the hallway".

resident and left the resident's room.

resident with the wheelchair leg raised, about to strike the resident with the wheelchair leg while

-The PCA grabbed the wheelchair leg from behind Resident #1's back and "moved back fast

-Resident #1 snatched the covers from off the

-Resident #1 continued to wander up and down

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 270	Continued From page	8	D 270			
D 270	the halls for about 30 while the PCA was try safety. -Another resident cam upset, reporting to the entered his room and was trying to get dres -The PCA did not try t was trying to remove area. -The PCA stated, "No him; I was trying to ge safety". The PCA stathe other residents of #1 would calm down. -Ambulances arrived transported both residevaluation. Interviews with 10 SC 10 of 10 staff member will be wi	minutes beating on doors ing to get other residents to be out of his room and was PCA that Resident #1 took his clothes while he sed. To engage Resident #1, but other residents from the one was really staying with the other residents to ted she thought if she got if the hall and quiet, Resident around 7:15 am and lents to the hospital for the ware of Resident tive, aggressive, and/or of others prior to the incident is interviewed had witnessed gressive and/or violent prior 7/15.	D 270			
	T .	s interviewed were not ion of increased supervision				
	revealed: -Staff routinely made all residentsSupervision of Resid the day of admission altercation with anoth	er male resident because ated the altercation when				

PRINTED: 03/10/2015 FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 270 Continued From page 9 D 270 -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

jaw, and neck areas.

pain" and had bruising and deformity on the chin,

-Nursing staff administered Dilaudid, Morphine, Ativan in response to multiple complaints of Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 270 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. As per the Plan of Protection, all On 02/23/15, the Administrator submitted a Plan residents at Salem Terrace were of Protection as follows: -All residents would be assessed immediately to evaluated by the DON, the Special determine the appropriate level of supervision Care Coordinaotr and the Resident required to maintain their safety and the safety of Care Coordinator for potential other residents. -Supervision would immediately be provided behaviors. Two residents in the based on the above assessment. SCU were identified as needing CORRECTION DATE FOR THE TYPE A1 additional intervention. These VIOLATION SHALL NOT EXCEED MARCH 26. residents have received additional 2015. evaluation and support from their healthcare providers. D 273 10A NCAC 13F .0902(b) Health Care D 273

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: _ С HAL034098 B. WING 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 273 Continued From page 11 D 273 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs SIC's and Med Aides have been of residents. re-educated on reporting. documentation and intervention processes for residents who begin This Rule is not met as evidenced by: to display aggressive and/or TYPE A1 VIOLATION violent behaviors. (Please see Based on record reviews and interviews, the Attachment G for complete facility failed to notify the physician and refer to mental health services for 1 of 1 sampled training packet) (Please see residents (Resident #1) with violent behavior Attachment E & F for all resulting in the physical assault and subsequent death of another resident. signatures of attendees to The findings are: training) This list reflects all Review of Resident #1's hospital-generated FL-2 SIC's and Med Aides currently dated 02/03/15 revealed: employed at Salem Terrace. This -Diagnoses included Lewy body dementia and recurrent falls. information will be placed in the -The resident was not designated as physically or SIC Manuel and kept available verbally abusive or dangerous to self or others. for all new staff training and for Review of hospital discharge information dated current staff reference. 02/01/15 revealed: SIC's and Med Aides will report -Lewy body dementia with agitation and "violent outbursts". agitated and/or violent behaviors -Recent physical assault by resident of three family members prior to hospitalization. to the Special Care Coordinator -Attempted to swing at hospital Certified Nursing and the Resident Care Assistant (CNA). Coordinator so that referrals can Review of the facility's New Admission Notice be made to the appropriate revealed Resident #1 was admitted on 02/03/15 physician and/or mental health at 3:00 pm, professional for follow up. Review of facility care notes, behavior reports, and incident reports revealed:

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 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. Intake processes have been -The physician's office did not have an active or examined and changes made to inactive file on Resident #1. -Resident #1's name was unfamiliar. process of referring newly admitted -All faxes received at the physician's office were residents to Physician's Home filed under the appropriate resident's name and Visits. In the event of any incidents the facility did not have any record of having seen Resident #1 at any time. prior to the first visit by the -The nurse called back to clarify that the facility physician, residents exhibiting any sent an intake packet for Resident #1 on aggressive and/or violent tendencies 02/03/15 but the packet was incomplete; it did not contain the FL-2, insurance card or Medication will be assessed at a local healthcare Administration Record (MAR), center. -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

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 273 | Continued From page 14 D 273 Room (ER). -The DCC stated, "My rule of thumb is all residents with violent episodes be sent out (to -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.

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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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evaluated".

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

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02/06/15, she heard a staff member screaming

-The staff member was trying to get Resident #1 out of another male resident's room and reported

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the resident lay in bed.

independently, the staff were busy getting people

-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

-The female resident was crying and saying,

-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

-When the PCA reached the residents, Resident #1 shoved the female resident into the PCA and

-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

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

up and dressed for the day.

"Stop, please, stop".

the residents.

fist.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 Continued From page 19 D 273 -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 -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.

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02/07/15.

-She was discharged to a hospice facility on

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		inical Notes revealed:	1			
		mitted on 02/07/15 at 2:50			İ	
	pm following an assau				·	
		able to get aggressive				
	treatment due to her a	_	1			
		ed to complain of "severe	•			
		g and deformity on the chin,				
	jaw, and neck areas.	Annual Discussion Brown Co.			Ì	
		stered Dilaudid, Morphine,				
		multiple complaints of				
		d and morphine are narcotic				
		is used to treat anxiety.)				
	at 7:20 am.	uently expired on 02/09/15				
	at 7,20 am.					
	Interview on 02/19/15	at 12:15 pm with a hospice				
	nurse revealed:	ат тат та посрто				
	-Hospice services wer	re initiated on 07/15/14 for				
	failure to thrive.					
	-At the time of initiatio	n of hospice services, the				
	resident was very thin	, frail, and consistently short				
	of breath with an adm	ission weight of 74;				
	however, the resident	showed significant				
	improvement and was	no longer "end of life" at		•		
	the time of the inciden	t on 02/07/15.				
		at 6:45 am with a PCA				
İ	revealed prior to the ir	ncident of 02/07/15, the				
		ble to walk short distances,		As per the Plan of protection	all	
		ress herself with minimal		Supervisor's and Med Aides		
ļ		elf, propel herself in her				
	wheelchair throughout	the hallways, toilet herself,]]	inserviced prior regarding pro	per	
	and shower herself wi	th supervision only.		procedures for reporting and	2-10-15	
	O= 00/00/47 !! * :		<u> </u>	following up on incidents incl	uding &	
		inistrator submitted a Plan				
	of Protection as follow			notification of the appropriate		
		edication aides would be		manager and physician for fur	ther on soing	
	inserviced prior to thei			instructions. (See attachments		
		edure for reporting and		& G)	10, 1°	
	rollowing up incidents	including notification of the	1 F	(X, (T)	[[

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING; _ C HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 338 Continued From page 22 D 338 Review of hospital discharge information dated 02/01/15 revealed; Upon admission, appropriate -Lewy body dementia with agitation and "violent monitoring will be set up for 72 outbursts". hours for the new resident based on -Recent physical assault by resident of three the needs and available history of family members prior to hospitalization. -Attempted to swing at the hospital Certified the resident. The Special Care Unit Nursing Assistant (CNA). Admission Staff Rounds Policy & Interview on 02/16/15 at 11:30 am with the Procedure (Attachment C) will be Director of Nursing (DON) revealed: used as a recommended guideline. -It was her responsibility to assess potential More frequent monitoring for longer residents to determine whether or not the resident periods of time can be put in place if would be appropriate for admission, but it was the Administrator's decision whether or not to accept indicated. Staff is required to the resident for admission. communicate needs to the Special -Sometimes the DON's recommendations for admission were followed and sometimes they Care Coordinator, the Resident Care Coordinator and/or the -She reviewed Resident #1's hospital FL-2 and Administrator. History and Physical, which included information regarding aggressive behavior and violence toward family members. In the event of an aggressive and/or -The DON sent an email to the Administrator violent behavior, the resident stating the facility could meet the resident's health care needs, but she had concerns regarding the involved will be transferred by resident's diagnosis and tendency toward ambulance or police escort to the violence. appropriate healthcare center. The -The DON stated she did not feel the resident should have been admitted to the facility and incident will be documented and thought the email conveyed that information reported to the attending physician, clearly. the Special Care Coordinator, the -The DON did not complete a documented preadmission screening because she did not Resident Care Coordinator and/or think the facility was going to accept the resident the Administrator. (See Attachment for admission based on her review of the I) resident's information and recommendation. -On 02/03/15, the day of admission, the DON was informed by the Administrator that the resident

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
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		WINSTO	N SALEM, NC 2	7127	
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D 338	Continued From page	23	D 338		
	verbally expressed he facility's ability to man behaviors. -The Administrator to happened, they could to the family. Interview on 02/19/15 Dementia Care Coordelt was the DON and to determine the approposition to the SCU. -The DCC saw an emadmission indicating the was not to accept the because of his diagnosaggressive behavior as	Id the DON if anything I discharge the resident back Is at 2:23 pm with the Idinator (DCC) revealed: Administrator's responsibility repriateness of admissions It is a prior to the resident's It is a prior to the facility I is and prior history of and violence.		If a resident is transferred to the hospital as a result of an aggress or violent behavior and the hosp is able to offer effective solution and return the resident to us, the Resident Care Management will establish a schedule of monitorir based on the Policy & Guideline for Returning Residents Back to Salem Terrace after Agitated Incidents. (Attachment H)	ital ongowy s ng s
	-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 behaviorThe 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 behaviorsThe Administrator stated to the best of her knowledge, she thought the DON was willing to			All Med Aides and/or Supervise have been re-trained on the Policentitled Resident on Resident All Policy. (Attachment I)) See signature sheets for attendees of training. The list represents all SIC's and all Med Aides current employed at Salem Terrace. (Attachment E & F) Resident of Resident Abuse Policy will be entered into the SIC manual and be used for all ongoing training new Med Aides and Supervisors See Attachment G for all handon given to staff at mandatory train	the thy m will for s. uts

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: С B. WING **HAL034098** 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) iD (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) D 338 Continued From page 24 D 338 "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 -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

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02/09/15 at 7:20 am.

home revealed the female resident expired on

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

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 338 D 338 Continued From page 25 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. Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 02/24/2015 HAL034098 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 338 D 338 Continued From page 26 -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 -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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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 Continued From page 27 D 338 -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

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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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D 338	Continued From page	: 28	D 338			
	fistThe female resident "Stop, please, stop".	hed her in the face with his was crying and saying,				
	-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 incidentThe PCA then began to gather the other					
	residents and put the safety because Resid	m into the TV room for lent #1 was still very agitated vith his hands and with his				
	beltThe PCA observed F	Resident #1 enter another				
		and she followed. She had taken the leg off the				:
	resident's wheelchair	and was standing over the elchair leg raised, about to				
		h the wheelchair leg while				
	-The PCA grabbed th					
	•	d the covers from off the esident's room.				
	the halls for about 30 while the PCA was try	ed to wander up and down minutes beating on doors ring to get other residents to				
		ne out of his room and was				:
		e PCA that Resident #1 took his clothes while he sed.				

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ С B. WING HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 D 338 Continued From page 29 -The PCA did not try to engage Resident #1, but was trying to remove other residents from the -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

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nurse revealed:

-Hospice services were initiated on 07/15/14 for

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 338 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. D914 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,

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED		
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D914	Continued From page neglect, and exploitat		D914			
	facility failed to ensure neglect related to the protection for residenthe Special Care Unit outbursts, failure to profailure to notify a physhealth services for a raggressive behaviors. The findings are: A. Based on interview facility failed to ensure neglect related to failure protection for residenthe Special Care Unit outbursts who had phyresidents resulting in death of one resident. NCAC 13F .0909 (Typ. B. Based on interview facility failed to provid sampled residents (Rewith the resident's assignation of the symptoms, which result and subsequent death to Tag 270, 10A NCAC Violation).] C. Based on record refacility failed to notify the mental health services residents (Resident #resulting in the physical resulting in the physical resulting in the physical residents (Resident #resulting in the physical residents in the providents in the physical residents in the physical residents in the physical residents in the providents in the physical residents in the providents in the physical residents in the providents in the providents in the physical residents in the providents in	and record reviews, the e residents were free of failure to provide safety and its by admitting a resident to with a history of violent rovide supervision, and sician or obtain mental resident with violent and was and record reviews, the e residents were free of the provide safety and its by admitting a resident to with a history of violent ysical altercations with injury to residents and the [Refer to Tag 338, 10A to A1 Violation).] The sident #1) in accordance is essed needs and current alted in the physical assault in of another resident. [Refer C 13F .0901(b) (Type A1 eviews and interviews, the the physician and refer to		To ensure the safety and freed from harm for all residents, al potential residents for the SCU be evaluated and assessed in proceduring the Salem Terrace's Special Care Unit Admission & Procedure. (Attachment A Pre-admission screening will a completed through the onsite physical assessment, record reand interviews with family and when available. A Pre-Admis Assessment Form will be completed. (See Attachment E All available assessment documentation and interviews be considered when deciding of making a bed offer.	U will person s Policy A) The be eview d staff ssion will	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING HAL034098 02/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD **SALEM TERRACE** WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D914 Continued From page 32 D914 NCAC 13F .0902(b) (Type A1 Violation).] Upon admission, appropriate monitoring will be set up for 72 hours for the new resident based on the needs and available history of the resident. The Special Care Unit Admission Staff Rounds Policy & Procedure (Attachment C) will be used as a recommended guideline. More frequent monitoring for longer periods of time can be put in place if indicated. Staff is required to communicate needs to the Special Care Coordinator, the Resident Care Coordinator and/or the Administrator. In the event of an aggressive and/or violent behavior, the resident involved will be transferred by ambulance or police escort to the appropriate healthcare center. The incident will be documented and reported to the attending physician, the Special Care Coordinator, the Resident Care Coordinator and/or the Administrator. (See Attachment

Division of	of Health Service Regu	ilation			FORWAPPROVED
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	NCAC 13F .0902(b) (Type A1 Violation).]		If a resident is transferred to the	2-10-15
	. , ,			hospital as a result of an aggres	sive ongown
				or violent behavior and the hos	pital
	,			is able to offer effective solution	
				and return the resident to us, the	9
				Resident Care Management wil	1
		•		establish a schedule of monitori	ng
				based on the Policy & Guideline	es
				for Returning Residents Back to)
				Salem Terrace after Agitated	
				Incidents. (Attachment H)	
				SIC's and Med Aides have b	een same
				re-educated on reporting,	2-10-15
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				processes for residents who b	egin Mass
				to display aggressive and/or	
İ				violent behaviors as well as o	on I
				the Resident on Resident Abo	1
				Policy (See Attachment I) (
•				Attachment G for complete	
				training packet) (See Attach	ment
				E & F for all signatures of	
.				attendees to training) This list	et l
				reflects all SIC's and Med Ai	
					ues
				currently employed at Salem	
				Terrace. This information wi	
				be placed in the SIC Manuel	1 1
Nistalan - 200 - 1	4 O			kept available for all new state	tt [
Division of Heal STATE FORM	th Service Regulation		6899 £	training and for current staff	В
			t	reference.	ation sheet 33 of 33

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AFR - 2 2015

BHM Salem Terrace 2609 Old Salisbury Road Winston Salem, NC 27127 336-785-1935

March 31, 2015

Ms. Bonnie Moore, Licensure Consultant Adult Care Licensure Section Division of Health Service Regulation 12 Baretta Drive Ashville, NC 28806

Dear Bonnie,

I respectfully submit this Plan of Correction for Salem Terrace for the survey completed on February 24, 2015.

Please call me if there is anything that I need to amend in this packet.

Sincerely,

Wonne Peterson

(Vonnie)

Administrator

Shook, Linda

From:

Moore, Bonnie

Sent:

Wednesday, April 22, 2015 12:46 PM

To:

'Shelia Moore'

Cc:

Shook, Linda

Subject:

Plan of Correction

Attachments:

SALEM TERRACE 2015-03-31 POC-6ITF11 REVIEW.pdf

Please find attached to this email the approved Plan of Correction for Salem Terrace, HAL-034-098, Forsyth County. Thank you,

Bonnie Moore, RN
N.C. Department of Health and Human Services
Facility Survey Consultant - Division of Health Service Regulation
Adult Care Licensure Section
12 Barbetta Drive
Asheville, NC 28806
Phone: 336-341-8130

Phone: 336-341-8130 Fax: 828-260-5040

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