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	2809 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	10A NCAC 13F .0901(b) Personal Care and Supervision All resident care plans will be reviewed for accuracy and completion, to prevent further occurrences. All care plans will be brought to the Director of Resident Care prior to being placed in the resident's charts. New admission care plans will be reviewed during nursing standup daily, utilizing the "Salem Terrace Department Manager and SIC Meeting" form. Monday through Friday. Review of the care plans will begin 12/28/2017 and ongoing. The nursing staff will be in-serviced to the following topics: Staff Rounds Resident Monitoring Incontinence Care ADL's Transfers/Repositioning Con't Next page (2)	

Reviewed + accepted with addendum on pg 18. AJS 1/17/18

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

(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 270	Continued From page 1 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	D 270	All training contents will be added to staff training upon hire 12/28/2017 and ongoing. The resident care staff will routinely check on residents every two hours as needed. See attached policy. It is expected that two-hour intervals are the maximum time between rounds and the resident staff will be interacting with residents throughout their shift. Incontinent residents are monitored every two-hours as needed to ensure maintenance of personal hygiene. Increase Continue next page (3)	

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

(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 270	Continued From page 2 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".	D 270	of frequency of rounds for incontinent resident's may be necessary depending on personal care needs. The resident care staff will inform the SIC (Supervisor-in-Charge) of all incidents in each resident's change of condition to include falls with head injury, significant change, and death. The SIC will contact the physician, responsible party, the resident care director or administrator and the SIC will complete all necessary documentation. The SIC will place completed documentation in the place designated by the Resident Care Director for review on the next business day. The resident care coordinators will conduct daily audits on incidents, falls, and changes in condition Monday through Friday. Weekend incidents will be reviewed by the SIC and all documentation will be placed in the area designated by the Resident Care Director for review. Continue pg 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 1:46 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	SEE Attachment A: Policy on Staff Rounds Attachment B: Transfer Training Information Attachment C: Information provided to staff regarding care and incident reporting Attachment D: Department Manager and SIC form Attachment E: Employee Inservice sign- in sheet Attachment F: Information on Personal Care	

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

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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 11/16/17 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 6 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		

PERSONAL CARE RECORD

Month: _____ Date: _____

CHARTED DAILY

Form # MP4003L-1 (Rev. 12/14)
Reorder From: MED-PASS® 800-438-8884

BATHING
(Record when provided)

EVENT CODES:
S = Shower
ST = Shower/Tub
BB = Bed Bath
SB = Sponge Bath

ASSISTANCE CODES:
See below

SKIN/HAIR/FEET
(Provide Daily)

EVENT CODES:
SH = Shampoo/Hair Care
SC = Skin Care (wash face/hands/foot care)
NC = Nail Care

ASSISTANCE CODES:
See below

DAY OF THE MONTH		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1st SHIFT	Event																															
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ASSISTANCE CODES

I = **Independent** – The resident can perform the activity without help or with only occasional help.
P = **Prompt** – The resident needs to be reminded to perform the activity.
S = **Supervision** – The resident can perform the activity when another person provides oversight, encouragement and prompting.
LA = **Limited Assistance** – The resident is highly involved in performing the activity for him/herself, i.e., the resident requires assistance with dressing or walking less than 3 times a week.
EA = **Extensive Assistance** – The resident can perform part of the activity him/herself. The resident requires assistance with dressing or walking more than 3 times a week.
TD = **Totally Dependent** – Someone must complete the task for the resident at all times.
TL = **Therapeutic Leave** – Initial by date when resident is on therapeutic leave.
OOF = **Out of Facility** – Initial by date when resident is out of facility.
R = **Refused**
H = **Hospital** – Initial by date when resident is in the hospital.
O = **Other Instructions:** _____

Physician/Alt. Physician	Telephone No.	Diagnosis	Store Name

Resident/Patient/Client	Room	Bed	Patient Code	Admin. Date	Sex	Date Of Birth	Allergies	Charting For/Through	Page No.

AI-013117

PERSONAL CARE RECORD

Month: _____ Date: _____

CHARTED DAILY

PERSONAL HYGIENE
(Provided Daily)

EVENT CODES:
M = Mouth/Oral/Denture Care
S = Shave

ASSISTANCE CODES:
See below

DAY OF THE MONTH		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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O = **Other Instructions:** _____

COMMENTS

Special Instructions/Findings: _____

Patient Uses: ☐ Shower Bench/Chair ☐ Grab Bars ☐ Handheld Shower ☐ Reacher ☐ Walker ☐ Rollater ☐ Cane/Quad Cane ☐ Scooter
☐ Hoyer ☐ Transfer Board ☐ Wheelchair ☐ Pressure Relief Device ☐ BSC ☐ Elevated Toilet Seat ☐ Urinal ☐ Bed Pan ☐ Pad/Diapers

CERTIFICATION: I certify that the record of personal care services shown here is true and accurate, and the personal care aide identified below performed personal care tasks in a satisfactory manner.

Signature of Administrator or Designated Supervisor

INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE

PERSONAL CARE RECORD

Month: _____ Date: _____

CHARTED DAILY

Form # MP4003L-2 (Rev. 12/14)
Reorder From: MED-PASS® 800-438-8884

DRESSING
(Record when provided)

EVENT CODES:
- **DR** = Don/Remove Clothes/Socks/Shoes
- **AC** = Assist with Clothing/Shoes/Fasteners
- **TB** = Don/Remove TEDS/Braces/ Prothesis/Splints
- **HR** = Hang/Retrieve Clothing

ASSISTANCE CODES:
See below

TRANSFER/MOBILITY
(Chart Daily)

EVENT CODES:
- **BC** = To/From Bed/Chair
- **TS** = To/From Tub/Shower
- **TR** = Turn/Reposition
- **AR** = Ambulate Room to Room
- **AS** = Assist with Stairs
- **RO** = ROM

ASSISTANCE CODES:
See below

DAY OF THE MONTH		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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ASSISTANCE CODES

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- **H** = **Hospital** – Initial by date when resident is in the hospital.
- **O** = **Other Instructions:** _____

Physician/Alt. Physician	Telephone No.	Diagnosis	Store Name

Resident/Patient/Client	Room	Bed	Patient Code	Admin. Date	Sex	Date Of Birth	Allergies	Charting For/Through	Page No.

PERSONAL CARE RECORD

Month: _____ Date: _____

CHARTED DAILY

EATING
(Provided Daily)

EVENT CODES:
AF = Assist with Cutting/Feeding
TF = Tube Feeding
CG = Chop/Grind/Puree/Thicken

ASSISTANCE CODES:
See below

	DAY OF THE MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BREAKFAST	Event																															
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LUNCH	Event																															
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COMMENTS

CERTIFICATION: I certify that the record of personal care services shown here is true and accurate, and the personal care aide identified below performed personal care tasks in a satisfactory manner.

Signature of Administrator or Designated Supervisor

INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE

PERSONAL CARE RECORD

Month: ____________ Date: ____________

CHARTED BY EXCEPTION ONLY: NOTE OCCURRENCE

TOILETING/INCONTINENCE *(Chart daily)*

EVENT CODES:

- D = Diarrhea
- R = Routine Toileting
- I = Incontinence of Bowel and/or bladder
- C = Change linen/clothing due to incontinence
- B = Bath due to incontinence
- RF = Remove/Fasten Garments
- HT = Hygiene after Toileting/Incontinence
- TT = To/From BSC or Toilet
- CB = Clean BSC/Urinal/Bedpan
- OC = Ostomy Care
- CC = Catheter Care

ASSISTANCE CODES:

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- R = **Refused**
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- O = **Other Instructions:** ____________

	DAY OF THE MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1st SHIFT OCCURRENCE	Event Code																															
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	DAY OF THE MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Physician/Alt. Physician	Telephone No.	Diagnosis	Store Name

Resident/Patient/Client	Room	Bed	Patient Code	Admin. Date	Sex	Date Of Birth	Allergies	Charting For/Through	Page No.

Form # MP4003L-3 (Rev. 12/14)
Reorder From: MED-PASS 800-438-8884

IHN081012R

PERSONAL CARE RECORD

Month: ____________________ Date: ______________

CHARTED BY EXCEPTION ONLY: NOTE OCCURRENCE

TOILETING/INCONTINENCE *(Chart daily)*

EVENT CODES:

- **D** = Diarrhea
- **R** = Routine Toileting
- **I** = Incontinence of Bowel and/or bladder
- **C** = Change linen/clothing due to incontinence
- **B** = Bath due to incontinence
- **RF** = Remove/Fasten Garments
- **HT** = Hygiene after Toileting/Incontinence
- **TT** = To/From BSC or Toilet
- **CB** = Clean BSC/Urinal/Bedpan
- **OC** = Ostomy Care
- **CC** = Catheter Care

ASSISTANCE CODES:

See Below

	DAY OF THE MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
3rd SHIFT OCCURRENCE	Event Code																															
	Total # events																															
	Asst. Code																															
	Initials																															
	Event Code																															
	Total # events																															
	Asst. Code																															
	Initials																															
	Event Code																															
	Total # events																															
	Asst. Code																															
	Initials																															
	DAY OF THE MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

ASSISTANCE CODES

- I = **Independent** – The resident can perform the activity without help or with only occasional help.
- P = **Prompt** – The resident needs to be reminded to perform the activity.
- S = **Supervision** – The resident can perform the activity when another person provides oversight, encouragement and prompting.
- LA = **Limited Assistance** – The resident is highly involved in performing the activity for him/herself, i.e., the resident requires assistance with dressing or walking less than 3 times a week.
- EA = **Extensive Assistance** – The resident can perform part of the activity him/herself. The resident requires assistance with dressing or walking more than 3 times a week.
- TD = **Totally Dependent** – Someone must complete the task for the resident at all times.
- TL = **Therapeutic Leave** – Initial by date when resident is on therapeutic leave.
- OOF = **Out of Facility** – Initial by date when resident is out of facility.
- R = **Refused**
- H = **Hospital** – Initial by date when resident is in the hospital.
- O = **Other Instructions:** ______________________

COMMENTS

CERTIFICATION: I certify that the record of personal care services shown here is true and accurate, and the personal care aide identified below performed personal care tasks in a satisfactory manner.

Signature of Administrator or Designated Supervisor

INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE	INIT.	NAME OF PC AIDE

15 Minute Checks

600a		230p		1115p	
615a		245p		1130p	
630a		300p		1145p	
645a		315p		1200md	
700a		330p		1215a	
715a		345p		1230a	
730a		400p		1245a	
745a		415p		100a	
800a		430p		115a	
815a		445p		130a	
830a		500p		145a	
845a		515p		200a	
900a		545p		215a	
915a		600p		230a	
930a		615p		245a	
945a		630p		300a	
1000a		645p		315a	
1015a		700p		330a	
1030a		715p		345a	
1045a		730p		400a	
1100a		745p		415a	
1115a		800p		430a	
1130a		815p		445a	
1145a		830p		500a	
1200p		845p		515a	
1215p		900p		545a	
1230p		915p			
1245p.		930p			
100p		945p			
115p		1000p			
130p		1015p			
145p		1030p			
200p		1045p			
215p		1100p			

30 Minute Checks

600a		630p	
630a		700p	
700a		730p	
730a		800p	
800a		830p	
830a		900p	
900a		930p	
930a		1000p	
1000a		1030p	
1030a		1100p	
1100a		1130p	
1130a		1200md	
1200n		1230a	
1230p		100a	
100p		130a	
130p		200a	
200p		230a	
230p		300a	
300p		330a	
330p		400a	
400p		430a	
430p		500a	
500p		530a	
530p		600a	
600p			

Repositioning

Level II

Purpose

The purpose of this procedure is to provide guidelines for the assessment of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chairbound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

General Guidelines

1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief.
2. Assessment of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals.
3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.
4. The care plan for a resident at risk of friction or shearing during repositioning may require the use of lifting devices for repositioning.
5. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing.

Assessment

Assessment for Appropriate Repositioning

1. Assess residents who can reposition independently to determine the following:
   a. Is a positioning device needed to maintain independent positioning?
   b. Does the resident need instruction about why turning is important?
   c. Does the resident need encouragement to reposition?
   d. Does the resident require monitoring to assure that turning occurs?
2. Assess the resident for an existing pressure ulcer. If present, positioning the resident on the existing ulcer should be avoided.
3. Assess residents who sit or recline in a chair with the back of the chair (or the back of the bed) elevated to or above a 30 degree angle:
   a. Does the resident need hourly position changes?
   b. Does the resident need position changes more frequently than hourly?
4. Components to assess when a resident is in a chair:
   a. Does the resident need intervention to maintain postural alignment?
   b. Is the resident's weight distribution even?
   c. Does the resident need devices to maintain sitting balance?
   d. Is the resident able to learn? If so, teach resident to shift his/her weight every 15 minutes while in the chair.
5. Does the resident have a Stage I pressure ulcer?

continues on next page

Interventions/ Care Strategies

A turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated.

1. Residents who are in bed should be on a q 2 hour turning program.
2. For residents with a Stage I or above pressure ulcer, q 2 hour turning is inadequate.
3. Residents who are in a chair should be on a q 1 hour repositioning program.
4. If ineffective, the turning and repositioning frequency will be increased.
5. Avoid placing resident on the greater trochanter for more than momentary placement.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

Equipment and Supplies

The following equipment and supplies will be necessary when repositioning.

1. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

Repositioning the Resident in Bed

1. Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure.
2. Wash and dry hands thoroughly.
3. Apply gloves.
4. Raise the bed to waist level.
5. Lower the side rail, if applicable, on the side where you are standing.
6. Encourage the resident to participate if able.
7. Lower the sheets.
8. Check for incontinence. Follow steps to care for the incontinent resident, if necessary.
9. Use two people and a draw sheet to avoid shearing while turning or moving the resident up in bed. Encourage resident to place feet flat on bed and assist with pushing up. Encourage the use of an overhead trapeze if resident is able to use one.
10. Raise the head of the bed as little and for as short of a time as possible, and only as necessary for meals, treatments and as medically necessary.
11. Move the resident to his or her back.
12. Move the resident's top leg and shoulder in the direction of the turn.
13. Encourage resident to hold the side rail with the top arm in the direction of the turn, if possible.
14. Place the resident in a comfortable position in accordance with the resident's individualized care plan.
15. Prevent skin-to-skin contact with use of sheets, pillows or positioning devices.
16. Lower the bed into lowest position and place the side rails in the appropriate position as indicated in the resident's plan of care.
17. Reposition the bed covers. Make the resident comfortable.
18. Place the call light within easy reach of the resident.
19. Wash and dry hands thoroughly.
20. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

continues on next page

Steps in the Procedure (continued)

Repositioning the Resident in the Chair

1. Encourage the chairfast resident, who is able to move, to change positions or shift weight at least every fifteen (15) minutes, or as often as possible.
2. Check the care plan, assignment sheet or the communication system to determine resident-specific positioning needs including special equipment; resident level of participation and the number of staff required to complete the procedure.
3. Ask the resident's permission to reposition or assist in repositioning. Take the resident to a private location, if indicated.
4. Assist the resident to change his or her position in the chair. Monitor the need for toileting or incontinence care when changing position.
5. Place resident in a comfortable position in accordance with the resident's individualized care plan.
6. Prevent skin to skin contact with use of sheets, pillows or positioning devices.
7. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The position in which the resident was placed. This may be on a flow sheet.
2. The name and title of the individual who gave the care.
3. Any change in the resident's condition.
4. Any problems or complaints made by the resident related to the procedure.
5. If the resident refused the care and the reason(s) why.
6. Observations of anything unusual exhibited by the resident.
7. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated.
3. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (CAAs)	Section M; (CAA 16)
Survey Tag Numbers	F309; F314
Related Documents	
Risk of Exposure	Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____

Sims' Position

Level II

Purpose

The purpose of this procedure is to position the resident for a rectal examination or enema administration.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.

Steps in the Procedure

1. Wash and dry your hands thoroughly before beginning the procedure.
2. Raise the height of the bed to a comfortable working level.
3. Lower the side rails on the side of the bed you are working, if up.
4. Drape the resident with a blanket. Avoid unnecessary exposure of the resident's body.
5. Encourage the resident to assist you as much as possible.
6. Turn the resident on his or her left side.
7. Extend the left leg and arm. The left arm rests behind the resident.
8. Flex the right leg and arm.
9. Position the resident's head on the pillow.
10. Reposition the bed covers. Make the resident comfortable.
11. Place the call light within easy reach of the resident.
12. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
13. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that care was given.
2. The name and title of the individual(s) who assisted with the care.
3. The position in which the resident was placed.
4. The reason for changing the resident's position.
5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure.
6. Any problems or complaints made by the resident related to the procedure.
7. If the resident refused the treatment, the reason(s) why and the intervention taken.
8. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the care.
2. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (CAAs)	Section G; (CAA 5; CAA 16)
Survey Tag Numbers	F310
Related Documents	
Risk of Exposure	Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____

Supine Position

Level II

Purpose

The purpose of this procedure is to place the resident on his or her back with the legs together and the knees slightly bent. This position is used primarily for physical examinations and assessments. This position is also called the horizontal recumbent position.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.

Steps in the Procedure

1. Wash and dry your hands thoroughly before beginning the procedure.
2. Lock arms with the resident to position the pillow under his or her head.
3. Drape the resident with a blanket. Avoid unnecessary exposure of the resident's body.
4. Encourage the resident to assist you as much as possible.
5. Instruct the resident to turn on his/her back. Assist as necessary.
6. Bring or instruct the resident to bring his or her legs together.
7. Bend or instruct the resident to bend his or her knees slightly to relax the stomach muscles.
8. Reposition the bed covers. Make the resident comfortable.
9. Place the call light within easy reach of the resident.
10. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
11. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that care was given.
2. The name and title of the individual(s) who assisted with the care.
3. The position in which the resident was placed.
4. The reason for changing the resident's position.
5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure.
6. Any problems or complaints made by the resident related to the procedure.
7. If the resident refused the treatment, the reason(s) why and the intervention taken.
8. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the care.
2. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (CAAs)	Section G; (CAA 5; CAA 16)
Survey Tag Numbers	F310
Related Documents	
Risk of Exposure	Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____

Turning a Resident On His/Her Side Away From You

Level II

Purpose

The purposes of this procedure are to provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.

Steps in the Procedure

1. Wash and dry your hands thoroughly before beginning the procedure.
2. Unless otherwise instructed, lower the head and footrest of the bed.
3. Lower the side rails on the side of the bed you are working, if up.
4. Loosen the covers as necessary. Avoid unnecessary exposure of the resident's body.
5. Slide both your arms under the resident's back to his/her far shoulder.
6. Slide the resident's shoulders toward you on your arms. (Note: Keep your knees bent and your back straight as you slide the resident toward you.)
7. Slide both your arms (as far as you can) under the resident's buttocks.
8. Slide the resident's buttocks toward you. (Note: Keep your knees bent and your back straight as you slide the resident's buttocks toward you.)
9. Slide both arms under the resident's feet and ankles.
10. Slide the resident's feet toward you. (**Note**: Keep your knees bent and your back straight as you slide the resident's feet toward you.)
11. Cross the resident's arms over his/her chest.
12. Cross the resident's leg nearest you over the leg farthest from you.
13. Stand with your weight evenly distributed on both feet. (Note: Your feet should be approximately 12 inches apart.)
14. Keep your back straight.
15. Place one hand on the resident's shoulder nearest you.
16. Place your second hand under the resident's buttocks.
17. Gently turn the resident away from you.
18. Should the resident become weak or faint during the procedure, cease the procedure and summon the staff/charge nurse.
19. Place pillows behind the resident's back to keep his/her body in proper alignment.
20. Support the resident's head with the palm of your hand.
21. With the second hand, position a pillow under the resident's neck and head.
22. Position the resident's arms and legs in a comfortable position and free from pressure.
23. Place a pillow between the resident's knees if this is comfortable to him/her.
24. Reposition the bed covers. Make the resident comfortable.
25. Reposition the bed.
26. Place the call light within easy reach of the resident.
27. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
28. Wash and dry your hands thoroughly.

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Prone Position

Level II

Purpose

The purpose of this procedure is to place the resident on his or her stomach. The resident's head is turned to one side and the arms are bent at the elbows toward the resident's head or positioned at the resident's side.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.

Steps in the Procedure

1. Wash and dry your hands thoroughly before beginning the procedure.
2. Raise the height of the bed to a comfortable working level. Unless otherwise instructed, lower the head and foot rest of the bed.
3. Lower the side rails on the side of the bed you are working, if up.
4. Avoid unnecessary exposure of the resident's body.
5. Encourage the resident to assist you as much as possible.
6. Instruct or assist the resident to turn on his or her stomach.
7. Position the resident's head on the pillow so that it is turned to the left or right side.
8. Position the resident's arms so that they are bent at the elbows toward the head or positioned at the resident's side.
9. Reposition the bed to its lowest horizontal position for the safety of the resident.
10. Reposition the bed covers. Make the resident comfortable.
11. Place the call light within easy reach of the resident.
12. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
13. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that care was given.
2. The name and title of the individual(s) who assisted with the care.
3. The position in which the resident was placed.
4. The reason for changing the resident' position.
5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure.
6. Any problems or complaints made by the resident related to the procedure.
7. If the resident refused the treatment, the reason(s) why and the intervention taken.
8. The signature and title of the person recording the data.

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The Side-Lying Position

Level II

Purpose

The purpose of this procedure is to relieve pressure points on the bedfast resident to prevent pressure ulcers. The resident is positioned on his or her side (left or right) with pillows placed under the resident's head, against the back, between the resident's legs to support the weight of the leg and foot, and under the arm to support the weight of the arm.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.

Steps in the Procedure

1. Wash and dry your hands thoroughly before beginning the procedure.
2. Raise the height of the bed to a comfortable working level. Unless otherwise instructed, lower the head and footrest of the bed.
3. Lower the side rails on the side of the bed you are working, if up.
4. Avoid unnecessary exposure of the resident's body.
5. Encourage the resident to assist you as much as possible.
6. Turn the resident on his or her side.
7. Position the top leg by bending it at the knee and bringing it to a 90° angle. Keep the bottom leg straight or slightly bent.
8. Place a pillow between the resident's legs to support the weight of the leg and foot.
9. Place a pillow under the top arm. Be sure the bottom arm is placed in a comfortable position.
10. Position a pillow (or pillows) against the resident's back.
11. Place a pillow under the resident's head.
12. When the procedure has been completed, reposition the bed covers. Make the resident comfortable.
13. Reposition the bed to its lowest horizontal position for the safety of the resident.
14. Place the call light within easy reach of the resident.
15. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
16. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that care was given.
2. The name and title of the individual(s) who assisted with the care.
3. The position in which the resident was placed.
4. The reason for changing the resident's position.
5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure.
6. Any problems or complaints made by the resident related to the procedure.
7. If the resident refused the treatment, the reason(s) why and the intervention taken.
8. The signature and title of the person recording the data.

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Locking Arms with the Resident

Level II

Purpose

The purposes of this procedure are to raise the resident's head and shoulders from the pillow so that the pillow can be adjusted and to assist the resident in moving to the head of the bed.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.

General Guidelines

When moving a resident who cannot assist you, two (2) nursing assistants will be needed to lift the resident.

Steps in the Procedure

1. Wash and dry your hands thoroughly before beginning the procedure.
2. Adjust the bed to a comfortable working position. (Note: Be sure the wheels are locked.)
3. Lower the bedside rails on the side you are working, if up. Lower the bed covers as necessary.
4. Face the head of the bed.
5. Stand with your feet approximately 12 inches apart with one foot ahead of the other.
6. Bend slightly at the knees.
7. Instruct the resident to place his or her arm under your arm and behind your shoulder. The resident's hand should be over the top of your shoulder. (Note: If you are standing on the resident's right, the resident's right arm will be locked with your right arm. The resident's right arm should be under your right arm, behind your shoulder with his or her hand on top of your right shoulder.)
8. Place your arm under the resident's arm with your hand on his or her shoulder.
9. **Count "1, 2, 3, go,"** so that you and the resident will be working together. This will allow the resident to pull himself or herself up as you support the resident. The resident should now have his or her head and shoulders raised.
10. With your free hand, turn or replace the pillow.
11. When you have repositioned or replaced the pillow, support the head and shoulder with your free hand while the resident gently eases himself or herself down.
12. Should the resident become weak or faint during the procedure, cease the procedure and summon the staff/charge nurse.
13. Reposition the bed to its lowest position for the safety of the resident.
14. Reposition the bed covers. Make the resident comfortable.
15. Place the call light within easy reach of the resident.
16. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
17. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that care was given.
2. The name and title of the individual(s) who assisted with the care.
3. The position in which the resident was placed.
4. The reason for changing the resident's position.

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Accidents and Incidents – Investigating and Reporting

Highlights

Policy Statement

All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.

Policy Interpretation and Implementation

Initiation of Investigation

1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.

Data Included on Report of Incident/Accident Form

2. The following data, as applicable, shall be included on the *Report of Incident/Accident* form:

   a. The date and time the accident or incident took place;
   b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.);
   c. The circumstances surrounding the accident or incident;
   d. Where the accident or incident took place;
   e. The name(s) of witnesses and their accounts of the accident or incident;
   f. The injured person's account of the accident or incident;
   g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions;
   h. The date/time the injured person's family was notified and by whom;
   i. The condition of the injured person, including his/her vital signs;
   j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.);
   k. Any corrective action taken;
   l. Follow-up information;
   m. Other pertinent data as necessary or required; and
   n. The signature and title of the person completing the report.

Documentation Protocols

3. This facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device.

4. This facility will adhere to the definitions in the Medical Device Reporting Act when filing the Food and Drug Administration MED-WATCH Form 3500A.

5. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a *Report of Incident/Accident* form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident.

6. The Director of Nursing shall ensure that the Administrator receives a copy of the *Report of Incident/Accident* form for each occurrence.

References	
OBRA Regulatory Reference Numbers	483.13(c); 483.25(h)(2)
Survey Tag Numbers	F226; F323
Related Documents	First Aid Treatment (*Emergency and First Aid*) Report of Incident/Accident (*See CD-ROM*)
Policy Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____

BHM SALEM TERRACE
Resident Incident and Accident Report

Resident Name: _____

Date of Incident: _____ Time: _____ AM PM Shift: 1st 2nd 3rd

Type of incident: (check all that apply)

_____ Fall _____ Sudden Illness _____ Missing Resident
_____ Skin Tear _____ Disruptive Behavior _____ Equipment Related
_____ Alleged Abuse from Employee _____ Alleged Abuse from Resident
_____ Other (describe): _____

Describe Incident:

_____

_____

_____

_____

Describe the action taken in response to the incident:

_____

_____

Location of Incident:

_____ Resident Room _____ Resident Bathroom _____ Hallway
_____ Living Room _____ Common Restroom/Bath _____ Dining Room
_____ Activity Room _____ Exterior grounds of community
_____ Off premises (describe): _____
_____ Other (describe): _____

Vital Signs: B/P _____/_____ Pulse: _____ Respirations: _____

Was EMS called: YES NO Was resident taken to hospital: YES NO
Name of Hospital: _____

Physician Notified: _____ Date: _____ Time: _____

Family Member Notified: _____ Date: _____ Time: _____

Licensure Agency Notified: _____ Date: _____ Time: _____

Staff Completing Report: _____ Date: _____ Time: _____

Resident Care Director Signature: _____ Date: _____

Executive Director Signature: _____ Date: _____

BHM Salem Terrace
24-Hour Post Fall Checklist

Resident Name: _____ Date & Time of Fall: _____

1. Always keep this 24-Hour Post Fall Checklist with the 24-Hour Report Book until completion.
2. The RCD or SIC must make entries in the resident care notes a minimum of every 8 hours post fall for 24 hours.
3. Circle Y or N each 8, 16, and 24 hours and follow the directions.
4. The RCD will file the completed 24-Hour Post Fall Checklist with the Accident form and the post fall checklist.

8-Hour Documentation: Date: _____ Time: _____

16-Hour Documentation: Date: _____ Time: _____

24-Hour Documentation: Date: _____ Time: _____

1. Does the resident have new or unusual complaints of pain/discomfort?	8 Hours Y N	16 Hours Y N	24 Hours Y N
If yes: Have the RCD assess if available of call the doctor for direction and notify the family or responsible party. Document these contacts in the resident care notes. If no: Document Post Fall check-up with date/time in resident care notes	Initials:	Initials:	Initials:

2. Does the resident have a change in walking ability (I. e. limp)?	8 Hours Y N	16 Hours Y N	24 Hours Y N
If yes: Have the RCD assess if available of call the doctor for direction and notify the family or responsible party. Document these contacts in the resident care notes. If no: Document Post Fall check-up with date/time in resident care notes	Initials:	Initials:	Initials:

3. Does the resident have any outward rotation of the leg(s) or arm(s)?	8 Hours Y N	16 Hours Y N	24 Hours Y N
If yes: Have the RCD assess if available of call the doctor for direction and notify the family or responsible party. Document these contacts in the resident care notes. If no: Document Post Fall check-up with date/time in resident care notes	Initials:	Initials:	Initials:

4. Does the resident have increased drowiness?	8 Hours Y N	16 Hours Y N	24 Hours Y N
If yes: Have the RCD assess if available of call the doctor for direction and notify the family or responsible party. Document these contacts in the resident care notes. If no: Document Post Fall check-up with date/time in resident care notes	Initials:	Initials:	Initials:

5. Does the resident have trouble or is reluctant to get out of bed?	8 Hours Y N	16 Hours Y N	24 Hours Y N
If yes: Have the RCD assess if available of call the doctor for direction and notify the family or responsible party. Document these contacts in the resident care notes. If no: Document Post Fall check-up with date/time in resident care notes	Initials:	Initials:	Initials:

Post Fall Checklist

Resident Name: _____ Date of Fall: _____ Time of Fall: _____

This checklist is to be completed by the SIC whenever a resident falls.

- Seek medical attention when the resident has any unusual pain, bleeding, head injury or body distortion after a fall
- Notify the family of responsible party. Continue your attempts until you reach them
- Notify the doctor of the fall. Continue your attempts until you have reached the doctor's office
- Check on the resident frequently after a fall and document these checks in the progress notes
- Fill out an accident report and give it to the RCD for review
- The SIC will complete the 24-hour post fall checklist and file in the 24-hour report book until complete. Once complete give to RCD to file with accident report
- When 911 must be called, call 911. Neither the resident nor the POA mat prevent the call

Please use the following questions as a guide when a resident falls. Circle yes or no

1. Is the resident alert and able to talk to you?
   Yes or No If no: Call 911

2. Did the resident hit their head?
   Yes or No If yes: Have RCD assess if available or call 911

3. Is the resident complaining of unusual pain?
   Yes or No If yes: Do not move resident and have RCD assess if available or call 911

4. Is there any bleeding?
   Yes or No If yes: Have RCD assess if available or call 911

5. Does the leg, hip or other joint appear to turn out?
   Yes or No If yes: Do not move resident and have RCD assess if available or call 911

6. Is there a scrape or skin tear?
   Yes or No If yes: Check the resident record for standing first aid orders

7. Did you notify the doctor?
   Yes or No If no: Do so now (regardless of 911 transport or injury) and document
   If yes: Document the date, time and person you spoke with in the care notes

8. Did you notify the family or responsible party for the resident?
   Yes or No If no: Do so now regardless of 911 transport or injury and document your attempts
   If yes: Document the date, time, and person you spoke with in the care notes

9. If 911 responded and the EMT recommended transportation by ambulance for further medical attention or evaluation, did the POA allow 911 to transport the resident to hospital?
   Yes or No or N/A If no: Obtain now a copy of the EMS report signed by the EMT and the POA
   If yes: Document the time of the 911 transport in the care notes

10. Did you complete the accident report as required?
    Yes or No If no: Complete now and put in RCD office for her review

11. Did you note the accident in the Resident Care Notes?
    Yes or No If no: Complete now
    If yes: Ensure the entry is signed with the date and time

12. Did you place the 24-hour Post Fall Checklist in the 24-hour report book?
    Yes or No If no: Complete top with resident name, date and time of fall and place in 24-hour report book now.

Person Completing Checklist: _____ Date/Time Completed: _____
Signature

Salem Terrace
Department Manager & SIC Meeting
Date:

Meeting Agenda:

Attending

EMPLOYEE INSERVICE SIGN-IN SHEET

TOPIC:____

PRESENTER:____

DATE____

TIME:____

EMPLOYEE NAME (print)	EMPLOYEE SIGNATURE

Perineal Care

Level II

Purpose

The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure:

1. Wash basin;
2. Towels;
3. Washcloth;
4. Soap (or other authorized cleansing agent); and
5. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Steps in the Procedure

1. Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached.
2. Wash and dry your hands thoroughly.
3. Fill the wash basin one-half (1/2) full of warm water. Place the wash basin on the bedside stand within easy reach.
4. Fold the bedspread or blanket toward the foot of the bed.
5. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet.
6. Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident's body.
7. Put on gloves.
8. Instruct the resident to bend his or her knees and put his or her feet flat on the mattress. Assist as necessary.
9. For a female resident:
   a. Wet washcloth and apply soap or skin cleansing agent.
   b. Wash perineal area, wiping from front to back.
      (1) Separate labia and wash area downward from front to back. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.)
      (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia.
      (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.)
      (4) Gently dry perineum.
   c. Instruct or assist the resident to turn on her side with her top leg slightly bent, if able.
   d. Rinse wash cloth and apply soap or skin cleansing agent.

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Steps in the Procedure (continued)

18. Clean your equipment and return it to its designated storage area (i.e., bedside stand, bathroom, etc.).
19. Discard disposable equipment and supplies in designated containers.
20. Discard towels in soiled laundry container.
21. Clean the overbed table and return it to its proper position.
22. Reposition the bed covers. Make the resident comfortable.
23. Place the call light within easy reach of the resident.
24. Wash and dry your hands thoroughly.
25. If the resident desires, return the door and curtains to the open position and if visitors are waiting tell them they may now enter the room.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record.
2. Complaints of pain or discomfort of mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record.
3. If the resident refused the treatment, the reason(s) why and the intervention taken.
4. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the mouth care.
2. Report other information in accordance with facility policy and professional standards of practice.

References	
MDS (CAAs)	Section L
Survey Tag Numbers	F272
Related Documents	
Risk of Exposure	Blood–Body Fluids–Infectious Diseases–Air Contaminants–Hazardous Chemicals
Procedure Revised	Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____

Steps in the Procedure (continued)

e. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia.
f. Rinse thoroughly using the same technique as described in "e" above.
g. Dry area thoroughly.

10. For a male resident:
    a. Wet washcloth and apply soap or skin cleansing agent.
    b. Wash perineal area starting with urethra and working outward. (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.)
        (1) Retract foreskin of the uncircumcised male.
        (2) Wash and rinse urethral area using a circular motion.
        (3) Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or water to clean the urethra.
    c. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.)
    d. Gently dry perineum following same sequence.
    e. Reposition foreskin of uncircumcised male.
    f. Instruct or assist the resident to turn on his side with his upper leg slightly bent, if able.
    g. Rinse washcloth and apply soap or skin cleansing agent.
    h. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks.
    i. Dry area thoroughly.
11. Discard disposable items into designated containers.
12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly.
13. Reposition the bed covers. Make the resident comfortable.
14. Place the call light within easy reach of the resident.
15. Clean wash basin and return to designated storage area.
16. Clean the bedside stand.
17. Wash and dry your hands thoroughly.
18. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

Documentation

The following information should be recorded in the resident's medical record:

1. The date and time that perineal care was given.
2. The name and title of the individual(s) giving the perineal care.
3. Any discharge, odor, bleeding, skin care problems or irritation, complaints of pain or discomfort.
4. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain.
5. How the resident tolerated the procedure or any changes in the resident's ability to participate in the procedure.
6. If the resident refused the procedure, the reason(s) why and the intervention taken.
7. The signature and title of the person recording the data.

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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

(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 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	All Therapeutic diets, including Nutritional supplements and Thickened liquids, shall be Served as ordered by Resident Physician. Food Service Monitoring Worksheet has been developed to record Resident name, diagnosis, date, and type of diet per current FL2. IF there is a Diet Change per FL2 Diet change Date Is recorded with new Diet Order on the Form Meal observation and Resident Interview Notes are also recorded. Diet Cards are completed Per current Physician order And are placed on Resident Tray. Dietary personnel match Diet Card to Residents' Dietary Tray (Please review Dietary Attachment A).	
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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SALEM TERRACE	2809 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 310	Continued From page 6 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 10/16/17 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,	D 310	Meal Service Audit Form Records 28 items as related To Resident's meals. This form Is used to monitor 4 Residents on Daily basis for an inclusion of all residents within the month. To begin 12/28/2017 and on going. (Meal Service Attachment B)	

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D 310	Continued From page 7 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.	D 310		

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D 310	Continued From page 8 -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	D 310		

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D 310	Continued From page 9 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	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 310	Continued From page 10 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 Helmlich 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	D 310		

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D 310	Continued From page 11 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.	D 310		

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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		

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
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D 310	Continued From page 13 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:	D 310		

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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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D 310	Continued From page 15 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."	D 310		

MEAL SERVICE AUDIT

ATTACHMENT B 2 PAGES

Meal Service Audit

Resident Name _____ **Date** _____

Diet _____

	YES	NO	COMMENTS
Diet on the diet sheet posted is consistent with physician order			
Food is consistent with posted menu			
Food was delivered on time			
Diet preferences/dislikes are honored (see page 2 on Res. Reg)			
Condiments are provided within dietary restrictions			
Food temperature is appropriate for food items (>100 degrees)			
Food items were covered on way to dining room			
Substitutions were offered if requested or food not eaten			
Substitutes are provided within 15 minutes of request			
Resident was positioned appropriately for eating			
Resident received appropriate assistance with eating (based on care plan or observed need)			
Resident was afforded sufficient time to eat			
Meals served at the same time to other nearby residents			
Disposable dinnerware was not used			
Tray was attractively arranged: food appeared appealing			
Resident appeared satisfied with meal			
Residents appear to understand dietary restrictions			
Percentage of meal consumed (Observed)			% =

Food Service Monitoring Worksheet

Facility

Meal **Surveyor**

	FL2			Diet Change from FL2			
Resident Name	Diagnosis	Date	Type Diet	Diet Change Date	New Diet Order	Diet List	Meal Observation & Resident Interview Notes

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D 421	Continued From page 16	D 421		
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	Upon the written authorization of the Resident or his legal representative or Payee, the Business Office Manager, under the supervision of the Administrator, will provide an Accounting of the money Received and disbursed. The balance in RT account will be available to the Resident or legal representativ or Payee per posted hours of Business Office operations. The record of each RT transaction will be signed by the Resident, Legal Representative, or payee, or marked by the Resident, if the resident is not adjudicated incompetent. Two witnesses' signatures must verify monthly the accuracy of the disbursement of RT Funds. The record will be maintained in Salem Terrace Business Office.	

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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	An Independent Agent is currently reviewing Resident Trust Accounts 12/28/2017 An Independent Agent from conducted/completed Resident trust accounts on 12/27/2017.	

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D 421	Continued From page 18 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	D 421		

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D 421	Continued From page 19 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	D 421		

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D 421	Continued From page 20 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	D 421		

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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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D 421	Continued From page 24 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).	D 421		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
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		

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

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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		

Resident Trust Banking Hours and Policy

1. The Resident or his/her legal representative may review the Individual Resident Trust Account Ledger by stating the request to Business Office personnel during regular business hours 9:00 AM – 5:00 PM, Monday thru Friday. Receipting of incoming money to be deposited into the Individual Resident Trust Account Ledger is also handled during these hours.

2. Withdrawals from resident trust funds may be processed through the Business Office between 10:30 AM and 11:30 PM, Monday thru Friday.
   If there is a special request for funds for the weekend, the resident or his/her legal representative, may contact the business office during regular business hours and request that funds be held out for the resident that coming weekend. They will need to sign the Resident Trust Ledger prior to close of business (5:00 PM) on the Friday of the weekend the funds are needed. Those funds will be held on the nursing med cart for the resident and/or legal representative to pick up on the weekend.
   The Resident or his/her legal representative are legally responsible for all funds that are withdrew from the Resident Trust Account by them.

3. Upon request, or upon transfer/discharge of the resident, the Facility shall promptly return all of the resident's funds to the resident, legal guardian, or designated representative.

4. If a resident passed away, funds will be payable to the Estate.

5. Additional information regarding Resident Trust Fund Services, contact the Business Office Manager or the Administrator.

6. The Resident Trust Account is subject to any and all regulations and audit procedures required by federal and state agencies.

Name [signature] Administrator

Date 11/16/17

History Note: *Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165; Eff. July 1, 2005.*

10A NCAC 13F .1104 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS

(a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident with two witnesses' signatures. The statement shall be maintained in the home.

(b) Upon the written authorization of the resident or his legal representative or payee, an administrator or the administrator's designee may handle the personal money for a resident, provided an accurate accounting of monies received and disbursed and the balance on hand is available upon request of the resident or his legal representative or payee.

(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.

(d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.

(e) All or any portion of a resident's personal funds shall be available to the resident or his legal representative or payee upon request during regular office hours, except as provided in Rule .1105 of this Subchapter.

(f) The resident's personal needs allowance shall be credited to the resident" account within 24 hours of the check being deposited following endorsement.

History Note: *Authority G.S. 131D-2.16; 143B-165; Eff. July 1, 2005.*

10A NCAC 13F .1105 REFUND OF PERSONAL FUNDS

(a) When the administrator or the administrator's designee handles a resident's personal money at the resident's or his payee's request, the balance shall be given to the resident or the resident's responsible person within 14 days of the resident's leaving the home.

(b) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given all of his personal funds within 30 days after death.

History Note: *Authority G.S. 131D-2.16; 143B-165; Eff. July 1, 2005.*

10A NCAC 13F .1106 SETTLEMENT OF COST OF CARE

(a) If a resident of an adult care home, after being notified by the facility of its intent to discharge the resident in accordance with Rule .0702 of this Subchapter, moves out of the facility before the period of time specified in the notice has elapsed, the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility.

(b) If a resident moves out of the facility without giving notice, as may be required by the facility according to Rule .0702 (h) of this Subchapter, or before the facility's required notice period has elapsed, the resident owes the facility an amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves before the facility's required notice period has elapsed, the former facility is entitled to the required payment for the notice period before the new facility receives any payment. The facility shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days after the resident leaves the facility.

(c) When there is an exception to the notice, as provided in Rule .0702(h) of this Subchapter, to protect the health or safety of the resident or others in the facility, the resident is only required to pay for any nights spent in the facility. A refund shall be made to the resident by the facility within 14 days from the date of notice.

(d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(h) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility.

(e) When a resident leaves the facility with the intent of returning to it, the following apply: