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	HAL034098	A. BUILDING: _____ B. WING _____	11/16/2017

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 an anuual survey and a State Involved Complaint Investigation on November 14-16, 2017. The complaints were initiated by Forsyth County Department of Social Services on 9/28/17, 10/26/17 and 11/3/17.	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 B VIOLATION Based on record reviews and interviews, the facility failed to provide supervision checks for 1 of 5 sampled residents (Resident #1) every 2 hours during the night shift which resulted in Resident #1's unnoticed death. The findings are: Review of Resident #1's current FL2 dated 11/23/16 revealed: -Diagnoses included dementia, atrial fibrillation, cardiomyopathy, hypothyroidism, hypertension, gout and depression. -Resident #1 was incontinent of bowel and bladder and was semi-ambulatory. Review of Resident #1's Care Plan dated	D 270		

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11/23/16 revealed Resident #1 needed:
-No assistance or supervision with eating.
-Limited assistance with toileting.
-Limited assistance with ambulation.
-Limited assistance with bathing.
-Limited assistance with dressing.
-Limiting assistance with grooming.
-No assistance or supervision with transfers.

Interview on 11/15/17 at 10:10 am with a medication aide (MA) revealed:
-She was working 3rd shift the night Resident #1 passed away (08/10/17).
-She was the MA for the entire facility that night, which was normal scheduling for 3rd shift.
-There were 2 staff on duty on the Assisted Living Unit (ALU) side of the facility that night.
-She visualized Resident #1 at midnight when Resident #1 was sleeping in her bed, breathing normally, "That was the last time I saw her".
-The staff normally checked on each resident every 2 hours.
-She did not have the opportunity to check on Resident #1 any more that night.
-She was unaware if other staff on duty the morning of 08/10/17 had time to check on Resident #1.
-She left the facility at the end of her shift, at around 7:00 am the next morning.
-Resident #1 had been found unresponsive in her bed by first shift staff around 8:00 am on 08/10/17.

Telephone interview on 11/15/17 at 1:35 pm with the previous Administrator, who was in charge of the facility on the night Resident #1 passed away revealed:
-Resident #1's death on 08/10/17 was "unexpected". "She had not been sick at all".
-Emergency Medical Services (EMS) was called

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and and after they arrived, they pronounced her death.
-Cookies were found in bed with Resident #1, under her pillow.
-EMS did not report that she had choked.
-Staff reported they had completed rounds every 2 hours and checked on each resident.
-He was unable to recall exactly how many staff worked the night of 08/10/17, but "We were adequately staffed that night, according to regulations".

Telephone interview on 11/15/17 at 3:05 pm with Resident #1's family member revealed:
-He had a copy of the death certificate in front of him.
-His review of the death certificate indicated the cause of death was "undetermined natural causes" and the contributing factors were "hypertension, anemia, coronary arterial disease, and hyperlipidemia".

Interview on 11/15/17 at 3:30 pm with the Resident Care Director (RCD) revealed the policy was for staff on duty to check residents at least every 2 hours.

Interview on 11/16/17 at 1:15 pm with a MA revealed:
-She was working on 08/10/17, the morning Resident #1 was discovered to have passed away during the night.
-"It was a normal morning, I was working on my med pass and noticed that I had not seen her (Resident #1)".
-"Resident #1's roommate came to my medication cart and told me that she could not wake her (Resident #1) up".
-I went to wake Resident #1 up , but "she was already gone".

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D 270	Continued From page 3 -She was cool to the touch and her body was stiff. Review of the Emergency Medical Services report, dated 08/10/17 at 9:00 am revealed: -Documentation of "obvious death". -Documentation of "female unresponsive pale cool and stiff lying in her bed at a nursing home". -Documentation of "No signs of suspicious death noted". Interview on 11/16/17 at 1:45 pm with Resident #1's licensed prescribing practitioner revealed: -Even though Resident #1 had several co-morbidities, her death was not anticipated. -The staff at the facility should check on residents at least every 2 hours around the clock. Interview on 11/16/17 at 1:50 pm with the RCD revealed: -Residents were to be visually checked by staff every 2 hours at a minimum. -A few residents were on more frequent checks, every 30 minutes, for example. Confidential interviews with 5 residents, on 11/16/17 between 10:50 am and 11:25 am revealed: -One of 5 residents said, "I saw one of them (facility staff) peek in my door one time at night". -Two of 5 residents stated, "I don't think they check on us during 3rd shift". -One of 5 residents said, "One night, I think my blood sugar was low, so I yelled for help. Nobody came. I ate some of my roommate's candy and went back to sleep. I guess I was alright". -Four of 5 residents said they had never needed help on 3rd shift. -One of 5 residents said, "I'm sure that staff is here, I hear them outside my door". -One of 5 residents said, "I'm not sure they check	D 270		

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D 270	Continued From page 4 on us during 3rd shift". Attempted interviews on 11/15/17 at 11:49 am and 11/15/17 at 1:50 pm with the PCA who worked on the ALU of the building the night Resident #1 passed away were unsuccessful. Interview on 11/16/17 at 4:30 pm with the Administrator revealed: -He had been the Administrator at this facility for 11 days. -Staff were supposed to check on residents every 2 hours throughout the day and night, for 24 hours a day. -Staff were to provide more frequent supervision as needed. Based on record reviews and interviews, the facility failed to provide 2 hour safety checks for Resident #1 which resulted in Resident #1's death being unnoticed by staff until the next shift. The facility's failure to provide 2 hour checks on Resident #1 per policy was detrimental to the safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection on 11/16/17 at 5:00 pm which included: -All residents were expected to be checked by resident care staff at the beginning/change of every shift and minimally every 2 hours or as directed by the RCD or designee. -The resident care staff would routinely check on resident every 2 hours as needed. -It is expected that 2 hour intervals are the maximum time between rounds and the resident care staff would be interacting with residents throughout their shift. -The staff would inform the SIC of all incidents and each resident's change of condition to	D 270		

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D 270	Continued From page 5 include falls, with head injury, significant change and death. -The resident care coordinators would conduct daily audits on incidents, falls and changes in resident condition Monday through Friday. Weekend incidents would be reviewed by the SIC and all documentation placed in the area designated by the RCD. The audits would be conducted daily for 3 months. CORRECTION DATE FOR THE B VIOLATION SHALL NOT EXCEED, DECEMBER 31, 2017	D 270		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served as ordered by the physician for 2 of 6 sampled residents (#11 and #12) who had an order for a Mechanical Soft (MS) diet (Resident #11) and an order for a No Concentrated Sweets (NCS) diet (Resident #12). The findings are: A. Review of Resident #11's FL2 dated 8/16/17 revealed: -Diagnoses included diabetes mellitus II without complication, gastroesophageal reflux disease,	D 310		

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high cholesterol, hypertension, Parkinson's disease, vitamin B12 deficiency, and hyperlipidemia.
-There was a physician's order for a NCS diet.

Review of the therapeutic diet list posted in the kitchen dated 9/16/17 revealed resident was to be served a MS, NCS diet.

Review of Resident #11's diet order signed on 10/18/17 revealed an order for a MS, NAS diet.

Review of the regular menu for the lunch meal service on 11/14/17 revealed chef's entrée of choice (baked chicken), rice or pasta, chef's vegetable choice (broccoli), fruit of choice (pears), and a roll.

Review of the therapeutic diet spreadsheet for NAS and MS diets to be served on 11/14/17 at the lunch meal revealed Resident #11 was to be served a regular meal with no added salt and with the entrée of the cook's choice (baked chicken) ground.

Observation of the lunch meal on 11/14/17 at 12:25pm revealed:
-Resident #11 was served a baked chicken thigh, rice, broccoli, pears, a roll, water, tea, and coffee.
-The baked chicken was whole and was not ground as ordered by the physician.
-Resident #11 ate 100% of the baked chicken.
-Resident #11 had no difficulties with swallowing
-Meals cards were placed on each resident's tray with their meals and staff served meal trays according to the name on the meal card.

Observation of the breakfast meal service on 11/15/17 at 8:13 am revealed Resident #11 was served MS sausage, eggs, grits, roll, milk, coffee,

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water, and cranberry juice.

Interview with Resident #11 on 11/15/17 at 9:13 am revealed:
-"I am not on a special diet."
-"I am borderline diabetic, but I can eat anything I want."
-He was on a MS diet due to a choking on a piece of chicken with skin on it about a month ago.
-He had been given a swallowing test and his food had been MS since then.
-He had received a whole chicken thigh with skin on 11/14/17 for lunch.
-"Getting a whole of piece of chicken was unusual. I usually get my meat ground up."
-"I was real careful when I ate the chicken."
-He did not have any difficulties with choking while eating his lunch on 11/14/17.

Interview with a cook on 11/15/17 at 9:37 am revealed:
-He had worked at the facility since 1995.
-Dietary staff did not prepare meals with salt.
-Each resident's diet order was written on a meal card that was placed on each resident's service tray when served.
-Dietary staff prepared each resident's plate according to their meal card.
-Each tray was served according to the meal card.
-He was not aware Resident #11 was served a regular meal for lunch on 11/14/17.

Interview with a dietary coordinator on 10/15/17 at 9:44 am revealed:
-She had worked as a dietary coordinator for about a month.
-There was not currently a dietary manager.
-Meals were prepared according to each resident's diet order.

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-Each resident's diet order was written on their meal card and was placed on their serving tray with their meal.
-Staff who served the plates were responsible for checking to make sure that meals served matched the diet order on the meal cards.
-"MS meats were prepared in a chopping machine."
-All meats for residents on MS diets were chopped except for meats like barbeque and meatloaf which were already ground or chopped.
-No salt was used when cooking or preparing meals.
-She was not aware Resident #11 was served a regular meal for lunch on 11/14/17.

Interview with a Personal Care Aide (PCA) on 11/15/17 at 10:06 am revealed:
-She served meals to residents during the breakfast and lunch meals.
-Each resident had a meal card that listed the resident's name and diet order.
-She checked the meals on the tray and compared them to the meal card sometimes.
-If the meals on the tray did not match the meal card, she would let the dietary staff know.
-She was not aware Resident #11 was served a regular meal for lunch on 11/14/17.

Interview with a second PCA on 11/15/417 at 10:14 am revealed:
-She served meals to residents during the breakfast and lunch meals.
-Diet orders were written on each resident's meal card.
-The dietary staff informed the PCAs when an order had changed.
-If the meal on the tray did not match the meal card, she would inform the dietary staff.
-She was not aware Resident #11 was served a

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regular meal for lunch on 11/14/17.

Interview with the Director of Nursing on 11/15/17 at 10:42 am revealed:
-She had worked at the facility for about 2 months.
-Each resident's name, room number and diet order was written on each resident's card.
-Her expectations were the residents were served diets according to their meal card and that the meal card matched the diet order.
-The serving staff should have checked to see that the residents were served the correct tray and diet order according to their meal card.
-"The nursing staff and medical records staff were responsible for making sure that dietary was notified of changes in diet orders.
-MS diets should be soft and chopped but not ground.
-She was not aware Resident #11 was served a regular meal for lunch on 11/14/17.
-"We will be having an in-service on therapeutic diets."

Interview with the Administrator on 11/15/17 at 11:28 am revealed:
-He had worked at the facility for 10 days.
-Residents had meal cards that matched with their diet orders.
-The meal card indicated what each resident should or should not eat and their diet order.
-The dietary staff were responsible for ensuring that the diet order matched the meal card.
-The dietary staff were responsible for preparing plates to be served to residents according to their diet order.
-The serving staff should not have served a tray to residents that did not match their diet order.
-The serving staff were responsible for double checking trays to make sure that the plates being

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served matched the diet orders.
-He was not aware Resident #11 was served a regular meal for lunch on 11/14/17.

Interview with Resident #11's physician on 11/15/17 at 12:00 pm revealed:
-Resident #11 was placed on a MS diet about a month ago due to choking on a piece of chicken and staff had to do the Heimlich maneuver on him.
-Speech Therapy evaluated Resident #11 and his diet order changed to MS.
-"I expect for Resident #11 to be served a MS diet according to the order, but sometimes residents don't like ground foods."
-"Resident #11 was on a NCS diet due to his diagnosis of diabetes, but I am more concerned with him aspirating than I am with his blood sugar level."
-"He has not had any other aspiration episodes since his diet order was changed to MS."

B. Review of Resident #12's FL-2 revealed:
-Diagnoses included convulsions, diabetic retinopathy, hyperlipidemia, hypertension, diabetes mellitus II without complications, reflux esophagitis, iron deficiency, hemiplegia of dominant side, and constipation.
-There was a physician's order for a No Concentrated Sweets (NCS), No Added Salt (NAS) diet.

Review of Resident #12's diet order signed on 10/18/17 revealed an order for a NAS, NCS diet.

Review of the therapeutic diet list posted in the kitchen on 11/14/17 revealed resident was to be served a NAS, NCS diet.

Review of the regular menu for the lunch meal

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service on 11/14/17 revealed chef's entrée of choice (baked chicken), rice or pasta, chef's vegetable choice (broccoli), fruit of choice (pears), and a roll.

Review of the therapeutic diet spreadsheet for NCS and NAS diets to be served on 11/14/17 at the lunch meal revealed Resident #12 was to be served a regular meal with no added salt.

Observation of the lunch meal service on 11/14/17 at 12:25pm revealed:
-Resident #12 was served a baked chicken thigh, rice, broccoli, pears, a roll, water, unsweetened tea, and coffee.
-Resident #12 added 3 single serve granulated sugar packets to her coffee.
-The number of grams in a single serve packet was not identified on the packet.

Observation of the breakfast meal service on 11/15/17 at 8:13 am revealed:
-Resident #12 was served 2 strips of bacon, eggs, grits, rice crispy cereal, milk, coffee, water, and cranberry juice.
-Resident #12 added 3 single serve granulated sugar packets to her coffee and 4 single serve granulated sugar packets to her rice crispy cereal.

Interview with Resident #12 on 11/15/17 at 9:30 am revealed:
-She was on a "diabetic diet."
-"I can't have cookies, but I can have sugar."
-She used 3 single serve granulated sugar packets in her coffee.
-She used 4 single serve granulated sugar packets in her cereal.
-No one ever told her that she could not add granulated sugar to her coffee or cereal.

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D 310	Continued From page 12 -She went into the dining hall twice a day between meals to get coffee and added 3 single serve granulated sugar packets to her coffee. -Granulated sugar packets were on the dining tables and were also available near the coffee in the dining hall. Observation of the dining hall on 11/15/17 at 9:35 am revealed: -The doors to the dining hall were open. -Coffee was available on a counter in the dining hall for residents. -Residents were entering the dining hall and serving themselves coffee. -There was staff in the kitchen, but there was no staff in the dining hall as residents went in and out. -Each dining table contained a tray of salt, pepper, sweetener, creamer, and granulated sugar packets. -A tray of salt, pepper, sweetener, creamer, and granulated sugar packets were also available near the coffee station. Interview with a cook on 11/15/17 at 9:37 am revealed: -He had worked at the facility since 1995. -The PCAs who assisted in the dining during meals were responsible for monitoring to ensure that residents served a NCS or NAS diet were not adding granulated sugar or salt to their meals. Interview with a dietary coordinator on 11/15/17 at 9:44 am revealed: -She had worked in her current position for about a month. -She did not know if residents added granulated sugar to their food or drinks. -The PCAs were responsible for monitoring to ensure that residents served a NCS or NAS diet	D 310		

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(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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were not adding granulated sugar or salt to their meals.
-Residents were able to come into the dining hall to get coffee anytime they wanted to.
-Granulated sugar, sweeteners, and salt packets were available to everyone.
-The doors to the dining hall were open throughout the day except when the floors were being cleaned.
-No one monitored who came in and out and what they got with their coffee or from the tables between meals.

Interview with a resident on 11/15/17 at 9:59 am revealed:
-The door to the dining hall was normally open every day all day until around 10:00 pm for residents to get coffee.
-The doors were normally closed when the floors were being mopped.
-Granulated sugar, cream, and sweetener was available to everybody.
-"Some people cheat and eat the white sugar."

Interview with a PCA on 11/15/17 at 10:06 am revealed:
-She served meals to residents during the breakfast and lunch meals.
-Each resident had a meal card that listed the resident's name and diet order.
-"We don't know if residents add sugar or salt to their meals unless we are at that table."
-She had never been told to monitor residents who were on therapeutic diets to ensure that were not adding granulated sugar or salt to their meals.
-She was not aware that Resident #12 added granulated sugar to her coffee and cereal.

Interview with a second PCA on 11/15/17 at 10:14 am revealed:

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D 310	Continued From page 14 -She served meals to residents during the breakfast and lunch meals. -Diet orders were written on each resident's meal card. -"Residents let us know when they want sugar and salt added to their meals." -She was not aware Resident #12 added granulated sugar to her coffee and cereal. Interview with the Director of Nursing on 11/15/17 at 10:42 am revealed: -She had worked at the facility for about 2 months. -Each resident's name, room number and diet order was written on each resident's card. -Her expectations were that the residents were served according to their meal card and that the meal card matched the diet order. -The PCAs who served the meals were responsible for ensuring residents who were on therapeutic diets were not adding salt or granulated sugar to their meals. -She was not aware Resident #12 added granulated sugar to her coffee and cereal. -Residents were able to go into the dining hall for coffee throughout the day. -Sometimes staff members monitored the dining hall between meals and sometimes they did not. -"We will be having an in-service on therapeutic diets." -"We're going to have to come up with a system for residents who are on NCS and NAS diets, but there is not a system at this time." Interview with the Administrator on 11/15/17 at 11:28 am revealed: -He had worked at the facility for 10 days. -Residents had meal cards that matched with their diet orders. -The meal card indicated what each resident	D 310		

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should or should not eat and their diet order.
-The staff was aware of which residents were on a therapeutic diet because the diet order was listed on the meal card.
-The staff that served the meals was responsible for monitoring those who were on therapeutic diets to ensure that residents did not add granulated sugar or salt to their meals.
-He was not aware Resident #12 added granulated sugar to her coffee and cereal.

Observation of the breakfast meal service on 11/16/17 at 8:23 am revealed:
-Resident #12 was served 1 piece of sausage, eggs, grits, 1 biscuit, rice crispy cereal, coffee, milk, water, and juice.
-Resident #12 added 3 single serve granulated sugar packets to her coffee and 4 single serve granulated sugar packets to her rice crispy cereal.

Interview with Resident #12's physician on 11/16/17 at 10:32 am revealed:
-Resident #12 was on a NCS, NAS diet due to her having diagnoses of hypertension and diabetes.
-Resident #12 was not to have any added table salt, cakes, or pies.
-It was not okay for Resident #12 to add granulated sugar to her food or beverages.
-She was not aware that Resident #12 was adding granulated sugar to her food and beverages.
-Resident #12's blood sugars had been within normal range.
-She had no concerns with Residents #12's blood sugars at this time, but "she should not be adding granulated sugar to her beverages or food."

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D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and signed by the resident with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds for 3 of 3 sampled residents (Resident #4, #10 and #11). The findings are: A. Review of Resident #10's current FL2 dated 03/16/17 revealed diagnoses included chronic pain, glaucoma, depression, seizures, marijuana abuse, and tobacco abuse. Review of Resident #10's record revealed no signed documentation for permission by Resident #10 or designee for the facility to manage the resident's funds. Interview with Resident #10 on 11/14/17 at	D 421		

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D 421	Continued From page 17 12:41pm revealed: -Resident was private pay. -He received a little over $2000.00 a month deposited in his account. -Whenever he went to get money from the Business Office Manager (BOM), he was sometimes told he did not have any money, he had spent it all. -He had glaucoma and he could not see how much money he was being given. -He had requested that his family member go into the facility Business Office with him when he received his money so the family member could count the money for him, but the request was denied by the BOM. -He wanted to get $350.00 on 11/10/17 but was told by the BOM he only had $200.00 in his account. -He asked the transportation aide if she could go with him when he received his money so she could count his money for him. -He did not understand why he was told he did not have money when he knew he should have more money available than what the BOM told him he had. -He had never signed any transaction because he had glaucoma and could not see to sign. -He only received money for when his family member took the resident shopping. Interview on 11/14/17 at 3:30pm with transportation aide revealed: -Numerous residents were complaining to her about being told they did not have money in their accounts. -The facility BOM could not explain what happened to the residents' money when asked. -A resident who was vision impaired had concerns about not having much money. He tried to get $350.00 from his account and was told by	D 421		

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the BOM he could only get $200.00.

Review of Resident #10's Trust Account Ledger revealed:
-There was $600.00 deposited into Resident #10's account every month until August 2017.
-There was $200.00 deposited into the resident's account starting August 2017 without an explanation for the change in the deposit.
-There was $400.00 not accounted for in the resident's trust fund account.
-On 11/16/17, a deposit was made of $309.00 into Resident #10's account with no documentation on the ledger explaining the deposit.
-In 2017, debits were made from Resident #10's account totaling $1914.31 listing bills for pharmacy, and insurance with no documentation of amounts withdrawn for each bill payment.
-In 2017, debits were made from the account totaling $3164.00 with no documentation of an explanation for the debits on the ledger.
-A remaining balance of Resident #10's account was listed as $9.97.
-The ledger contained no signatures.

Observation of Resident #10's Trust Account funds in the facility on 11/16/17 revealed that $9.97 was on hand for the resident to receive.

Review of Resident #10's account balance and observation of the account fund on hand revealed a discrepancy of $1300.97 and the amount of $1300.97 was unaccounted for.

Refer to interview on 11/14/17 at 10:45am with Business Office Manager.

Refer to interview on 11/15/17 at 11:20am with the Financial Controller in the facility's corporate

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office.

Refer to interview on 11/15/17 at 4:30pm with a Co-Owners of the facility.

Refer to interview on 11/16/17 at 9:00am with the Owner of the facility.

B. Review of Resident #4's current FL2 dated 08/29/17 revealed diagnoses included chronic urinary tract infection, breast cancer, diabetes mellitus, and chronic artery disease. There was not a diagnosis of mental limitations.

Review of Resident #4's record revealed no signed documentation for permission by Resident #4 or designee for the facility to manage the resident's funds.

Interview with Resident #4's Power of Attorney (POA) on 11/16/17 at 9:15am revealed:
-He had heard other residents complain about not getting their trust account fund money and their accounts being short.
-He decided to look into Resident #4's account and saw the same problems other residents had been complaining about.
-Resident #4's trust money included $20.00 from the state and $46.00 from Social Security Special Assistance (SSA).
-Medicaid paid the $20.00 and the family member paid the $46.00 which totaled the $66.00 each Medicaid resident was entitled to when living in an Assisted Living Facility to use for personal funds.
-When the facility started to get Medicaid, Medicaid funds of $20.00 should have been deposited into the resident's account.
-Each month, calls were made from the BOM stating that the POA was not paying the right

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amount, but no one could say exactly how much he needed to pay the facility.
-A request was made for an accounting of resident's trust fund to the BOM and the Controller, but one was never provided.

Review of Resident #4's Trust Fund Account Ledger revealed:
-In 2017, debits were made from the account totaling $319.00 with documentation the withdrawals were made and signed by Resident #4's POA.
-In 2017, deposits were made to the account totaling $343.00
-In June 2017 and October 2017 there were no deposits or withdrawals documented on the ledger.
-The beginning balance on the trust account in January of 2017 was $156.00.
-A remaining balance account was listed as $119.
-There was no documentation of any signatures on the ledger.

Observation of Resident #4's Trust Account Funds in the facility on 11/16/17 revealed that $119.00 was on hand.

Review of Resident #4's account balance and observation of the account fund on hand revealed a discrepancy of $180 and $180.00 was unaccounted for.

Refer to interview on 11/14/17 at 10:45am with Business Office Manager.

Refer to interview on 11/15/17 at 11:20am with the Financial Controller in the facility's corporate office.

Refer to interview on 11/15/17 at 4:30pm with a

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D 421	Continued From page 21 Co-Owners of the facility. Refer to interview on 11/16/17 at 9:00am with the Owner of the facility. C. Review of Resident #11's current FL2 dated 02/16/17 revealed diagnoses which included Alzheimer's disease, hyperlipidemia and paranoid schizophrenia. Review of Resident #11's record revealed no signed documentation for permission by Resident #11 or designee for the facility to manage the resident's funds. Interview with Resident #11's legal guardian on 11/20/17 at 11:46am revealed: -Resident #11 was private pay. -She had not been Resident #11's legal guardian very long. -Everything was already in place when she was assigned the case. -She was aware there was another account for him and it was through a local bank. -She was not aware of who deposited monies into Resident #11's trust fund account. -She had access to his Social Security. -All of his medical and dental bills came to her and she pay those bills. -She had asked the BOM on several occasions if the resident needed anything, and she was always told no by the BOM. -In November 2016 a request was made by the facility BOM for $250.00 for Resident #11, but it was not for clothing. -The legal guardian was told by the BOM the facility used the requested fund of $250 for an electronic device that Resident #11 had wanted. -She did not have access to the resident's trust fund account funds.	D 421		

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D 421	Continued From page 22 Interview with the representative of Resident #11's trust fund through the local bank on 11/20/17 at 12:35pm revealed: -She was responsible for paying $5500.00 per month for the resident's room and board to the facility. -He was being charged $5500.00 per month for two semi private rooms at $3350.00 each instead of the rate of $3600.00 for a private room. -She was not aware resident was charged $5000 per month by the facility. -She had only send the $5500.00 per month to the facility. -She was not aware of who sent money to Resident #11's Trust fund account. Review of Resident #11's Trust Account Ledger on 11/16/17 revealed: - In 2017, deposits of $465.57 were made to the resident's trust fund account. -In 2017, debits were made from the account totaling $925.00. -Debits of $572.00 were documented as medical in nature and clothing. -All medical and clothing needs were to be paid for by the legal guardian. Observation of Resident's #11 Trust Account funds in the facility on 11/16/17 revealed that $239.00 was on hand. Review of Resident #11's account balance and observation of the Trust Account funds on hand revealed a discrepancy of $203.27. The amount of $203.27 was unaccounted for. Interview on 11/16/17 at 12:00pm with the Financial Controller for all of the Residents' Trust Fund Accounts revealed:	D 421		

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D 421	Continued From page 23 -There was a spread sheet for all of the Trust funds transaction but she could not access it at this time. -The BOM had access to all of the residents' trust accounts. -Another staff in the office was responsible for all of the financial transactions. -She supervised the staff who was responsible for all of the financial transactions. -She could not state who was responsible for Resident #11's Trust funds account. -She could not say where the money in Resident #11's Trust fund account was coming from. -She had no knowledge where Resident #11 received his personal funds from. -She could not say how much money was deposited to his account. -She could not say why she did not know these answers even though she was the Financial Controller for the facility. Refer to interview on 11/14/17 at 10:45am with Business Office Manager. Refer to interview on 11/15/17 at 11:20am with the Financial Controller in the facility's corporate office. Refer to interview on 11/15/17 at 4:30pm with a Co-Owners of the facility. Refer to interview on 11/16/17 at 9:00am with the Owner of the facility. _____ Interview on 11/14/17 at 10:45am with Business Office Manager revealed: -She did not know how much money each resident received monthly -She did not have access to any of the financial	D 421		

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information pertaining to the residents' funds.
-She did not know how much each resident paid for their monthly room/board.
-All monies were sent directly from the Corporate Office.
-Corporate Office told her how much was to be deposited into each account monthly.
-The Corporate Office staff determined that each resident should have at least $30.00 per month applied towards pharmacy bills.
- Cash monies brought into the facility for a resident must be sent to the Corporate Office and then disbursed to the resident.
-She was not aware of the need to have two signatures monthly to verify accuracy on the residents' account ledgers.

Interview on 11/15/17 at 11:20am with the Financial Controller in the facility's corporate office revealed:
-The facility BOM had access to all of the information that was requested.
-There was a petty cash box in the business office that always had up to $1500.00 on hand for residents use.
-She would fax all of the information requested about the residents' trust funds to the facility.

Interview on 11/15/17 at 4:30pm with a Co-Owner of the facility revealed:
-She had no knowledge of the day to day operations of the residents' trust funds accounts.
-The corporate office was responsible for managing the residents' trust fund accounts.
-Family members, upon request were to be given an account of the residents' trust account.
-She would notify the Corporate Office for a detailed accounting of the information requested.
-No information was received on this day (11/15/17).

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D 421	Continued From page 25 Interview on 11/16/17 at 9:00am with the Owner of the facility revealed: -She would go to the Corporate Office to help the Controller gather all of the requested information. -She did not know why the information was not faxed as requested. -She would make sure the BOM had access to all residents' trust funds. -She would have the Controller come to the facility and bring resident account records for review. As of 3:30pm on 11/15/17, no faxed information from the Financial Controller had been received. _____ Based on observations, interviews and record reviews, the facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and signed by the resident with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds for Resident #4, #10 and #11. The facility's failure to provide the residents' with an accurate accountability and access to funds for residents to make purchases, and billing transactions was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 11/16/17 as follows: -Immediately, the BOM will ensure compliance within state and facility guidelines regarding resident personal funds. -The business office staff will provide individual resident trust account review for each resident or representative by submitting a request to the business office manager during regular business hours on Monday through Friday at 9:00 am to	D 421		

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D 421	Continued From page 26 5:00 pm. -The business office staff will provide a receipt to the resident or representative for funds to be deposited as recorded on the resident trust fund account ledger during business hours from 9:00 am to 5:00 pm Monday through Friday. -The business office manager will process withdrawals from the resident or representative during regular business hours on Monday through Friday at 10:30 am to 11:30 am. -Should there be a special request for resident funds on the weekend, the resident or representative may contact the business office and request funds for the coming weekend. -The resident or representative will need to sign the resident trust ledger prior to the close of business on Friday at 5:00 pm of the weekend the funds are needed. -Those funds will be held on the nursing medication cart for the resident or representative for pick up on the weekend. -The facility shall promptly return all funds to the resident, legal guardian, or designated representative upon residents' transfer or discharge. -Should a resident expire, all funds will be payable to the resident's estate. -The resident's trust account will be audited weekly for 3 months and ongoing by the business office manager, Administrator, and administrative designee. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, December 31, 2017.	D 421		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

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 _____	11/16/2017

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

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D912	Continued From page 27 Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to Personal Care and Supervision and Accounting for Residents' Personal Funds. The findings are: A. Based on record reviews and interviews, the facility failed to provide supervision checks for 1 of 5 sampled residents (Resident #1) every 2 hours during the night shift which resulted in Resident #1's unnoticed death. [Refer to Tag 0269 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)] B. Based on observations, interviews and record reviews, the facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and signed by the resident with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds for 3 of 3 sampled residents (Resident #4, #10 and #11). [Refer to Tag 0421 10A NCAC 13F .1104(c) Accounting For Residents' Personal Funds (Type B violation)]	D912		