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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	=160
		HAL034098	B. WING		R- 02/1	C 6/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SALEM TE	ERRACE		SALISBURY R SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 000}	Initial Comments		{D 000}			
	conducted an follow-uinvestigation on Febru February 16, 2018. Ti	artment of Social Services up survey and complaint uary 14, 2018 through the complaint investigation uary 6, 2018 by the Forsyth				
D 072	10A NCAC 13F .0305	5(m) Physical Environment	D 072			
	(m) The requirement(1) The outside ground facilities shall be main condition;(2) If the home has a the fence shall not proor entering freely or b(3) Outdoor walkways					
	failed to maintain the and safe condition as damaged fascia board	as evidenced by: ns, and interviews, the facility outside grounds in a clean s evidenced by weather ds and weather damaged utside of one of the 500 Hall				
	The findings are:					
	initial tour on 02/14/18 facility had a front hal entrance toward the solocated in pods (circu toward the front of the	side of the facility during the 8 at 9:00 am revealed the Ilway leading from the south with residents' room Ilar structures extending e building) which were joined d by the facility as the 500				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			V. BOILDING; -		B.C.
		HAL034098	B. WING		R-C 02/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
SALEM T	EDDACE	2609 OL	D SALISBURY R	OAD	
SALEIVI II	ERRACE	WINSTO	N SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 072	Continued From page	e 1	D 072		
	Hall.				
	Observation of the out 02/16/18 at 10:00 am -The 500 Hall had poparking lot between the The pods had alumin fascia boards with virithe wooden fascia boweather damage. The pod located at the second roof rafters as a siding. A 4 to 5 foot section road had missing alunexposed decaying fascia boards of the overhead insects and vermin (litto enter into roof area -A 4 to 5 foot section southern-most end of decaying fascia board rafter as a result of the covering. This could a enter to roof area. On the back side of the activity room, there we soffit detached from the exposing wooded struinsects and potentially area. Interview on 02/16/18 facility's Maintenance -He was aware the facon frepair for the pod control of the pod contr	ds that were facing the he highway and the building. hum covered eaves and hyl covered soffits to protect hard and rafters from The right end (southern end), treet, had exposed fascia result of missing aluminum of the pod's eave facing the minum covering which so board and decaying rafter. This could allow ke mice, squirrels, or bats) at the pod had exposed and do and ends of overhead he missing aluminum hallow insects and varmints to the pod and next to the has a 3 foot section of vinyl he corner of the eave fucture. This could allow your varmints to enter to roof Be at 10:07 am with the expired and soffit was in need			

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repair about a year ago.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 50.25.1.10.		R-C	
		HAL034098	B. WING		02/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
	OLIMANA DV. OT		SALEM, NC 2		.	\dashv
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 072	Continued From page	2	D 072			
	soffits be repaired wh because the cost would he had mentioned that least 2 times with the facility's Executive Director within the lass lot of repairs that need and eaves due to the linterview on 02/16/18 Executive Director (El-She was informed by on at least 2 occasion repair to the fascia, early of the roof. -She had informed the the need for repairs. -At this point, no infort for when the repairs to soffits would be corrected.	ne facility's new Executive t 4 weeks, but there was a ded to be done to the fascia delayed roof repair. at 1:00 pm with the D) revealed: the Maintenance Director as that the facility needed aves and soffits along areas e owners and they knew of mation had been provided to the fascia, eaves, and cted.				
D 243	10A NCAC 13F .0704 Information On Home	(a)(1) Resident Contract, And	D 243			
	(a) An adult care hon administrator-in-charg with the resident or re information on the hor when changes are ma statement indicating t	and Resident Register ne administrator or ge shall furnish and review				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034098	B. WING		R-	C 6/2018
		HALU34096			02/1	0/2010
NAME OF PROVID	ER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TERRA	ACE	2609 OLD	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 243 Cor	ntinued From page	: 3	D 243			
requiby 6 in the info (1) appp (A) service (C) admires in the kep (D) notice less character (E) share (F) that recipe social control (E) share (F) that recipe social control (E) share (F) that recipe social control (E) share (uired by this Rule seach person to whe resident's recommation shall incluit the resident controllies: the contract shall vices and accommitifferent levels of seer charges or fees; the contract shall conditions that the contract shall conditions that the contract shall ministrator or administrator or administrator or responsible resident or responsible resident or responsible resident or resident or resident or resident or resident or an amendation and signature; gratuities in additional the maximum monet may be charged the maximum monet maxi	shall be signed and dated om it is given and retained d in the home. The de the following: act to which the following specify rates for resident rodations, including the cost ervice, if applicable, and any disclose any health needs facility has determined it to G.S. 131D-2(a1)(4); be signed and dated by the instrator-in-charge and the e person, a copy given to ensible person and a copy record; sponsible person shall be ensigned in the change for rate the facility, of any changes in rovided an amended ment to the contract for sign to the established rates is and enthly adult care home rate to Special Assistance end by the North Carolina mission and the North				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL034098	B. WING		R-C 02/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
041 514 5		2609 OLD	SALISBURY R	OAD	
SALEM T	ERRACE	WINSTON	I SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)) BE COMPLETE
D 243	Continued From page	2 4	D 243		
	facility failed to assure the resident/responsil change in rate was in private pay residents	as evidenced by: ews and interviews, the e the Administrator notified ble party 30 days before a itiated for 2 of 7 sampled (Residents #8, and #18).			
	The findings are:				
	03/16/17 revealed dia	t #8's current FL2 dated agnoses included chronic ession, seizures, marijuana abuse.			
	dated 10/16/12 revea	uoted as \$1900.00 on dent's room rate was 0. nentation of a signed			
	#8 revealed: -The resident was pride received a little of deposited in his accoration-When he went to get Office Manager (BON told he only had \$49 in the had glaucoma and much money he was the had requested his facility Business Official his money so the fam.	ver \$2000.00 a month unt. money from the Business d), in January 2018, he was in his trust fund account. d he could not see how			

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Division (of Health Service Regu	ulation			FORM	M APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE S	
		HAL034098	B. WING		1	-C 16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE		
		2609 OL	D SALISBURY RO	DAD .		
SALEM TI	ERRACE	WINSTO	N SALEM, NC 27	127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 243	Continued From page	e 5	D 243			
	on his account with the He was tired of the E resident there was not the resident knew he money. He did not understar not have money available him he had. He had never signed had glaucoma and conducted him he had. He only received monember took the resident was "concomplaining about he have any money in hither had called the conduction one would called the had been told by corporate because the handled the residents.	BOM always telling the ormoney in his account when was supposed to have and why he was told he did in he knew he should have than what the BOM told any transaction because he ould not see to sign. Oney for when his family ident shopping. B at 2:45 pm with a family constantly" calling him the was being told he did not is account. Orporate office several times a him back. If the new BOM to call the property in the second of the seco				

Corporate Office Manager in reference to the Trust Funds Account of Resident #8 revealed: -She produced Resident #8's statement which

Interview on 02/15/18 at 8:35 am with a

was returning his calls.

-She produced Resident #8's statement which showed Resident #8's room/board rate was changed effective 03/01/2015 without documentation authorizing the change.

-He was getting a little frustrated because no one

-He had the resident's permission to get the needed information about his account.

-The resident would be reimbursed a total of

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL034098	B. WING		02/16/2018
					1 02/10/2010
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
SALEM TI	ERRACE		SALISBURY R		
		WINSTON	I SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 243	Continued From page	e 6	D 243		
	\$3400.00. -The resident was du previous year when warmount of \$200.00 w Trust Fund Account in \$600.00. -There was no docum this deposit change. -The \$1600.00 would Resident #8's Trust A Interview on 02/15/18 Administrator reveale. She did not feel there the room rate quoted the facility was priv was free enterprise the dollar amount they child a potential residen the actual room rates.	e \$1400.00 from the vithout authorization, an as being deposited into natead of the normal mentation of authorization of also be reimbursed to account Fund. B at 4:00 pm of the ed: e was anything wrong with to Resident #8. ate owned and since this ne facility could charge any			
	02/16/17 revealed dia	debility, hyperlipidemia,			
	_	greement dated 06/06/13 of \$4500.00 for a private Care Unit.			
	signed by Resident # a changed room rate room on the Special 0	nt agreement dated 02/19/14 18's legal guardian showed of \$5500.00 for a private Care Unit. There was no the change in room rate ns in the facility.			

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SI COMPLE	
					R-0	c
		HAL034098	B. WING		1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
SALEM TE	FRRACE	2609 OLD	SALISBURY R	OAD		
OALLIN II	INVAOL	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 243	Continued From page	÷ 7	D 243			
	rate for a private roon	nce monthly rates show the n in the Special Care Unit mi private was \$3350.00.				
	#18's legal guardian of resident #18 was pro-She had not been the Everything was alreat assigned the guardiant -She knew there was through a bank that propayments for the residents funds. -She only had access benefits funds. -She paid all of the modern -She was notified in Not that the resident was room but was actually -She contacted the Control of the she was not the contacted the Control of the she was not the contacted the Control of the she was not the contacted the Control of the she was not the contacted the Control of the she was not the control of the control of the she was not the control of the contro	ivate pay. e guardian very long. idy in place when she was n case. another account set up aid the room/board				
	business and they haw hatever price they of to". -She was going to local liting the reside because of his trust at linterview on 02/15/18 Corporate Office Man Funds Account for Results -She did not know of quoted room rates in were posted by the overshe knew there was	d the right to charge hose whenever they wanted ok further into the situation. Int was being over charged ccount. at 8:35 am with a lager in reference to Trust esident #18 revealed: the discrepancy in the relation to the rates that				

-She knew the resident's agreement reflected the room was supposed to be a private room and the resident was actually in a semi private room and

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R-	С
		HAL034098	B. WING			6/2018
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE		SALISBURY RO			
(VA) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	SALEM, NC 2	PROVIDER'S PLAN OF CORRECTION	ı	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 243	Continued From page	· 8	D 243			
	#18 was being charge posted room ratesThere was no docum room rate was increaseight months in the farage eight months in the resident room rates. Interview on 02/15/18 Administrator revealers eight months eight e	dentation as to why Resident and so much more than the ded so much more than the dentation to show why the sed by \$1000.00 after only cility. The sed by \$1000.00 after only cility.				
	the actual room rates problem with "upping facility.	were, there should not be a the rates" to benefit the				
D 269	10A NCAC 13F .0901 Supervision	(a) Personal Care and	D 269			
	care to residents according plans and attend to a	Personal Care and staff shall provide personal ording to the residents' care by other personal care be unable to attend to for				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					
		1141 024000	B WING		R-C
		HAL034098	B. W. C		02/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM TERRACE			SALEM, NC 2		
	OLIMANA DV OT		1		.,
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 269	Continued From page	. 0	D 269		
D 209	Continued From page	9	D 209		
	This Rule is not met	as evidenced by:			
		ews and interviews, the			
		e 1 of 7 sampled residents			
		orovided staff assistance			
	•	wheelchair and assistance			
		belongings to another			
	resident room.	selengings to amoune.			
	The findings are:				
	Review of the facility's	s Staff Rounds Policy			
	revealed:	,			
		be routinely checked at 2			
	hour intervals.	be realinely enconed at E			
		ere the maximum time			
		nds and staff were expected			
		ents throughout their shift.			
		s were to be monitored every			
		uently to maintain personal			
	-	dentity to maintain personal			
	hygiene.				
	Paview of Pacident #	19's current FL2 dated			
	2/5/2018 revealed:	193 Current 1 L2 dated			
		age renal disease, type 2			
		on, bilateral leg amputation,			
		• •			
	•	eft arm paresis, colostomy,			
	and chronic back pair				
	-Resident #19 was no				
		d assistance with bathing			
	and dressing due to it	тітювіііту.			
	Observation on 00/45	1/10 at 2:00 pm revealed			
		5/18 at 3:00 pm revealed			
		en placed in a different room			
	with a new roommate	2.			
		3 at 9:30 am with Resident			
	#19 revealed:				
		d from her previous room on			
	02/15/18 to another re	esident room with a new	1		

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roommate.

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					R-	.c.
		HAL034098	B. WING		1	6/2018
		11112001000	<u>l</u>		1 02/1	0/2010
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	DDACE	2609 OLD	SALISBURY R	OAD		
SALEIVI IE	INNAUE	WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIAIE	DATE
				- ,		
D 269	Continued From page	e 10	D 269			
	-She was new to the 1 02/05/18.	facility and had arrived on				
	-She was non-ambula	atory and relied on a power				
	chair and staff assista	ance to complete her				
	activities of daily living	y. er from her power chair to				
		thout staff assistance.				
		aff to help her into bed				
		previous night on 02/15/18.				
	•	assist her to bed, or to				
		ate throughout third shift.				
		up in her power chair				
	-	t that her dentures fell out of				
	her mouth.					
		nad picked up and cleaned				
	her dentures for her t					
	-Her new roommate h	•				
		s that morning, because they				
		assistance and staff told				
	them it "wasn't their jo	bb" to help them unpack or				
	organize the room.					
	Interview on 02/16/18	s at 10:50 am with the				
	Director of Nursing (E					
	-She did not know this					
	performing rounds on					
		that rounds were completed				
	•	ours) or more frequently as				
	needed.	,				
	Interview on 02/16/19	at 10:20 am with a first shift				
	medication aide (MA)	*** ***********************************				
	, ,	formed her this morning				
		her shift that third shift staff				
		sident to bed the night				
	•	lept in her power chair. The				
		third shift staff had not been				
	in the room all night.	ama sime otan naa not boon				
	-The DON knew of th	e situation.				

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STATEMENT	of Health Service Regu FOF DEFICIENCIES DEF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R-C 02/16/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
SALEM TE	ERRACE		SALISBURY RO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 269	#19's roommate rever- Staff had not perform to her knowledge, and in her power wheelch was supposed to be p -She was attempting and other belongings her and her new room not help them. -She and her new room very well and were er	at 9:35 am with Resident aled: ned any rounds on third shift d had left her new roommate air all night long when she	D 269		
D 273	to meet the routine ar of residents. This Rule is not met TYPE A2 VIOLATION Based on observation reviews, the facility fa notification for 1 of 7 s #5) related to physical	2 Health Care assure referral and follow-up and acute health care needs as evidenced by: I as, interviews, and record illed to assure physician sampled residents (Resident ally and verbally aggressive ff, and other residents, and	D 273		
	Review of Resident #	5's current El 2 dated			

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03/22/17 revealed:

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	_	
		HAL034098	B. WING	B. WING		R-C 02/16/2018	
	I				02/1	0/2010	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
SALEM TE	RRACE		SALISBURY R				
	WINSTON		N SALEM, NC 2	7127			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 273	Continued From page	e 12	D 273				
	-Diagnoses of multiple and deep vein thrombe. She was listed as "co-she was non-ambula assistance with bathir -She was incontinent. Review of Resident # revealed an admission. Review on 02/15/18 of Notes revealed: -An entry dated 04/17 aggression toward outleasting and cooling ut that the resident was encouraged her to conher roommate. -An entry dated 05/03 aggression to an outs staff member. -An entry dated 05/17 aggression, rude and other residents, staff -An entry dated 06/22 aggression toward "the resident, which cause the other resident to the resident of verbal agging the dining room. The called to speak with the service of the resident with the dining room. The called to speak with the service of the resident with the dining room. The called to speak with the service of the resident with the dining room. The called to speak with the service of the resident with the dining room.	e falls, impaired mobility, posis. Constantly oriented." Actory and required and, dressing, and feeding. Of bowel and bladder. 5's Resident Register and date of 12/02/16. Of Resident #5's Resident 7/17 documented verbal attained physical therapy staff. Of 17 documented a ar roommate over the anit in the room. Staff wrote agitated and that they me to a compromise with a compromise with a compromise with a disrespectful behavior to and outside agencies. Of 17 documented verbal and outside agencies. Of 18 documented verbal and there are to fight Resident #5. Of 19 documented verbal and outside agencies. Of 19 documented verbal are new lady" and another and the "new lady" to cry and threaten to fight Resident #5. Of 19 documented another are gression to several residents are Director of Nursing was also.					
	altercation with anoth	er resident, where Resident ent with her wheelchair.					

Division of Health Service Regulation

-An entry dated 09/02/17 documented an

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Division of	<u>of Health Service Regu</u>	ılation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					D 0	
			B. WING		R-C	
		HAL034098	B: *******		02/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODE		
		2609 OL	D SALISBURY R	OAD		
SALEM T	ERRACE	WINSTO	N SALEM, NC 2	7127		
0/10/15	STIMMADY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	N O(5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	\ -7	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
				DEFICIENCY)		
D 273	Continued From page	- 13	D 273			
52.0	Continued From page	3 10	52.0			
	argument with her roo	ommate.				
	-An entry dated 09/03	3/17 documented a physical				
	altercation with her ro	oommate.				
	-An entry dated 09/05	5/17 documented Resident				
	#5 demanding staff m	nove her roommate out of				
	her room because the	e roommate's remote				
	changed Resident #5	s's TV channels.				
	-An entry dated 10/29					
	disagreement with her roommate (unknown					
	resident) regarding "h	•				
	, , ,	5/17 documented Resident				
	1	ow her roommate on the				
	_	laced the roommate's				
	wheelchair in her exit					
		2/17 documented Resident				
	_	ommate, attacked a staff				
		elchair, and threatened staff				
	· ·	1 was called to help redirect				
	the resident. Residen	•				
		th racial slurs when they				
	entered the facility.	0/40 de aumante d'af				
	-An entry dated 01/22					
		around Resident #5's left				
	eye.	2/40 de como coto de como contra				
	·	0/18 documented arguments				
		and Resident #4, her new				
		e called to the room on				
	multiple occasions.					
	_	3/18 documented Resident				
		sion toward Resident #4.				
		to go to the hospital for				
	psychiatric evaluation					
	-An entry dated 02/14	1/18 documented Resident				
		orted via EMS to a hospital				
	for a psychiatric evalu	uation.				
	-An entry dated 02/15	5/18 documented Resident				
		rom her previous room to a				
	new room with a diffe					

Interview on 02/14/18 at 10:20 am with Resident

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NAME OF PROVIDER OR SUPPLIER 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) D 273 Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.	Division of Health Service Regulation							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.			` '	` '				
NAME OF PROVIDER OR SUPPLIER SALEM TERRACE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (YA) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.				_				
SALEM TERRACE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.			HAL034098	B. WING		02/16/2018		
CX4 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 D 273 Continued From page 14 D 273 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.	NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.	SALEM T	EDDACE	2609 OLI	D SALISBURY ROA	AD			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.	SALEWI II	EM TERRACE WINSTON		N SALEM, NC 271	27			
#5 revealed: -She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	SHOULD BE COMPLETE		
-She had had several different roommates since moving to the facilityShe was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence careShe was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford itShe had "ran off her roommates" several times.	D 273	73 Continued From page 14		D 273				
Interview on 02/14/18 at 10:30 am with Resident #5's family member revealed: -They were aware of the altercation on 2/13/18Resident #5 had had several different roommates since moving to the facilityResident #5 could be difficult to get along withThey wanted to move Resident #5 to a private room but could not afford the costResident #5 insisted she was not responsible for Resident #4's injuries as she did not hit her "on purpose" and wasn't "aiming for her" when she threw the salt shakerThey were currently in the facility to facilitate Resident #5 going to the hospital for an evaluation and to talk to administration about options for moving Resident #5 or the roommate to avoid future conflictsThey had spoken with staff before regarding	D 213	#5 revealed: -She had had several moving to the facilityShe was wheelchair assist her with bathin incontinence careShe was being accus with a crystal salt sha under her refrigerator "made it all up, and heven know Resident there." -She did not know hobecause she "was as -She wanted a private itShe had "ran off her Interview on 02/14/18 #5's family member re-They were aware of -Resident #5 had had roommates since more resident #5 could be -They wanted to move room but could not af -Resident #4's injuries purpose" and wasn't threw the salt shakerThey were currently Resident #5 going to evaluation and to talk options for moving Reto avoid future conflict	bound and relied on staff to g, dressing, eating, and sed of hitting her roommate the that she had hidden to but that the roommate ow did she (Resident #4) #5 had a salt shaker under w Resident #4 was injured leep." to room but could not afford to roommates several times. B at 10:30 am with Resident evealed: the altercation on 2/13/18. It several different wing to the facility. The difficult to get along with the Resident #5 to a private ford the cost. She was not responsible for as she did not hit her "on "aiming for her" when she in the facility to facilitate the hospital for an at oadministration about esident #5 or the roommate its.					

Resident #5's behaviors when she had prior issues with other roommates, where they requested a private room, but could not afford the

increased cost they were quoted.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	HAL034098		B. WING	B. WING		
SALEM TERRACE 2609 OLD			DRESS, CITY, STA SALISBURY RO SALEM, NC 2'	OAD		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Observation on 02/14/law enforcement was transporting Resident evaluation due to her She had refused to be and was not cooperatenforcement, or EMS informed her she could interview on 2/16/18 medication aide (MA) - She knew of Resider and had written sever send to the PCP She had requested a needed) Ativan to recult request to the PCP restaff were unable to or requests for medic facility. Interview on 02/16/18 #5's primary care prospected in the properties of the propertie	Insible party for Resident #5. Insible party for Resident #5. Insible party for Resident #5. Insible at 11:00 am revealed called to assist EMS in a state to the hospital for volatile behavior on 2/13/18. Insible transported on 2/13/18 are transported on 2/13/18	D 273			

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-He had given a verbal order for Depakote for

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL034098	B. WING		02/16/2018	
NAME OF D		etheet /	DDDESS CITY STA	TE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA			
SALEM TE	RRACE		D SALISBURY R			
			ON SALEM, NC 2			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
D 273	Continued From page	e 16	D 273			
	agitation at hedtime t	to begin immediately, until				
		nt #5 during his facility visit				
	on Wednesday, 2/28/					
		a request from the facility				
		r agitation for Resident #5.				
	Interview on 02/14/18 at 11:50 am with					
	Administrator revealed:					
	-She had been told by staff after the incident on					
		cation started after Resident				
		floor to separate "her part"				
	of the room from Res	ved to the facility on 2/9/18.				
	-Staff's normal respon					
	•	rect her or remove her from				
	the situation.					
	-She was new to the	administrator position at this				
	facility, so she was no	ot sure if staff would be able				
		nted behavior reports or				
		he PCP, because she and				
	her staff were still wo					
	everything" from the					
		keep Resident #4 and				
	· ·	d and have Resident #5				
	"medicated" to avoid	rurmer issues. a psychiatric evaluation for				
	•	assault incident and had				
	Resident #5 sent to a					
		cted by the hospital after				
		and told that the resident's				
		spital staff Resident #5 did				
		health issues, so the hospital				
	did not perform a psy					
		ught back to the facility				

anywhere else."

different areas of the building.

because "she didn't have a choice to send her

-She had moved residents around to separate Resident #4 and Resident #5 into rooms in two

-She had spoken to the resident and family

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PRINTED: 03/09/2018 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		D.O.	
		HAL034098	B. WING		R-C 02/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	FRRACE	2609 OLD	SALISBURY R	OAD		
OALLIN 11	INIAOL	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 17	D 273			
	but Resident #5 canneach month for a privalent #5 because money." -She thought that Resident #5 because money." -She thought that Resident #4 took on Resident #5, she wouthe facility and keep For "couldn't get rid of any	y other placement for she didn't have enough sident #5 "acted out to try m," so she "wasn't going to ut a restraining order on all move Resident #4 out of Resident #5, because she yone that's a problem."				
	The facility's failure to notify Resident #5's physician related to physically and verbally aggressive behaviors toward staff, other residents, and outside agency staff members placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. Review of the Plan of Protection submitted by the facility dated 02/16/18 revealed: -The facility will inservice staff on the steps to take when a resident shows a change in mental status, as well as physicial status, to ensure that routine and acute health care needs are brought to the apprropriate provider. -All residents will be assessed today (02/16/18) to determine if any residents meet the need for physician referrals today, and refferral will be made immediately by the Director of Nursing. -The Director of Nursing will be responsible for ensuring ongoing compliance. CORRECTION DATE FOR THE TYPE A2					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL034098	B. WING		02/16/201	18
NAME OF D	ROVIDER OR SUPPLIER	STDEET ADI	DRESS, CITY, STA	TE ZID CODE	•	
NAIVIE OF FI	ROVIDER OR SUFFLIER		SALISBURY R			
SALEM TE	SALEM TERRACE					
			SALEM, NC 2			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
D 273	Continued From page	e 18	D 273			
	VIOLATION SHALL N 2018.	NOT EXCEED, March 18,				
D 338	10A NCAC 13F .0909	Resident Rights	D 338			
	10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.					
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents were provided a safe environment at the facility regarding 1 resident (Resident #5) who displayed physically and verbally aggressive behaviors resulting in physical injury to another resident (Resident #4).					
	The findings are:					
	03/22/17 revealed: -Diagnoses included mobility, and deep ve -She was listed as "co -She was non-ambula assistance with bathir -She was incontinent	onstantly oriented." atory and required ng, dressing, and feeding. of bowel and bladder. 5's Resident Register				
	Review of Resident #	5's Resident Notes				

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revealed:

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Division of	Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		HAL034098	B. WING		R-C 02/16/2018			
SALEM TERRACE 2609 OLD S		RESS, CITY, STA SALISBURY RO SALEM, NC 2	OAD					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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 220	0	- 40	D 220					

D 338 | Continued From page 19 D 338 -An entry dated 04/17/17 documented verbal aggression toward outside physical therapy staff. -An entry dated 04/26/17 documented a disagreement with her roommate over the heating and cooling unit in the room. Staff documented the resident was agitated and they encouraged her to come to a compromise with her roommate. -An entry dated 05/3/17 documented verbal aggression to an outside home health agency -An entry dated 05/17/17 documented verbal aggression, rude and disrespectful behavior to other residents, staff and outside agencies. -An entry dated 06/22/17 documented verbal aggression toward "the new lady" and another resident, which caused the "new lady" to cry and the other resident to threaten to fight Resident #5. -An entry dated 6/23/17 documented another instance of verbal aggression to several residents in the dining room. The Director of Nursing was called to speak with her. -An entry dated 7/12/17 documented Resident #5 was given a new roommate. -An entry dated 7/28/17 documented an altercation with another resident, where Resident #5 ran over the resident with her wheelchair. -An entry dated 9/2/17 documented an argument with her roommate. -An entry dated 9/3/17 documented a physical altercation with her roommate. -An entry dated 9/5/17 documented Resident #5 demanding staff move her roommate out of her room because the roommate's remote changed Resident #5's TV channels. -An entry dated 10/29/17 documented a disagreement with her roommate regarding "her side of the room." -An entry dated 11/5/17 documented Resident #5 threatening to "throw her roommate on the floor"

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AND PLAN OF CORRECTION HALO34098 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE_ZIP CODE 2699 OLD SALISBURY ROAD WINSTON SALEM, RC 27127 MINSTON SALEM, RC 27127 D 338 Continued From page 20 D 338 Continued From page 20 D 338 Continued From page 20 D 338 D 238 D 238 D 24	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SALEM TERRACE SOLD SALISBURY ROAD WINSTON SALEM, NC 27127 CALL OF THE PROVIDER OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE ONLY A prefer in her exit path. - An entry dated 1/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial sturs. 911 was called to help redirect the resident, Resident 450 and threatened to the responding officer with racial sturs when they entered the facility. - An entry dated 1/22/18 documented an unexplained bruising around Resident #5 self eye. - An entry dated 2/10/18 documented any unexplained bruising around Resident #4. Resident #5 and Resident #4. Her new roommate. Staff were called to the room on multiple occasions. - An entry dated 2/13/18 documented Resident #4. Resident #6 refused to go to the hospital for psychiatric evaluation. - An entry dated 2/15/18 documented Resident #5 was finally transported via EMS to a hospital for apsychiatric evaluation. - An entry dated 2/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of Resident #5's incident reports revealed: - There were no behavior reports found on file for any incident before the 2/13/18 physical assault. - There was one incident report detailing Resident #5's unexplained bruising to her left eye on 1/22/18, which documented the resident defined.	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SALEM TERRACE SOLD SALISBURY ROAD WINSTON SALEM, NC 27127 CALL OF THE PROVIDER OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETE ONLY A prefer in her exit path. - An entry dated 1/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial sturs. 911 was called to help redirect the resident, Resident 450 and threatened to the responding officer with racial sturs when they entered the facility. - An entry dated 1/22/18 documented an unexplained bruising around Resident #5 self eye. - An entry dated 2/10/18 documented any unexplained bruising around Resident #4. Resident #5 and Resident #4. Her new roommate. Staff were called to the room on multiple occasions. - An entry dated 2/13/18 documented Resident #4. Resident #6 refused to go to the hospital for psychiatric evaluation. - An entry dated 2/15/18 documented Resident #5 was finally transported via EMS to a hospital for apsychiatric evaluation. - An entry dated 2/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of Resident #5's incident reports revealed: - There were no behavior reports found on file for any incident before the 2/13/18 physical assault. - There was one incident report detailing Resident #5's unexplained bruising to her left eye on 1/22/18, which documented the resident defined.						R-C	
SALEM TERRACE CASI ID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION COMPLETE COMPLETE COMPLETE CASIN SHOULD BE CASIS REFERENCE OF TO THE APPROPRIATE COMPLETE COMPLETE CASIS REFERENCE OF TO THE APPROPRIATE COMPLETE COMPLETE CASIS REFERENCE OF TO THE APPROPRIATE COMPLETE COMPLETE COMPLETE CASIS REFERENCE OF THE APPROPRIATE COMPLETE COMPLE			HAL034098	B. WING		_	
CALL DATE DATE CALL DATE DATE CALL DATE	NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET A			TE, ZIP CODE		
CALL DATE DATE CALL DATE DATE CALL DATE		2609 OLI					
CAU ID PREFIX (FACH DEFOCK) MEAN TER PERCECED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG D PREFIX (FACH DEFOCK) MEW TER PERCECED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG D SAR	SALEM TE	ERRACE					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 338 Continued From page 20 because staff placed the roommate's wheelchair in her exit path. -An entry dated 11/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial slurs. 911 was called to help redirect the resident. Resident also referred to the responding officer with racial slurs when they entered the facility. -An entry dated 1/12/18 documented an unexplained bruising around Resident #5's left eye. -An entry dated 2/10/18 documented arguments between Resident #5 and Resident #4, her new roommate. Staff were called to the room on multiple occasions. -An entry dated 2/13/18 documented Resident #5's physical aggression toward Resident #4. Resident #5's physical aggression toward Resident #4. Resident #5's revealed: -An entry dated 2/15/18 documented Resident #5 was finally transported via EMS to a hospital for psychiatric evaluation. -An entry dated 2/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of Resident #5's incident reports revealed: -There were no behavior reports found on file for any incident before the 2/13/18 physical assault. -There was one incident report detailing Resident #5's unexplained bruising to her left eye on 1/22/18, which documented the resident denied	24.0.1=			1			0.450
because staff placed the roommate's wheelchair in her exit path. -An entry dated 11/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial slurs. 911 was called to help redirect the resident. Resident also referred to the responding officer with racial slurs when they entered the facility. -An entry dated 1/22/18 documented an unexplained bruising around Resident #5's left eye. -An entry dated 2/10/18 documented arguments between Resident #5 and Resident #4, her new roommate. Staff were called to the room on multiple occasions. -An entry dated 2/13/18 documented Resident #5's physical aggression toward Resident #4. Resident #5 refused to go to the hospital for psychiatric evaluation. -An entry dated 2/14/18 documented Resident #5 was finally transported via EMS to a hospital for a psychiatric evaluation. -An entry dated 2/14/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of Resident #5's incident reports revealed: -There were no behavior reports found on file for any incident before the 2/13/18 physical assault. -There was one incident report detailing Resident #5's unexplained bruising to her left eye on 1/22/18, which documented the resident denied	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE CC	OMPLETE
in her exit path. -An entry dated 11/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial slurs. 911 was called to help redirect the resident. Resident also referred to the responding officer with racial slurs when they entered the facility. -An entry dated 1/22/18 documented an unexplained bruising around Resident #5's left eye. -An entry dated 2/10/18 documented arguments between Resident #5 and Resident #4, her new roommate. Staff were called to the room on multiple occasions. -An entry dated 2/13/18 documented Resident #5's physical aggression toward Resident #4. Resident #5' refused to go to the hospital for psychiatric evaluation. -An entry dated 2/14/18 documented Resident #5 was finally transported via EMS to a hospital for a psychiatric evaluation. -An entry dated 2/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of Resident #5's incident reports revealed: -There were no behavior reports found on file for any incident before the 2/13/18 physical assault. -There was one incident report detailing Resident #5's unexplained bruising to her left eye on 1/22/18, which documented the resident denied	D 338	Continued From page	e 20	D 338			
falling, any physical altercations, or hitting her face on any object. The incident report was sent to Resident #5's physician and to the local county Department of Social Services, and her family	D 330	because staff placed in her exit path. -An entry dated 11/12 #5 threatened her rooperson with her whee using racial slurs. 911 the resident. Residen responding officer witentered the facility. -An entry dated 1/22/unexplained bruising eye. -An entry dated 2/10/between Resident #5 roommate. Staff were multiple occasions. -An entry dated 2/13/#5's physical aggress Resident #5 refused to psychiatric evaluation. -An entry dated 2/14/was finally transporte psychiatric evaluation. -An entry dated 2/15/had been moved from new room with a difference were no behaven any incident before the There was one incident #5's unexplained bruin 1/22/18, which docump falling, any physical and face on any object. The Resident #5's physical and face on any object.	the roommate's wheelchair 2/17 documented Resident ommate, attacked a staff clichair, and threatened staff I was called to help redirect at also referred to the th racial slurs when they 18 documented an around Resident #5's left 18 documented arguments and Resident #4, her new a called to the room on 18 documented Resident sion toward Resident #4. to go to the hospital for a. 18 documented Resident #5 d via EMS to a hospital for a b. 18 documented Resident #5 n her previous room to a arent roommate. 18's incident reports vior reports found on file for a 2/13/18 physical assault. ent report detailing Resident sing to her left eye on mented the resident denied altercations, or hitting her the incident report was sent sician and to the local county	D 336			

Division of Health Service Regulation

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					R-	C
		HAL034098	B. WING			6/2018
		11AE034090			1 02/1	0/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	FRRACE	2609 OLD	SALISBURY R	OAD		
OALLIN 11	WINSTON		SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG	REGOLATORT ORT	, , , , , , , , , , , , , , , , , , , ,		DEFICIENCY)	WAIL	
			+			
D 338	Continued From page	e 21	D 338			
	Interview on 02/14/18	3 at 10:20 am with Resident				
	#5 revealed:					
	-She had several diffe	erent roommates since				
	moving to the facility.					
	-She was wheelchair	bound and relied on staff to				
		g, dressing, eating, and				
	incontinence care.					
		sed of hitting her roommate				
		ker that she had hidden				
	_	, but the roommate "made it				
	all up".	w Resident #4 was injured				
	because Resident #5					
		e room but could not afford				
	it.	s room but oodid not unord				
	Interview on 02/14/18	at 10:30 am with Resident				
	#5's family member re	evealed:				
		the altercation on 2/13/18.				
	-Resident #5 had had					
	roommates since mov					
		e difficult to get along with.				
	·	wanted to move Resident #5				
	•	could not afford the cost.				
		she was not responsible for				
		as she did not hit her "on "aiming for her" when she				
	threw the salt shaker.	-				
		was currently in the facility to				
		going to the hospital for an				
		to administration about				
	options for moving Re	esident #5 or the roommate				
	to avoid future conflic	ts.				
	-The family member h	nad spoken with staff before				
		5's behaviors when she had				
	•	r roommates, where the				
	-	sted a private room, but				
	could not afford the in	ncreased cost the family				

member was quoted.

-The family member was the responsible party for

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-C	
		HAL034098	B. WING		1	6/2018
					1 0=	0.2010
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
iAG		,	170	DEFICIENCY)		
D 220	Oti	. 00	D 338			
D 338	Continued From page	22	D 336			
	Resident #5.					
		/18 at 12:25 pm of an				
	interaction between a					
	Administrator reveale					
		uested to feed Resident #5				
	in her temporary room per Resident #5's request to avoid the dining room. -The Administrator instructed staff that they were not to feed residents meals in their rooms.					
		ated "If they get hungry				
	enough they'll come e					
	0 ,					
	Interview on 02/16/18	at 9:45 am with Resident				
	#5's primary care pro					
	-He did not know Res	•				
	=	ues before being contacted				
	by the hospital on 2/1					
		documentation that staff at did not be a did				
	than the unexplained					
		sident #5 in January 2018				
	and had not been info					
	aggressive behaviors					
		er mentioned any of her				
		or other residents and				
		and healthy for her age.				
		al order for Depakote, used				
	to treat agitation, at be					
	•	could see Resident #5				
	during his facility visit	on Wednesday, 2/28/18.				
	Interview on 2/16/19	at 10:20 am with a first shift				
	medication aide (MA)					
		nt #5's frequent behaviors				
		al behavior reports before to				
	send to the PCP.					

-She had requested an order for a PRN (as needed) Ativan to reduce agitation with Resident

#5, but had been denied by the PCP.

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Division of Health Service Regulation					TORWIA	TTROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		HAL034098	B. WING		02/16/2	2018
NAME OF D	DOVIDED OD CUDDUED	OTDEET AL	DDDECC CITY CTA	TE 7/D CODE	-	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SALEM TE	ERRACE		D SALISBURY R			
		N SALEM, NC 2				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE ((X5) COMPLETE DATE
D 338	Continued From page	23	D 338			
	. •					
		a date for when she sent a				
	· ·	garding the PRN Ativan.				
		locate any behavior reports ation for Resident #5 in the				
	facility.	ation for resident #5 in the				
	idomty.					
	Interview on 2/14/18 a	at 11:50 am with the				
	Administrator revealed:					
	-She had been told by	staff after the incident on				
	2/13/18 that the altero	cation started after Resident				
	#5 drew a line on the	floor to separate "her part"				
	of the room from Resi					
		ved to the facility on 2/9/18.				
	-Staff's normal respon					
		rect her or remove her from				
	the situation.	Administrator position at this				
		Administrator position at this of sure if staff would be able				
		nted behavior reports or				
	•	he PCP, because she and				
	her staff were still wor					
	everything" from the p					
		keep Resident #4 and				
		d and have Resident #5				
	"medicated" to avoid	further issues.				
	-She had requested a	psychiatric evaluation for				
		assault incident and had				
	Resident #5 sent to a	•				
		cted by the hospital after				
		nd told that the resident's				
		spital staff Resident #5 did				
		nealth issues, so the hospital				
	did not perform a psy					
		ught back to the facility				
	because "she didn't h	ave a choice to send her	1			

anywhere else."

different areas of the building.

-She had moved residents around to separate Resident #4 and Resident #5 into rooms in two

-She had spoken to the resident and family

STATE FORM 6899 7GVN12 If continuation sheet 24 of 72

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						0
		HAL034098	B. WING		R-0 02/1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
041 514 5		2609 OLD	SALISBURY R	OAD		
SALEM TE	RRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	24	D 338			
	before regarding a pri but Resident #5 cann each month for a private room reward her behavior." -She thought that Resand get a private room reward her behavior." -If Resident #4 took oo Resident #4 took oo Resident #5, she wout the facility and keep F "couldn't get rid of any If Resident #5 had an would send her back another evaluation. 2. Review of Resident #5 had ar would send her back another evaluation. 2. Review of Resident -Diagnoses included of the cervical spine, cer hemiplegia, multi-infa arthritis, chronic region abnormal gait. -The resident was integeniambulatory, and bladder. Review of Resident #revealed an admission Observation on 02/14 room location reveale -Resident #4 had bee containing only a bed mattress. -All of Resident #4's bester the containing only a bed mattress.	vate room for Resident #5, ot pay for the different rate ate room. y other placement for she didn't have enough sident #5 "acted out to try n," so she "wasn't going to ut a restraining order on ald move Resident #4 out of Resident #5, because she yone that's a problem." The further altercations, she out to the hospital for the wasn't disease of rebrovascular accident with a ret dementia, rheumatoid anal pain syndrome, and an a remittently disoriented, a incontinent of bowel and was Resident Register and ate of 02/09/18.				

-There was no call bell in place in the spare room,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED		
R-C		
HAL034098 B. WING 02/16/2018		
11/12/04/00		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
SALEM TERRACE 2609 OLD SALISBURY ROAD		
WINSTON SALEM, NC 27127		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XI		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAY		
DEFICIENCY)		
D 338 Continued From page 25		
and Resident #4 did not have a call bell pendant		
on her person.		
Review of Resident #4's Resident Notes and		
Incident Reports since admission revealed:		
-Resident #4 was physically assaulted by		
Resident #5 on 02/13/18.		
-The assault resulted in a loss of consciousness.		
-Emergency Medical Services (EMS) was called to attend to Resident #4.		
-Resident #4 was taken to a local hospital for		
examination and treatment for her injuries.		
-Documented injuries included a facial hematoma		
on the right temple, and a concussion.		
Review of EMS notes dated 02/13/18 for		
Resident #4 revealed EMS notes documented		
Resident #4 had a loss of consciousness for 2		
hours.		
Review of hospital Emergency Department (ED)		
discharge paperwork dated 02/13/18 for Resident #4 revealed:		
-Resident #4 was evaluated for a head injury and		
diagnosed with a mild concussion.		
-The reason for visit and primary diagnosis listed		
on the hospital discharge information was		
"assault victim."		
-Discharge instructions included, "have someone		
stay with you for the first 24 hours after your		
injury."		
Review of the police report for the incident on		
02/13/18 revealed: Officers responded to the facility on 03/13/18 at		
-Officers responded to the facility on 02/13/18 at 11:10 pm for a report of simple assault.		
-Law Enforcement at was contacted by staff		
11:00 pm when they were alerted to Resident #4's		

injuries.

-Officers named resident #5 as the offender in the

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL034098	B. WING		02/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		2609 OL	D SALISBURY R	OAD	
SALEM TERRACE		N SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
D 338	Continued From page	26	D 338		
	assault.				
		at officers and refused to			
		ey threatened her with jail			
	time.				
		rviewed at the hospital and			
	-	consistent with assault.			
	Resident #4 with an o	ther Resident #5 assaulted			
		ted to the domestic violence			
	unit for further investig				
	•				
	Observation of Reside	ent #4 and Resident #5's			
		18 at 10:20 am revealed a			
		with a marker or crayon on			
	the noor separating ti	ne room into two sections.			
		at 10:30 am with Resident			
	#4 revealed:				
	-Resident #5 was her	roommate. into the facility on 02/09/18.			
	-Resident #5 had bee	-			
	toward her since she	, 55			
		wn a line separating the			
	room and told Reside	nt #4 she could not cross it.			
		steady on her feet and used			
		ed her to occasionally step			
		ing to get to the restroom. d Resident #5 got into an			
	argument regarding s				
		gan throwing Resident #4's			
	belongings in the floo	-			
	-When Resident #4 b	ent over to retrieve her			
	0 0	oor, Resident #5 hit her in			
	the head with an unkr				
		by EMS she had lost			
	consciousness for an between 45 minutes t	unknown amount of time			

-Staff did not discover Resident #4 unconscious in her room, and Resident #5 did not report

Resident #4's injuries to staff.

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-	С	
HAL034098		B. WING		1	6/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM T	FRRACE	2609 OLD	SALISBURY R	OAD		
OALLIII I		WINSTON	I SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 27	D 338			
D 330	-When Resident #4 re went to the nurse's st assistance from staffStaff called 911 and came to the facilityShe was transported she received a CAT st to determine the serictShe returned to the famWhen she arrived be to place her back in the roommate that assautShe complained and needed to be placed roommateStaff then moved her placed it on an empty unoccupied room that renovationsShe was placed in the access to any of her leaded to be able to the room where she can be done her bed to be able to the room when she got up for the Resident #5 had brain an off her roommate. Observation on 02/15 interaction between a Administrator reveale separating Resident #4 Administrator stated, order so they don't hake Resident #4 has a procession on the separating Resident #4 has a procession on the separating Resident #4 has a procession when the separat	egained consciousness, she ration and requested law enforcement and EMS I by EMS to a hospital where scan and neurological testing pusness of her head injury. Facility by EMS around 4:00 rack at the facility, staff tried the same room with her led her. I EMS told staff that she separately from the rattress from her bed and room box spring in an at was undergoing re spare room without belongings. Felchair and walker across could not access them from reach the restroom. Her again until morning breakfast. Togged to her that she "always s." Sold at 12:25 pm of an affirst shift MA and the				

Division of Health Service Regulation

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PRINTED: 03/09/2018 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL034098	B. WING		02/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
	OLUMBA DV OT		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	28	D 338			
	Resident #4 had beer room with a new room	i/18 at 3:00 pm revealed in placed back in her original inmate, and Resident #5 had the room and placed in a fection of the hall.				
D 392	10A NCAC 13F .1008	8(a) Controlled Substances	D 392			
	10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.					
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 3 of 7 residents sampled (#7,#14, and #1) who were prescribed controlled substances including oxycodone, clonazepam, and Ativan (lorazepam).					
	The findings are:					
	Controlled Substance Controlled drug order Administration Record or Assisted Living at t controlled drug so that document the administrate, time, and quant	stration of each dose as to ity.				
	Review of the facility's	s Medication Administration				

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						<u> </u>
		1141 004000	B. WING		R-	
		HAL034098			02/1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE		SALEM, NC 2			
	CLIMMA DV CT		T	T		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 392	Continued From page	20	D 392			
D 392	Continued From page	29	D 392			
	Record (MAR) policy	revealed:				
	-"All staff members ac	dministering medication				
	shall indicated admini	istered doses with his/her				
	initials in the appropri	ate block on the MAR.				
	-Staff should docume					
		of the MAR for medications				
	given as needed (PRI	N).				
	,	•				
	1. Review of Resider	nt #7's current FL2 dated				
	06/08/17 revealed diagnoses included arthritis,					
	atrial flutter, and cong	gestive heart failure.				
	_					
	Review of Resident #	7's Resident Register an				
	admission date of 06/	_				
	A. Review of Resider	nt #7's physician's orders				
	dated 10/05/17 revea	led an order for oxycodone				
	10 mg (a narcotic pair	n reliever used to treat				
	moderate to extreme	pain) take 1 tablet by mouth				
	3 times a day for pain	i.				
	Review of Resident #	7's physician's orders dated				
	11/02/17 revealed a s	subsequent physician's order				
		(a narcotic pain reliever				
	used to treat moderat	te to extreme pain) take 1				
	tablet by mouth 3 time	es a day, as needed for				
	pain.	•				
	Review of Resident #	7's November 2017				
	Medication Administra	ation Record (MAR)				
	revealed:					
	-An entry for Oxycodo	one 10 mg one tablet 3 times				
	a day was transcribed	d on the MAR, scheduled for				
		am, 2:00 pm, and 8:00 pm.				
		ocumented from 11/01/17 to				
	11/09/17.					
	-An entry for Oxycodo	one 10 mg one tablet 3 times			ĺ	
	a day was handwritte					
		nistration as needed (nrn)				

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from 11/10/17 to 11/30/17. (Medications

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPL	EIED
			B. WING		R-	_
		HAL034098	B. WING		02/1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE	2609 OLD	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 30	D 392			
	-	ould have documentation a administered, reason for ffectiveness of the				
	day was transcribed of	ation Record (MAR) 10 mg one tablet 3 times a				
	Review of Resident #7's CSCS (Controlled Substance Count Sheet) for oxycodone 10 mg dispensed on 11/02/17 and documented for administration from 11/10/17 to 12/10/17 compared to Resident #7's November 2017 and December 2017 MARs revealed: -There were 20 doses of oxycodone 10 mg documented as administered on the CSCS that were not documented on the November 2017 MAR. -There were 9 doses of oxycodone 10 mg documented as administered on the CSCS that were not documented on the December 2017 MAR.					
	the CSCS as administ on Resident #7's Nov time administered, re effectiveness were as -Oxycodone 10 mg w CSCS on 11/10/17 at but was not documen -Oxycodone 10 mg w CSCS on 11/11/17 at but was not documen -Oxycodone 10 mg w -Oxycodone 10 mg w	one 10 mg documented on stered but not documented sember 2017 MAR including ason for administering and as follows: as documented on the 8:00 pm as administered, sted on the resident's MAR. as documented on the 12:30 pm as administered, sted on the resident's MAR. as documented on the 8:00 pm, and 8:00				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
HAL034098		B. WING			R-C 2/16/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEIVI II	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 392	Continued From page	31	D 392			
D 392	pm as administered, it the resident's MAR. -Oxycodone 10 mg w CSCS on 11/18/17 at but was not documen -Oxycodone 10 mg w CSCS on 11/27/17 at but was not documen Examples of oxycodo the CSCS as adminis on Resident #7's Dec time administered, reseffectiveness were as -Oxycodone 10 mg w CSCS on 12/01/17 at but was not documen for time. -Oxycodone 10 mg w CSCS on 12/03/17 at but was not documen -Oxycodone 10 mg w CSCS on 12/05/17 at but was not documen -Oxycodone 10 mg w CSCS on 12/07/17 at but was not documen -Oxycodone 10 mg w CSCS on 12/07/17 at but was not documen -Oxycodone 10 mg w CSCS on 12/09/17 at but was not documen -Oxycodone 10 mg w CSCS on 12/05/17 at but was not docume	as documented on the 8:00 pm as administered, ted on the resident's MAR. as documented on the 2:00 pm as administered, ted on the resident's MAR. as documented on the 10 mg documented on tered but not documented ember 2017 MAR including ason for administering and	D 392			
	Refer to interview on	02/16/18 at 8:11 a.m. with				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLETED		
					R-C	
		HAL034098	B. WING		02/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	•	
TWWIL OF T	NOVIDEN ON OUT FEEL		SALISBURY R	•		
SALEM TE	ERRACE		SALEM, NC 2			
	OLIMANA DV OT		· ·			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	e 32	D 392			
	the Staff Developmen	nt Coordinator.				
	Refer to interview on 02/16/18 at 8:35 a.m. with a medication aide (MA).					
	Refer to interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MAS).					
	Refer to interview on 02/16/18 at 11:10 a.m. with the Director of Nursing.					
	Refer to interview on 02/16/18 at 2:35 pm with the Administrator.					
	B. Review of Resident #7's physician's orders dated 11/27/17 revealed an order for clonazepam 0.5 mg (used to treat anxiety) one tablet twice daily as needed. Not to exceed 2 tablets in 24 hour period.					
	Telephone interview on 02/15/18 at 11:10 am with the contract pharmacy revealed Resident #7 had clonazepam 0.5 mg one tablet twice a day, as needed, dispensed on 11/27/17 for a quantity of 60 tablets and on 12/21/17 for a quantity of 60 tablets.					
	anxiety) one tablet tw anxiety; Not to excee was transcribed on th administration 5 times (Medications adminis documentation for times	ation Record (MAR) 1 0.5 mg (used to treat 1 ce daily as needed for 2 tablets in 24 hour period 1 e MAR and documented for 2 from 11/28/17 to 11/30/17. 1 tered "prn" should have 1 e and by whom 1 for administration, and				

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Review of Resident #7's December 2017 MAR

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL034098	B. WING		02/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM TI	ERRACE	WINSTON	SALEM, NC 2	7127	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIE DATE
D 202	O	- 20	D 392		
D 392	Continued From page	2 33	D 392		
		0.5 mg one tablet 2 times a			
	•	nxiety, was transcribed on			
		ented for administration as			
	needed (prn) from 12	/01/17 to 12/31/17.			
	Review of Resident #	7's January 2018 MAR			
		0.5 mg one tablet 2 times a			
		nxiety, was transcribed on			
	•	ented for administration as			
	needed (prn) from 01/01/17 to 01/26/17.				
	Davious of Davidant #	7's CSCS (Controlled			
	Review of Resident #	eet) for clonazepam 0.5 mg			
		7 and documented for			
	•	1/27/17 to 12/26/17 (at 8:00			
		sident #7's November 2017			
	and December 2017 I				
	-There was 1 dose of	clonazepam 0.5 mg			
		nistered on the CSCS that			
		on the November 2017			
	MAR.	of alan area 0.5 man			
		of clonazepam 0.5 mg nistered on the CSCS that			
		I on the December 2017			
	MAR.	Ton the December 2017			
	W u C.				
	Examples of clonazer	oam 0.5 mg documented on			
	the CSCS as adminis	tered but not documented			
	on Resident #7's Nov	ember 2017 and December			
		time administered, reason			
		effectiveness) were as			
	follows:	was decomposited as the			
		was documented on the 4:00 pm as administered,			
	but was not documen	The state of the s			
	November 2017 MAR				
		was documented on the			
		8:00 am and 4:00 pm as			
		s not documented on the			
	resident's December				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SALEM TERRACE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CASH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MARClonazepam 0.5 mg was documented on the CSCS on 12/08/17 at 8:00 am as administered, CSCS on 12/08/17 at 8:00 am as administered,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	` `		(X3) DATE SURVEY COMPLETED	
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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the			A. BUILDING: _				
SALEM TERRACE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG D 392 Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MARClonazepam 0.5 mg was documented on the CSCS on mg was documented on the clonazepam 0.5 mg was documented 0.5 mg was doc	HAL034098 B. WING _		B. WING				
SALEM TERRACE WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG D 392 Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MARClonazepam 0.5 mg was documented on the	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•		
WINSTON SALEM, NC 27127 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the	CALEM TERRACE	2609 OLD	SALISBURY R	OAD			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the	SALEM TERRACE	WINSTON	SALEM, NC 2	7127			
-Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MARClonazepam 0.5 mg was documented on the	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE	
CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MARClonazepam 0.5 mg was documented on the	D 392 Continued From page	e 34	D 392				
but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/09/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. Review of Resident #7's CSCS for clonazepam 0.5 mg dispensed on 12/21/17 and documented for administration from 12/26/17 to 01/24/18 (at 8:00 am) compared to Resident #7's December 2017 and January 2018 MARs revealed there were 3 doses of clonazepam 0.5 mg documented as administered on the CSCS that were not documented on the January 2018 MAR. Doses of clonazepam 0.5 mg documented on the CSCS as administered but not documented on Resident #7's January 2018 MAR (including time administered, reason for administering and effectiveness) were as follows: -Clonazepam 0.5 mg was documented on the CSCS on 01/14/18 at 8:00 am as administered, but was not documented on the resident's January 2018 MARClonazepam 0.5 mg was documented on the CSCS on 01/14/18 at 4:00 pm as administered, but was not documented on the resident's January 2018 MARClonazepam 0.5 mg was documented on the CSCS on 01/14/18 at 01 pm as administered, but was not documented on the resident's January 2018 MAR.	-Clonazepam 0.5 mg CSCS on 12/07/17 a but was not documer December 2017 MAF -Clonazepam 0.5 mg CSCS on 12/08/17 a but was not documer December 2017 MAF -Clonazepam 0.5 mg CSCS on 12/09/17 a but was not documer December 2017 MAF -Clonazepam 0.5 mg CSCS on 12/21/17 a but was not documer December 2017 MAF -Clonazepam 0.5 mg CSCS on 12/21/17 a but was not documer December 2017 MAF -Clonazepam 0.5 mg CSCS on 12/21/17 a but was not documer December 2017 MAF Review of Resident # 0.5 mg dispensed on for administration from 8:00 am) compared t 2017 and January 20 were 3 doses of clonase administered on the J Doses of clonazepam CSCS as administered Resident #7's Januar administered, reason effectiveness) were a -Clonazepam 0.5 mg CSCS on 01/14/18 a but was not documer January 2018 MARClonazepam 0.5 mg CSCS on 01/14/18 a	was documented on the 4:00 pm as administered, ated on the resident's R. was documented on the 8:00 am as administered, ated on the resident's R. was documented on the 4:00 pm as administered, ated on the resident's R. was documented on the 4:00 pm as administered, ated on the resident's R. Was documented on the 4:00 pm as administered, ated on the resident's R. 47's CSCS for clonazepam 12/21/17 and documented m 12/26/17 to 01/24/18 (at to Resident #7's December 18 MARs revealed there azepam 0.5 mg documented are CSCS that were not anuary 2018 MAR. 10.5 mg documented on the ed but not documented on y 2018 MAR (including time for administering and as follows: was documented on the 8:00 am as administered, ated on the resident's	D 392				

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-Clonazepam 0.5 mg was documented on the

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Division c	of Health Service Regu	ulation			FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		HAL034098	B. WING		R- 02/1	-C 16/2018
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	ATE, ZIP CODE		
I SALEM TERRACE		SALISBURY R				
	OLIMAN DV. OT		N SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 35	D 392			
	CSCS on 01/23/18 at but was not documen January 2018 MAR.	t 8:00 pm as administered, nted on the resident's				
	Interview on 02/16/18 at 8:45 am with Resident #7 revealed: -She received her medication for anxiety 2 times a dayShe had to request the anxiety medication for a while but now it was scheduled 2 times a dayShe was not aware of a time when she did not receive her medication 2 times in a day. Refer to interview on 02/16/18 at 8:11 a.m. with the Staff Development Coordinator.					
	Refer to interview on medication aide (MA)	02/16/18 at 8:35 a.m. with a).				
	Refer to interview on Medication Aide/Supe	02/16/18 at 10:20 am with a ervisor (MAS).				
	Refer to interview on the Director of Nursin	02/16/18 at 11:10 a.m. with ng.				
	Refer to interview on Administrator.	02/16/18 at 2:35 pm with the				
	11/10/17 revealed dia	nt #14's current FL2 dated agnoses that included es mellitus, and chronic back				

revealed:

Review of Resident #14's Resident Register revealed an admission date of 05/08/17.

Review of Resident #14's physician's orders

-There was an order dated 11/17/17 for oxycodone 15 mg one tablet every 6 hours as

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Division C	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		СОМІ	PLETED
					l ,	R-C
		HAL034098	B. WING			1/16/2018
		TIAL COTOGO			1 02	110/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	ΓE, ZIP CODE		
SALEM TE	DDACE	2609 OLD	SALISBURY RO	DAD		
JALLIN IL	INIACL	WINSTON	N SALEM, NC 27	'127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	e 36	D 392			
	per day). -There was an order oxycodone 15 mg on needed for pain (Do reper day). -There was an order oxycodone 15 mg on needed for pain (Do reper day). -There was an order oxycodone 15 mg on needed for pain (Do reper day). -There was an order oxycodone 15 mg on needed for pain (Do reper day). Telephone interview of the contract pharmach had oxycodone 15 mg on 11/17/17, oxycod 6 hours as needed for than 3 tablets per day of 60. -On 12/11/17, oxycod 6 hours as needed for than 3 tablets per day of 30. -On 12/22/17, oxycod times a day as needed than 3 tablets per day of 90. -On 01/22/18, oxycod times a day as needed than 3 tablets per day of 60. Review of Resident #	e tablet every 6 hours as not use more than 3 tablets dated 12/22/17 for e tablet 3 times a day as not use more than 3 tablets				
	date 11/17/17 adminis	stered from 11/22/17 to o Resident #14's Medication				

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Administration Records (MARs) revealed:

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL034098	B. WING		02/16/2018
NAME OF B		070557	DDD500 0171/ 074	FF 710 000F	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
SALEM TE	ERRACE		D SALISBURY RO		
		WINSTO	N SALEM, NC 27	7127	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	I
		,		DEFICIENCY)	
D 202	0 (1 15	0.7	D 202		
D 392	Continued From page	37	D 392		
	-There were 7 doses	of oxycodone 15 mg			
	documented as admir	nistered on the CSCS that			
	were not documented	I on Resident #14's			
	December 2017 MAR	ds.			
	-Oxycodone 15 mg w	as documented on the			
	CSCS on 12/03/17 at	2:00 pm as administered,			
	but was not documen	ted on the resident's MAR.			
	-Oxycodone 15 mg was documented on the CSCS on 12/04/17 at 2:00 pm as administered,				
		ted on the resident's MAR.			
		as documented on the			
		2:00 pm as administered,			
		ted on the resident's MAR.			
		as documented on the			
		8:00 am and 2:00 pm as			
	resident's MAR.	s not documented on the			
		as decumented on the			
	-	as documented on the 4:30 pm as administered,			
		ted on the resident's MAR.			
		as documented on the			
		8:00 pm as administered,			
		ted on the resident's MAR.			
	Review of Resident #	14's CSCS for oxycodone			
	15 mg for dispense da	ate 12/11/17 administered			
	from 12/12/17 to 12/2	3/17 compared to Resident			
	#14's Medication Adm	ninistration Records (MARs)			
	revealed there were 1	11 doses of oxycodone 15			
	mg documented as a	dministered on the CSCS			
		ented on Resident #14's			
	December 2017 MAR				
	Examples were as fol				
		as documented on the			
		8:00 pm as administered,			
		ted on the resident's MAR.			
		as documented on the			
	CSCS on 12/19/17 at	8:00 am and 3:00 nm as	1		

Division of Health Service Regulation

resident's MAR.

administered, but was not documented on the

STATE FORM 6899 7GVN12 If continuation sheet 38 of 72

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	
			D WING		R-	
		HAL034098	B. WING		02/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TVAIVIL OF T	TOVIDER OR OUT FEIER					
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	KIATE	DAIL
D 392	Continued From page	e 38	D 392			
	0					
		as documented on the				
		2:05 pm as administered,				
		ted on the resident's MAR.				
		as documented on the				
	CSCS on 12/22/17 at	8:00 am and 2:00 pm as				
	administered, but was	s not documented on the				
	resident's MAR.					
	-Oxycodone 15 mg w	as documented on the				
	CSCS on 12/23/17 at	2:00 pm as administered,				
	but was not documen	ted on the resident's MAR.				
	Review of Resident #	14's CSCS for oxycodone				
	15 mg for dispense da	ate 12/22/17 administered				
		2/18 compared to Resident				
		there were 11 doses of				
		cumented as administered				
		re not documented on				
		mber 2017 and January				
	2018 MARs.	noon zonn and bandary				
	Examples were as fol	llows:				
	•	as documented on the				
		8:00 pm as administered,				
	but was not documen	•				
	December 2017 MAR					
		as documented on the				
		8:00 pm as administered,				
	but was not documen					
	December 2017 MAR					
	,	as documented on the				
		8:00 am and 2:00 pm as				
		s not documented on the				
	resident's December					
		as documented on the				
		8:00 pm as administered,				
	but was not documen	ted on the resident's				
	January 2018 MAR.					
		as documented on the				
	CSCS on 01/10/18 at	2:00 pm as administered,				
	but was not documen	ted on the resident's				

Division of Health Service Regulation

January 2018 MAR.

STATE FORM 6899 7GVN12 If continuation sheet 39 of 72

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
					R-C	
		HAL034098	B. WING		02/16/	
		13/1200 1000	I		1 02/10/	2010
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	FRRACE	2609 OL	D SALISBURY RO	DAD		
OALLINITE	WINSTON SA			7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	RIATE	DATE
			+			
D 392	Continued From page	e 39	D 392			
	-Oxycodone 15 mg w	as documented on the				
		5:00 pm as administered,				
	but was not documen	•				
	January 2018 MAR.					
	·					
	Review of Resident #	14's CSCS for oxycodone				
	15 mg for dispense da	ate 01/22/18 administered				
	from 01/23/17 to 02/1	4/18 compared to Resident				
	#14's MARs revealed	there were 16 doses of				
		cumented as administered				
		re not documented on				
		ry 2018 and February 2018				
	MARs.					
	Examples were as fol					
	-	as documented on the				
		6:00 pm as administered,				
	but was not documen	ted on the resident's				
	January 2018 MAR.	as documented on the				
		8:25 am as administered,				
	but was not documen	•				
	January 2018 MAR.	ted on the resident s				
	<u>-</u>	as documented on the				
		5:00 pm as administered,				
	but was not documen	ted on the resident's				
	January 2018 MAR.					
	-Oxycodone 15 mg w	as documented on the				
		12:00 pm as administered,				
	but was not documen	ted on the resident's				
	February 2018 MAR.					
	-	as documented on the				
		8:00 am as administered,				
	but was not documen	ted on the resident's				
	February 2018 MAR.					
	Intension on 00/40/40	at 9:00 am with Resident				
	#14 revealed:	at 3.00 am with Resident				

-She received her pain medication 3 times a day. -Her pain medication was ordered prn (as needed) and she knew to request the medication.

STATE FORM 6899 7GVN12 If continuation sheet 40 of 72

	of Health Service Regu					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		D 0	
		HAL034098	B. WING		R-C 02/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CALEME	FRRACE	2609 OLD	SALISBURY R	OAD		
SALEM T	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	· 40	D 392			
	-She was not aware of receive 3 tablets daily	of a time when she did not				
	Refer to interview on the Staff Developmen	02/16/18 at 8:11 a.m. with t Coordinator.				
	Refer to interview on medication aide (MA)	02/16/18 at 8:35 a.m. with a				
	Refer to interview on Medication Aide/Supe	02/16/18 at 10:20 am with a ervisor (MAS).				
	Refer to interview on the Director of Nursing	02/16/18 at 11:10 a.m. with g.				
	Refer to interview on Administrator.	02/16/18 at 2:35 pm with the				
		nt #1's current FL2 dated gnoses included dementia, ea and back pain.				
	04/06/17 revealed an (used to treat anxiety)	1's physician's orders dated order for Ativan 0.5 mg take ½ tablet 0.25mg every agitation not to exceed 2				
	Count Sheet (CSCS)	compared to Resident #1's				
	-There were 6 doses documented as admir were not documented 12/28, 1/14, 1/15, 1/2 -Ativan 0.25mg was d	nistered on the CDCS that on the MARs (12/16,				

documented on the resident's MAR.

STATE FORM 6899 7GVN12 If continuation sheet 41 of 72

Division	of Llocath Consider Dogs	ulation			FORM	APPROVED	
STATEMENT	of Health Service Regur FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R-C 02/16/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
SALEM TI	ERRACE		SALISBURY R				
			SALEM, NC 2			T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 392	Continued From page	e 41	D 392				
	-Ativan 0.25mg was o	documented on the CSCS on					
		as administered, but was not					
	documented on the re						
	_	documented on the CSCS on					
	01/14/18 at 8:00 pm as administered, but was not documented on the resident's MAR.						
	-Ativan 0.25mg was documented on the CSCS on						
	01/15/18 at 8:00 pm as administered, but was not						
	documented on the r						
	_	documented on the CSCS on as administered, but was not					
	documented on the re						
		documented on the CSCS on					
		as administered, but was not					
	documented on the re	esident's MAR.					
	Interview on 02/15/18	3 at 5:15 pm with a					
	medication aide (MA)						
		edications to Resident #1.					
		PRN (as needed) controlled ed it on the MAR and then					
	signed it out on the C						
	_	he medication, she would					
	then document on the	e MAR the time, medication					
	and reason given.						
		ne medication, she would hen document why the					
		the medication and dispose					
	of it.						
	-	nedication, she would go					
		on the effectiveness of it					
	with the resident and						
	,	It in training and on her state posed to document it.					

-She did not know why she had documented a prn medication on the CSCS but had not documented it on the MAR, "it was a mistake."

Refer to interview on 02/16/18 at 8:11 am with the

Staff Development Coordinator.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			_
		HAL034098	B. WING		R-0 02/10	5/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CALEME		2609 OLI	SALISBURY R	OAD		
SALEM TERRACE WINSTON			N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 42	D 392			
	Refer to interview on medication aide (MA)	02/16/18 at 8:35 am with a				
	Refer to interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MAS). Refer to interview on 02/16/18 at 11:10 am with the Director of Nursing. Refer to interview on 02/16/18 at 2:35 pm with the Administrator.					
	Interview on 02/16/18 at 8:11 am with the Staff Development Coordinator revealed: -The MA's were supposed to initial on the front of the MAR, turn over on the back and document date, route and reason and then wait and go back to document the effectiveness. -They were supposed to sign the medication out in the CSCS book. -Sometimes they would document in the nursing notes that they gave it but it was not required. -She was responsible for checking the MARs to make sure there were no holes in them, and that MAs had documented the reason given and signed. -She had been trying to check on this dailyShe started this process in January (she did not					
	recall the exact date) -She would check 1st medication pass, so t while the staff were s -For other shifts and t them the next day an- leave it for the MA to -The MARs were not	s shift right after the he MARs could be corrected till there. weekends, she would check d document the hole and				

Division of Health Service Regulation

-She looked at the CSCS to make sure

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Division of	of Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-0	C
		HAL034098	B. WING		1	6/2018
					1	5/LU:0
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•		
SALEM TE	ERRACE		SALISBURY RO			
		WINSTON	SALEM, NC 27	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
17.0		,		DEFICIENCY)		
D 202	Continue d From Bond	-10	D 392			
D 392	Continued From page	÷ 43	D 392			
	medications had beer	n signed out for.				
	-She had not compare	red the CSCS to the MARs				
	as part of her audit.					
		3 at 8:35 am with a MA				
	revealed:					
		CSCS log, documenting the				
	required information f	nrst. he medication she would				
	then document it on t					
		a system that was in place				
		ut they did have the CSCS				
		ed at the end of the week.				
		d on how to complete the				
		ed for giving medication.				
		end of the shift to check the				
		she had completed her				
	documentation.					
	Interview on 02/16/18	3 at 10:20 am with a				
		ervisor (MA/S) revealed:				
	· ·	staff should be logging				
	medication out on the	e CSCS, then documenting				
		residents' MAR, including				
		nation on back of the MAR				
	for reason, effectiveneral and initials.	ess, time of administration,				
		to review the MARs for				
	completeness prior to					
	-	ave a system in place for				
	, ,	CSCS sheets compared to				
	the residents' MARS I	for the "prn" medications.				
	Interview on 02/16/18	3 at 11:10 am with the				
	Director of Nursing re					
	-She expected the Ma	As to know how to document				
	on the MARs and CS	CS.				
	-They were taught ho	w as part of their orientation				

program.

-She observed all new MAs to make sure they

STATE FORM 6899 7GVN12 If continuation sheet 44 of 72

Division of	<u>f Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					_	0
		1141 02 4000	B. WING		R-	
		HAL034098			02/1	6/2018
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY RO	DAD		
SALEM TE	RRACE	WINSTO	N SALEM, NC 27	7127		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 392	Continued From page	44	D 392			
	. •					
		ident with the medication,				
		Rs and narcotic sheets.				
		ited daily for holes by the				
	Staff Development Co					
		elopment Coordinator being				
		ibility to check the MARs				
	-	are Coordinators (RCCs)				
	•	checking the MARs daily.				
	-There was a shift co					
		ed who had MARs that				
	needed to be finished					
	•	ent Coordinator called the				
	staff back in to correct	t when holes were found on				
	the MARs.					
	-Weekend problems v	were captured on Mondays.				
		ny documentation prior to the				
	new system (02/01/18	3) to show their chart audits.				
	-They educated their	staff by looking at				
	medication errors and	then gearing classes and				
	training on the proble	m areas.				
	-She did not know that	at the record audits did not				
	include matching the	MARs with the CSCS and				
	would add this to their	r process.				
	Interview on 02/16/18	at 2:35 pm with the				
	Administrator reveale					
		lity as Administrator the first				
	week of January 2018					
		edication aides were not				
		ninistration of "prn" controlled				
	medications properly.					
	-The Resident Care C	Coordinator (RCC) and				
	Special Care Unit Co	ordinator (SCUC) were				
	responsible to manag	ing medication				
	administration includi	ng compliance with control				
	drug documentation of	of administration.				
{D 421}	10A NCAC 13F .1104	(c) Accounting For	{D 421}			

Resident's Personal Funds

STATE FORM 6899 7GVN12 If continuation sheet 45 of 72

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R-C 02/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	2609 OLD	DRESS, CITY, STA SALISBURY RO SALEM, NC 2'	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 421}	Personal Funds (c) A record of each of the resident's personal funds resident, legal repressions the resident, if not with two witnesses' siverifying the accuracy personal funds. The in the home. This Rule is not met FOLLOW-UP TO TYFE Based on these finding Violation was not abased on observation reviews, the facility fat transaction involving was maintained in the resident with two with	Accounting For Resident's cransaction involving the use onal funds according to Rule shall be signed by the entative or payee or marked adjudicated incompetent, gnatures at least monthly of the disbursement of record shall be maintained as evidenced by: PE B VIOLATION ags, the previous Type B ted. as, interviews and record illed to ensure each the use of personal funds a facility and signed by the esses' signatures at least	{D 421}			
	personal funds for 7 c	uracy of the disbursement of of 7 sampled residents . #11, #12, #18 and #17).				
	03/16/17 revealed dia	t #8's current FL2 dated agnoses included chronic ession, seizures, marijuana buse.				
	signed documentation	8's record revealed no n for permission by Resident e facility to manage the				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D 0
		UAL 024000	B. WING		R-C
		HAL034098			02/16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OLI	SALISBURY R	OAD	
SALEM TE	ERRACE	WINSTO	N SALEM, NC 2	7127	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEI IGIENCI)	
{D 421}	Continued From page	e 46	{D 421}		
	. •				
		at 10:15am with Resident #8			
	revealed:				
	-The resident was pri				
		ver \$2000.00 a month			
	deposited in his acco				
		money from the Business			
		1), in January 2018, he was			
	_	n his trust fund account.			
	~	d he could not see how			
	much money he was				
		s family member go to the			
		e with him when he received			
		ily member could count the			
	BOM.	e request was denied by the			
		nember permission to check			
	on his account with th				
		SOM always telling the			
		money in his account when			
		was supposed to have			
	money.	was supposed to have			
		nd why he was told he did			
		he knew he should have			
	_	e than what the BOM told			
	him he had.				
		any transaction because he			
	had glaucoma and co	-			
	_	ney for when his family			
	member took the resi				
		5			
	Interview on 02/16/18	at 2:45 pm with a family			
	member revealed:				
	-Resident #8 was "co	nstantly" calling him			
		was being told he did not			
	have any money in hi				
		rporate office several times			
	but no one would call				

-He had been told by the new BOM to call corporate because they were the ones who

handled the residents' funds.

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DIVISION	i Health Service Regu	iialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	_
			D MANAGE		R-	_
		HAL034098	B. WING		02/1	6/2018
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	ATE ZID CODE		
INAIVIE OF F	NOVIDER OR SUFFLIER			,		
SALEM TI	ERRACE	2609 OLD	SALISBURY R	OAD		
· · · · · · · · · · · · · · · · · · ·		WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
{D 421}	Continued From page	2.47	{D 421}			
10 42 17	Continued From page	5 47	(0 421)			
	-He was under the im	pression that the money				
		re of in November 2017				
	when someone from					
	investigation.	the state and arr				
	_	e frustrated because no one				
	was returning his call					
	•					
		s permission to get the				
	needed information a	bout his account.				
		8's Trust Account Ledger for				
		January 2018 revealed:				
	-The trust account led	dger for December 2017 was				
	unavailable for review	V.				
	-The beginning balan	ce for 01/01/18 was				
	\$118.79.					
	-There was a deposit	of \$ 515.41 on 01/09/18.				
	-	wal of \$100.00 on 01/09/18				
	for pharmacy.	,				
		wal of \$430.00 on 01/10/18				
		ted for the withdrawal).				
	•	· · · · · · · · · · · · · · · · · · ·				
		wal of \$50.00 on 01/22/18				
	•	ted for the withdrawal).				
		remaining would have				
		trust account ledger for				
	January 2018.					
	-The ledger contained	d no signatures.				
	Observation of Resid	ent #8's Trust Account funds				
	in the facility on 01/22	2/18 revealed that \$54.20				
	was on hand for the r	esident to receive.				
	Based on review of R	Resident #8's account				
		tion of the account funds				
		accurate accounting of				
		could not be calculated due				
	to the missing Decem					
	to the missing Decem	ibel 2017 leugel .				
	Interview on 00/45/40	ot 9:25 am with a				
	Interview on 02/15/18					
	=	nager in reference to the				
	Trust Funds Account	of Resident #8 revealed:				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						<u></u>
		HAL034098	B. WING		R-	6/2018
		HAL034096			02/1	0/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CALEME	-DDAGE	2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
{D 421}	Continued From page	e 48	{D 421}			
	Cha waa unahla ta a	amplete the guidit for				
	-She was unable to co	•				
		the trust fund account				
	not located.	2017 and January 2018 was				
	-The resident was du	a \$1,100,00 from the				
		vithout authorization, an				
	'	as being deposited into				
		• .				
	Trust Fund Account instead of the normal \$600.00.					
		nentation of authorization of				
	this deposit change.	ichtation of authorization of				
		also be reimbursed to				
	Resident #8's Trust A					
		prevent the resident's family				
	member from stealing					
		nentation of Resident #8				
	complaining of his far	mily member stealing his				
	money.	,				
	•					
	Refer to interview on	02/14/18 at 12:15 pm the				
	Owner of the facility.					
		02/15/18 at 8:35 am with a				
	Corporate Office Man	nager.				
		02/15/18 at 4:00 pm with the				
	Administrator.					
	5					
	Refer to review of a p	police report dated 02/05/18.				
	0 Davison of Davidson	-t #0 t El O d-td				
		nt #9's current FL2 dated				
		agnoses included seizures,				
		rtension, diabetes, history of				
	, ,	vounds post exploratory				
		f subdural hematoma,				
	traumatic brain injury,					
		ered mental status related to				
	seizures.		1			

Division of Health Service Regulation

Review of Resident #9's record revealed no

STATE FORM 6899 7GVN12 If continuation sheet 49 of 72

Division of Health Service Regulation				TOTAL TROVES		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R-C 02/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CALEME		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{D 421}	Continued From page	49	{D 421}			
	signed documentation for permission by Resident #9 or designee for the facility to manage the resident's funds.					
	Interview on 02/14/18 at 10:30 am with Resident #9 revealed: -He received Medicaid fundsHe was told last month by the BOM that he did not have any money in his trust accountHe was offered \$10 but refused to take itHe was given paperwork to sign but he refused to sign the paperworkHe did not remember what the paperwork was forAt the end of the January 2018, he was given \$86.00.					
	-He did not remember ever being told that he did not have money in his accountHe only received \$66.00 each month.					
	Ledger for December revealed: -The beginning balanceThere was a deposit -There was a withdraw the pharmacy billThere was a withdraw (no reason document)	19's Trust Fund Account 2017 and January 2018 ce for December 2017 was of \$67.00 on 12/07/17. wal of \$9.60 on 12/07/17 for wal of \$57.40 on 12/08/17 ed for the withdrawal). ce for January 2018 was				

\$0.00 was on hand.

-There was a withdrawal of \$66 on 01/16/18 (no

Observation of Resident #9's Trust Account Funds in the facility on 02/14/18 revealed that

reason documented for the withdrawal). -The ledger contained no signatures.

STATE FORM 6899 7GVN12 If continuation sheet 50 of 72

	or Regulation		0.00 14111 7151 5	CONCERNATION	1000 DATE 6	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOWBER.	A. BUILDING: _		OOWII E	LILD
					R-	·C
		HAL034098	B. WING		02/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SALEM T	ERRACE	2609 OLD	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGOLATORI GIVE	is in the international of the	TAG	DEFICIENCY)		
{D 421}	Continued From page	e 50	{D 421}			
	Interview on 02/15/18	at 8:35 am with a				
		ager in reference to the				
		of Resident #9 revealed:				
		or money from his account				
	in January 2018.	o				
		ot have any funds but was				
		e refused to take the money.				
		February 2018, \$111.00				
	was deposited into his					
		nentation for the deposit.				
		out the deposit to Resident				
	#9's account.	•				
	Refer to interview on	02/14/18 at 12:15 pm the				
	Owner of the facility.	•				
	-					
	Refer to interview on	02/15/18 at 8:35 am with a				
	Corporate Office Man	ager.				
	Refer to interview on	02/15/18 at 4:00 pm with the				
	Administrator.					
	Refer to review of a p	olice report dated 02/05/18.				
		t #10's current FL2 dated				
		agnoses which included				
		yperlipemia, Vitamin B12				
		deficiency, insomnia,				
	depression, and urina	ary incontinence.				
	Deview of Desiders #	10's record revealed as				
		10's record revealed no				
		n for permission by Resident				
	_	ne facility to manage the				
	resident's funds.					
	Intonvious c= 00/44/40	ot 11:00 am with Desident				
		at 11:00 am with Resident				
	#10 revealed:	d Madiacid funds				
	-The resident receive					
	-Sne nad not experie	nced any issues with getting				1

Division of Health Service Regulation

STATE FORM 6899 7GVN12 If continuation sheet 51 of 72

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL034098	B. WING		02/16/2018
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
SALEM TE	ERRACE		SALISBURY RO		
		WINSTOI	N SALEM, NC 27	7127	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
iAG		,	IAG	DEFICIENCY)	
(5, 10.1)			(5.404)		
{D 421}	Continued From page	e 51	{D 421}		
	money out of her acc	ount.			
		a request for funds she			
		et her requested amount.			
	-She only received \$6				
	•	·			
	Review of Resident #	10's Trust Fund Account			
	Ledger for December	2017 and January 2018			
	revealed:				
	-The beginning balan	ce for December 2017 was			
	zero.				
	-There was a deposit	of \$66.00 on 12/07/17.			
	-There was a withdra	wal of \$5.00 for pharmacy			
	bill on 12/07/17.				
	-There was a withdra	wal of \$50.00 on 12/08/17			
	(no reason document	ed for the withdrawal).			
	-The ending balance	for December 2017 was			
	\$11.00.				
	-The beginning balan	ce for January was recorded			
	as \$0.00.				
		of \$67.00 on 01/09/18.			
	-There was a withdra	wal of \$5.00 on 01/09/18 for			
	pharmacy.				
		wal of \$61.00 on 01/10/18			
	`	ed for the withdrawal).			
	-The ending balance				
		should have reflected an			
		naining in the account.			
	-The ledger contained	d no signatures.			
	Deview of Desident	WAOLA Truck Associat Ladge			
		#10's Trust Account Ledger			
	on 02/14/18 revealed				
		ancy of \$12.00 for the			
	resident trust account				
	- rine amount of \$12.0	00 was not accounted for.			
	Interview on 02/15/18	2 at 9:35 am with a			
		ager in reference to the			
		for Resident #10 revealed:			
	Trust I unus Account	IOI INGSIDEIIL # IU IEVEAIEU.	1		

-There was a balance of \$11.00 for January. -The only explanation was poor math skills.

STATE FORM 6899 7GVN12 If continuation sheet 52 of 72

ווטופועום	n rieaith Service Regu	ialion				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SUI COMPLET	
71101 2111	or dorate or total	IBENTI IO/MIGIN NOMBER.	A. BUILDING: _		OOM! LE!	
			B. WING		R-C	
		HAL034098	b. WING		02/16	/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE		SALISBURY R			
_		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 421}	Continued From page	2 52	{D 421}			
	-The dollar amounts were not added correctlyThe Resident's Trust Fund Account would be adjusted to reflect the \$12.00 in the account. Refer to interview on 02/14/18 at 12:15 pm the					
	Owner of the facility.	o_				
	Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator.					
	Refer to review of a p	olice report dated 02/05/18.				
	4. Review of Resident #11's current FL2 dated 12/12/17 revealed diagnoses included otalgia of left ear, sensoinural hearing loss of both ears, edema of both legs, recurrent UTI, chronic abdominal pain, microcytia anemia, hepatitis, gastroparesis, debility, anemia of chronic disease, atomic neurogenic bladder and vascular disease.					
	documentation for pe	11's records revealed no rmission by Resident #11 or ty to manage the resident's				
	#11 revealed: -She was on Medicaid -She had not experier trust fund accountShe was always able she made a requestShe only gets \$66.00	to get money whenever				
	Review of Resident #	#11's Trust Account Ledger				

Division of Health Service Regulation

on 02/14/18 revealed:

STATE FORM 6899 7GVN12 If continuation sheet 53 of 72

Division (of Health Service Regu	ulation			FORM	1 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
		HAL034098	B. WING		R- 02/1	-C 1 6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STA	ATE, ZIP CODE		
0 A L E NA T	55540F	2609 OI	D SALISBURY R	OAD		
SALEM TI	ERRACE	WINSTO	ON SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{D 421}	Continued From page	e 53	{D 421}			
	\$1.00There was a deposit 12/07/17There was a withdra 12/07/17 for the phant 12/14/17 (no reason owithdrawal)There was a withdra 12/19/17 (no reason withdrawal)There was a withdra 12/19/17 (no reason withdrawal)The ending balance -The beginning balan \$0.00There was a deposit 01/09/18 -There was a withdra 01/09/18 for the phant 170/10/18 (no reason owithdrawal).	awal of \$10.00 made on macy. awal of \$40.00 made on documented for the awal of \$40.00 made on documented for the awas \$0.00. ace of January 2018 was a of \$66.00 made on awal of \$5.00 made on awal of \$5.00 made on awal of \$30.00 made on				

-The ending balance was \$0.00.

withdrawal).

-The ending balance should have reflected an amount of -\$23.00 in the account for December 2017 and January 2018.

-The ledger contained no signatures.

01/16/18 (no reason documented for the

Observation on Trust Fund Account for December 2017 revealed there was a balance of \$1.00.
-Resident #11 only had one deposit for the entire month of \$66.00 on 12/07/17.

-The resident had a total of \$99.00 in withdrawals for the month of December 2017.

-There was no documentation to show how resident was able to withdraw more money from the trust account than was deposited into the trust

Division of Health Service Regulation

STATE FORM 6899 7GVN12 If continuation sheet 54 of 72

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
7.1.12 . 27.11 .		ISENTI ISTANISITA	A. BUILDING: _			
		HAL034098	B. WING		R- 02/1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	-RRACE	2609 OLD	SALISBURY R	OAD		
JALLIN 11	WINSTON			7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 421}	Continued From page	e 54	{D 421}			
	account.					
	Interview on 02/15/18 Corporate Office Man Account Funds for Re had no explanation of to withdraw \$99.00 fn in December 2017, w available in the account Refer to interview on Owner of the facility. Refer to interview on Corporate Office Man Refer to interview on Administrator. Refer to review of a p	rager in reference to Trust esident #11 revealed she if how Resident #11 was able om the Trust Funds Account when there was only \$57.00 unt. 02/14/18 at 12:15 pm the				
	05/08/17 revealed dia	nt#12's current FL2 dated agnoses included right side urocognitive deficit, diabetes				
		ency anemia, depression,				
	#12 revealed: -She received Medica -She did not get any i	money from the facility. ny she did not get any				

Division of Health Service Regulation

-She was told by the facility she would get \$66.00

STATE FORM 6899 7GVN12 If continuation sheet 55 of 72

DIVISION	n Health Service Regu	ialion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
					R-0	_
		HAI 024008	B. WING		1	
		HAL034098			02/10	6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	RRACE		SALEM, NC 2			
			TOALLIN, NO 2			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
{D 421}	Continued From page	e 55	{D 421}			
	per month.					
	•	ey would be used to pay for				
	her room and board.	y weard so deed to pay to				
	nor room and board.					
	Review of the residen	its' Trust Funds Account				
		e were no ledgers set up for				
	Resident #12.	e were no leagers set up for				
	resident #12.					
	Interview on 02/16/18	at 11:30 am with the local				
	county Medicaid Supe					
	month.	ntitled to the \$66.00 per				
		100/ withholding of hor				
		10% withholding of her				
	Social Security payment	ent due to a previous				
	overpayment.	-4				
		at could had been submitted				
		e sure the facility received				
	their funds.					
		onsible for returning the				
	resident her funds.					
	Interview on 02/15/18					
		ager in reference to Trust				
	Funds Account for Re					
		t getting her \$66.00 due to				
		t was being taken out of her				
	Social Security Suppl					
		neck was going towards the				
	over payment.					
		evented the resident from				
		full Medicaid amount for her				
	room.					
		rence, the facility decided to				
		0 that the resident was				
	entitled to.					
		lent if she would voluntarily				
	allow the facility to take	ce a portion of the \$66.00 to				
	make up the difference	e for the shortage.				
	-The difference was \$					

Division of Health Service Regulation

-She did not know there was a form the Medicaid

STATE FORM 6899 7GVN12 If continuation sheet 56 of 72

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
			_		R-	C
		HAL034098	B. WING		02/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE		SALISBURY R			
0/0.15			SALEM, NC 2	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 421}	Continued From page	e 56	{D 421}			
	the over- payment red increased to make up -She knew Resident a personal money in ov	#12 had not received er a year.				
	should have to reimb	d she did not feel the facility urse Resident #12 for the eceived due to recoupment				
	Refer to interview on Owner of the facility.	02/14/18 at 12:15 pm the				
	Refer to interview on Corporate Office Man	02/15/18 at 8:35 am with a ager.				
	Refer to interview on Administrator.	02/15/18 at 4:00 pm with the				
	Refer to review of a p	olice report dated 02/05/18.				
	2/16/17 revealed diag	nt #18's current FL2 dated gnoses included Alzheimer's erlipidemia, Vitamin B12 oid schizophrenia.				
	documentation for pe	18's record revealed no rmission by the resident or ty to manage the residents				
	#18's legal guardian r -Resident #18 was pr -She had not been the	ivate pay. e guardian very long. idy in place when she was				

Division of Health Service Regulation

-She knew there was another account set up

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL034098	B. WING		02/16/2018
		HAL034090			02/10/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CALEME	-DDAGE	2609 OL	D SALISBURY R	OAD	
SALEM TE	RRACE	WINSTO	N SALEM, NC 2	7127	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
				,	
{D 421}	Continued From page	e 57	{D 421}		
	through a bank that p	aid the room/board			
	payments for the resi				
	• •	o deposited money into the			
	Resident Trust Fund				
		to the Social Security			
	benefits funds.	to the coolan coolanty			
		edical and dental bills.			
	•	SOM, in the past, whether			
	Resident #18 had any	needs and was told no.			
	-It seemed the reside	nt was being over charged			
	because of his trust a	ccount.			
	Review of Resident #	18 Trust Account Fund			
	ledger on 02/14/18 re				
		ce for December 2017 was			
	\$104.00.	sits made for the month of			
	December 2017.				
		wal of \$20.00 made on			
	12/11/17 (no reason o	ocumented for the			
	withdrawal).	wal of CE OO made on			
		wal of \$5.00 made on			
	12/13/17 (no reason of withdrawal)	documented for the			
	,	wal of \$10.00 made on			
	12/19/17 (no reason of				
	withdrawal)				
	•	wal of \$20.00 made on			
	12/26/17 (no reason o				
	withdrawal).				
	-The ending balance	for December 2017 should			
	have reflected an am	ount of \$49.00 remaining in			
	the account.				
	-The beginning balar	nce for January 2018 was			
	\$69.00.				
		nentation of any withdrawals			
	being made in the mo	_			
	-The ledger contained	d no signatures.			

Interview on 02/15/18 at 8:35 am with a

STATE FORM 6899 7GVN12 If continuation sheet 58 of 72

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
					R-0	
		HAL034098	B. WING		1	6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY RO			
0/0/15	OUR MADE OF DESIGNED OF DESIGN			PROVIDER'S PLAN OF CORRECTION	ı .	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 421}	Continued From page	e 58	{D 421}			
	Funds Account for Re	ager in reference to Trust esident #18 revealed she did of resident's personal funds				
	Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator.					
	Refer to review of a p	olice report dated 02/05/18.				
	08/29/17 revealed dia	t #17's current FL2 dated agnoses included chronic breast cancer, diabetes artery disease.				
	Review of Resident # resident passed away	#17's record revealed the on 12/14/17.				
	ledger for December - The beginning balan \$0.00.	ce for December 2017 was				
	-There was no docum made into the accoun December 2017.	nentation of any deposits t during the month of				
	of Attorney (POA) for -He knew there were the trust account fund -The discrepencies re tell him the Resident	at 9:50 am with the Power Resident #17 revealed: some "discrepancies" with ls. Iferred to the facility would be money and when the count of the resident's funds				

Division of Health Service Regulation

he was never given an account statement, and he

STATE FORM 6899 7GVN12 If continuation sheet 59 of 72

Division of Health Service Regulation					1 Oran	IAITROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R- 02/1	C 6/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	EDDACE	2609 OLI	SALISBURY R	OAD		
SALEM TERRACE WINSTOIL		SALEM, NC 2	7127			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 421}	one. -He knew an audit wa completed per the corHe was assured by the independent audit wo 24th of November 20: -He was told he would which was to be completed correctorHe had been unable co-owner about the animal and the had never received monies that may be only the had tried on number with either the owner not respond. Interview on 02/15/18 Corporate Office Maniform Funds Account for Resident #17 had parashe did not know the surrounding the resident #17From her understand trust account funds were surrounded to the corporate of the	oiding him. Its to have a copy of Int but was not provided with Its supposed to have been Its su	{D 421}	DEFICIENCY)		
	Refer to interview on Owner of the facility.	02/14/18 at 12:15 pm the				

Refer to interview on 02/15/18 at 8:35 am with a

Refer to interview on 02/15/18 at 4:00 pm with the

Corporate Office Manager.

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DIVISION	of fleatin Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		1141 024000	B. WING		R-C	
		HAL034098	B. WING		02/16	5/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLF	SALISBURY R	OAD		
SALEM T	SALEM TERRACE WINSTO					
	OUR MAR DV OT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	I	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
(D 424)	0	. 00	(D 424)			
{D 421}	Continued From page	9 60	{D 421}			
	Administrator.					
	Refer to review of a p	olice report dated 02/05/18.				
	Interview on 02/14/18	at 11:50 am with the Owner				
	of the facility revealed	i :				
	-She was going to hire	e her own independent CPA				
	to complete an audit.					
	-She did not know of	the results of the audit that				
	was supposed to have been conducted in					
	November 2017.					
	-She had no knowled	ge of the audit and had				
	nothing to do with it.					
	_	d find the most appropriate				
	CPA she would have					
		·				
	Interview on 02/14/18	at 8:35 am with a				
	Corporate Office Man	ager revealed:				
	-There was a situation	n where the Business Office				
	Manager (BOM) in the	e facility had been arrested				
	for embezzling funds	from the Residents Trust				
	Accounts.					
	- She was told in Nov	ember 2017, an				
		s ordered by the co-owner.				
	-She was later told the	-				
	completed.					
	I	ove all of the trust account				
		an audit at the Corporate				
	Office.					
		pay residents and Medicaid				
		d in the same Trust Funds				
	Accounts.					
		determine exactly which				
	1	counts compromised.				
		drawals were made on				
		pared with the trust account				
	ledgers.	pared with the trust account				
		nte' trust account ledgers				
		nts' trust account ledgers after the audit were				

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provided.

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Division of	of Health Service Regu	ılation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ILED
					R-C	
		HAL034098	B. WING		02/1	6/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
041 514 55		2609 OLE	SALISBURY RO	OAD		
SALEM TE	:RRACE	WINSTON	SALEM, NC 27	7127		
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
{D 421}	Continued From page	e 61	{D 421}			
	-During the time of th	e embezzlement she did not				
	have access to the tru					
	-There was a spread	sheet for all of the trust				
		ut she could not access it at				
	that time.					
		Corporate Business Office				
	no longer worked for	e Corporate Business Office				
		with total access to the trust				
	fund accounts.	man total access to the date				
	Interview on 02/15/18	3 at 4:00 pm of the				
	Administrator reveale					
	-She was not the Adn	ninistrator of the facility				
	during the time in Nov	vember 2017.				
		the many issues the facility				
	was having.					
	_	co-owner the audit was				
	never completed.	co-owner the audit was to be				
	on only 2 residents' tr					
	_	problems with the two				
	-	er was going to assume the				
	other account funds v					
	-She would personall	y keep abreast of the				
		ınts funds to ensure these				
	same issues do not h	appen again.				
	Review of a police re	port dated 02/05/18				
	revealed:					
		ted at the facility on 02/05/18				
	_	s' trust funds account money				
	to make a drug purch					
		happened on February 03,				
	that was on duty.	s called by one of the staff				
	-The Police searched	I the ROM with her				
		the facility bank bag along				
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· ···· · · · · · · · · · · · · · · · ·				

facility. Division of Health Service Regulation

with cash that she admitted came from the

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R-C 02/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 02/10/201	•
SALEM TE	ERRACE		SALISBURY ROSALEM, NC 2			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
{D 421}	fund account money, other larger portion we reviewing the safe the have been left in the second process. The facility failed to envolving the use of programmer process. The facility failed to envolving the use of process. The facility's failure to an accurate accountation for residents to make transactions was detrived for residents to make transactions was detrived for the resident Uabated Type B Violation. The facility provided a 02/15/18 as follows: The Corporate Busin ledgers of residents' freceived versus charge-Correct balances will each month. On-going audits will business Office at the ensure beginning balaresident is correct. The Corporate Busin responsible for auditing responsible for auditing the safe the saf	small amount of the trust that was in the safe, and the as still in the safe. After ere was only \$4.00 found to safe. Insure each transaction ersonal funds was lity and signed by the esses' signatures at least uracy of the disbursement of of 7 sampled residents 1. #11, #12, #18 and #17). In provide the residents' with ability and access to funds purchases, and billing imental to the safety and the safety and each of the safety and each of the safety and each of the safety and the safety and each of	{D 421}			
{D912}		laration of Residents' Rights	{D912}			

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	or riealth Service Regu		1		1	$\overline{}$	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LEAN	J. JOHNLOHON	IDENTIFICATION NOWIDER.	A. BUILDING: _	A. BUILDING:		COWI LL TED	
					R-C		
		HAL034098	B. WING		02/16/2018		
NAME OF P	ROVIDER OR SUPPLIER	QTDEET A	ADDRESS, CITY, STA	TE ZIP CODE	<u> </u>		
TVAINE OF T	NOVIDER OR OUT FEEL		D SALISBURY RO				
SALEM T	ERRACE		D SALISBURT RO ON SALEM, NC 27				
			IN SALEWI, NC 27				
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLET	E	
TAG	REGULATORY OR	EGO IDENTIL TING INI ONWATION)	TAG	DEFICIENCY)	MATE 57.112		
{D912}	Continued From page		{D912}				
(,			[[[]				
	_	nave the following rights:					
	2. To receive care an						
		e, and in compliance with state laws and rules and					
	regulations.	state laws allu luies allu					
	This Rule is not met as evidenced by:						
	Based on observation, record review, and						
		failed to assure every					
	resident had the right						
		dequate, appropriate, and in					
	Health Care.	s and regulations related to					
	Health Care.						
	The findings are:						
	Pasad on observation	ns, interviews, and record					
		ailed to assure physician					
	_	sampled residents (Resident					
		ally and verbally aggressive					
		ff, and other residents, and					
		members. [Refer to Tag					
		0902(b) Health Care (Type					
	B Violation).]						
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914				
		ration of Residents' Rights					
	_	nave the following rights:					
		al and physical abuse,					
	neglect, and exploitat	tion.					
	This Rule is not met	as evidenced by:					
		ns, record reviews and					
	interviews, the facility	-					
		rom exploitation related to					
		ents' Personal Funds.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETI	ED	
					R-C	
		HAL034098	B. WING		02/16/2018	
		TIAE034090			02/10/	2010
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM T	FRRACE	2609 OLD	SALISBURY R	OAD		
JALLIN II	LINIAGE	WINSTON	SALEM, NC 2	7127		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	Continued From page	e 64	D914			
D921	reviews, the facility fatransaction involving was maintained in the resident with two with monthly verifying acc personal funds for 7 of (Resident #8, #9, #10 [Refer to Tag 0421, 1 Accounting For Resid (Unabated Type B Vid G.S. 131D-21 (11) De Rights G.S. 131D-21 Declar Every resident shall have the finding for the resident and permitted to make consideration without fear of coercid This Rule is not met Based on observation reviews, the facility father ight to voice commetaliation as evidence Administrator to discharge the restraining order was who physically assauthe findings are:	the use of personal funds of facility and signed by the pesses' signatures at least uracy of the disbursement of of 7 sampled residents of 8 and #17). OA NCAC 13F .1104(c) dents' Personal Funds obtained of Resident's of Resident's of Resident's or the following rights: ed to exercise his or her ond citizen, and to be implaints and suggestions on or retaliation. The filed assure residents had obtained to assure residents had obtained and be free of ed by verbal threats by the marge Resident #4 if a filed against Resident #5 lted Resident #4 causing a	D921			

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAI 024009	B. WING			
		HAL034098			02/16/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE		SALEM, NC 2			
	OLIMANA DV OT		·			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-)	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
			1	DEFICIENCY)		
D921	Continued From page	65	D921			
D921	Continued From page	9 00	D921			
	-Diagnoses included	degenerative disc disease of				
	the cervical spine, cer	rebrovascular accident with				
	hemiplegia, multi-infa	rct dementia, rheumatoid				
	arthritis, chronic regio	onal pain syndrome, and an				
	abnormal gait.	•				
	-The resident was into	ermittently disoriented,				
		incontinent of bowel and				
	bladder.					
	Review of Resident #4's Resident Register					
	revealed an admissio	•				
	Review of Resident #	4's Resident Notes and				
	Incident Reports since	e admission revealed:				
	-Resident #4 was phy					
	Resident #5 on 02/13	-				
		in a loss of consciousness.				
		Services (EMS) was called				
	to attend to Resident					
		en to a local hospital for				
	examination and treat					
		included a facial hematoma				
	on the right temple, a					
	on the right temple, a	na a concacción.				
	Review of hospital En	mergency Department (ED)				
	•	and EMS notes dated				
	02/13/18 for Resident					
		aluated for a head injury and				
	diagnosed with a mile					
		and primary diagnosis listed				
	on the hospital discha					
	"assault victim."	argo information was				
	assault violiiii.					
	Interview on 02/14/18	at 10:30 am with Resident				
	#4 revealed:	at 10.00 am with resident				
	-Resident #5 was her	roommate				
		into the facility on 02/09/18.				
	-	en verbally aggressive				
	toward her since she					
	LOWALL HEL SHILLE SHE	moveu III.	1			

Division of Health Service Regulation

-Resident #5 had drawn a line separating the

STATE FORM 6899 7GVN12 If continuation sheet 66 of 72

Division	of Lloalth Comica Dogu	ulation			FORM	APPROVED
STATEMEN [*]	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	ETED
		HAL034098	B. WING		R- 02 /1	-C 16/2018
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM T	ERRACE		D SALISBURY R			
		WINSTO	N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D921	Continued From page	e 66	D921			
	-Resident #4 was und a walker, which cause over the line when try -On 02/13/18, she an argument regarding she -Resident #5 then be belongings in the floor-When Resident #4 belongings from the find the head with an unk -Resident #4 was told consciousness for an between 45 minutes she staff did not discove in her room, and Res Resident #4's injuries -When Resident #4 rewent to the nurse's stassistance from staff -Staff called 911 and came to the facilityShe was transported she received a CAT sto determine the sericus -She returned to the fam. -When she arrived be to place her back in the roommate that assaut-She complained and needed to be placed roommate.	gan throwing Resident #4's or. bent over to retrieve her floor, Resident #5 hit her in nown object. It she had lost unknown amount of time to 2 hours. It Resident #4 unconscious ident #5 did not report to staff. It egained consciousness, she tation and requested. It law enforcement and EMS If by EMS to a hospital where scan and neurological testing pusness of her head injury. If acility by EMS around 4:00 ack at the facility, staff tried the same room with her ollted her. It EMS told staff that she				

renovations.

placed it on an empty box spring in an unoccupied room that was undergoing

access to any of her belongings.

-She was placed in the spare room without

-Staff placed her wheelchair and walker across

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STATEMENT OF DEPICIENCIES AND BLAN OF CORRECTION (A) DELAN OF CORRECTION (A) DELAN OF CORRECTION (B) WIND (B) WIND (C) DELAN OF CORRECTION (B) WIND (C) DELAN OF CORRECTION (C) DELAN OF COR	DIVISION	n nealth Service Regu	lation				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2809 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 PRECOLATORY OR USE IDENTIFYING INFORMATION PRECEDUATION SALEM, NC 27127 PRECOLATORY OR USE IDENTIFYING INFORMATION PRECEDUATION SALEM, NC 27127 PRECOLATORY OR USE IDENTIFYING INFORMATION PRECEDUATION SALEM, NC 27127 D921 Continued From page 67 the room where she could not access them from her bed to be able to reach the restroom. Resident #3 had bragged to the that she "always ran of the room and 2/14/18 at 10/20 am revealed a black line appearing to be drawn with a marker or crayon on the floor separating the room into two sections. Second interview on 02/14/18 at 11/30 am with Resident #4 revealed: She was told by the Administrator that if she filled a restraining order she would be removed from the facility for "causing trouble." She had been harassed at breakfast by Resident #5 who approached her table while she was eating. She told staff Resident #6 was not supposed to be near her, and left the dining room. She felt she was threatened by the Administrator, who told her she should never have gone to the ED and that Resident #4 was "trouble." Review of Resident #5's current FL2 dated 03/22/17 revealed: Diagnoses included multiple falls, impaired mobility, and deep vein thrombosis. She was non-ambulatory and required assistance with bathing, dressing, and feeding. She was isled as "constantly oriented" She was non-ambulatory and required assistance with bathing, dressing, and feeding. She was isled as "constantly oriented" She was incontinent of bowl and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16.			` '	(X2) MULTIPLE	CONSTRUCTION	1 ' '	
MAIL OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRATE, 2IP CODE 2699 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 MAIL DEPOSIT OF DESCRIPCION OF DESCRIPCION OF SALEM PROVIDERS PLAN OF CORRECTION (EACH CORRECTION CEACH CHRICIPS) WINSTON SALEM, NC 27127 D921 Continued From page 67 the room where she could not access them from her bed to be able to reach the restroom. -Resident #5 had bragged to her that she "always ran off her roommakes." Observation of Resident #4 and Resident #5's shared room on 2/14/18 at 11:30 am with Resident #4 revealed. -She was told by the Administrator that if she filed a restraining order she would be removed from the facility for "causing trouble." -She had been harassed at breakfast by Resident #5 was not supposed to be near her, and left the dining room. -She felt she was threatened by the Administrator, the told her she should never have gone to the ED and that Resident #4 was "trouble." Review of Resident #5's current FL2 dated 03/22/17 revealed: -Diagnoses included multiple falls, impaired mobility, and deep vein thrombosis. -She was non-ambulatory and required assistance with bathing, dressing, and feeding. -She was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an administron date of 12/02/16.	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
MAIL OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 78P CODE 2689 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 MAIL DEPENDENCE SUPPLIES SALISBURY ROAD STREET OF DESCRIPCINGS PROVIDER OF AN OF CORRECTION PRIED AND SALISBURY ROAD PRIED AND SALISBURY ROAD STREET OF DESCRIPCINGS PRIVATED FRACED BY TILL RESULATORY OR LSG IDENTIFYING INFORMATION) D921 Continued From page 67 the room where she could not access them from her bed to be able to reach the restroom. -Resident #5 had bragged to her that she "always ran off her roommakes." Observation of Resident #4 and Resident #5's shared room on 2/14/18 at 11:30 am with Resident #4 revealed. -She was told by the Administrator that if she filed a restraining order she would be removed from the facility for "causing trouble." -She had been harsased at breakfast by Resident #5 was not supposed to be near her, and left the dining room. -She fet she was threatened by the Administrator, who told her she should never have gone to the ED and that Resident #4 was "trouble." Review of Resident #5's current FL2 dated 03/22/17 revealed: -Diagnoses included multiple falls, impaired mobility, and deep vein thrombosis. -She was non-ambulatory and required assistance with bathing, dressing, and feedingShe was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16.						_	•
NAME OF PROVIDER OR SUPPLIER SALEM TERRACE SUMMARY STATEMENT OF DEFICIENCES PACH DEFICIENCY MUST BE PRECEDED BY FILL PREFIX TAG D921 Continued From page 67 the room where she could not access them from her bed to be able to reach the restroom. Resident #5 had bragged to her that she "always ran off her roommates." Observation of Resident #4 and Resident #5's shared room on 2/14/18 at 11:30 am with Resident #4 revealed: She was told by the Administrator that if she filed a restraining order she would be removed from the facility for 'causing trouble." She had been harassed at breakfast by Resident #5 he had been harassed at breakfast by Resident #5 had bool did restraining room. She fall she was the had the should never have gone to the ED and that Resident #4 was "trouble." Review of Resident #5's current FL2 dated 03/22/17 revealed: Diagnoses included multiple falls, impaired mobility, and deep vein thrombosis. She was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16.				B WING		1	_
SALEM TERRACE 2669 OLD SALISBURY ROAD WINSTON SALEM, NC 27127			HAL034098	B. WING		02/1	16/2018
SALEM TERRACE 2669 OLD SALISBURY ROAD WINSTON SALEM, NC 27127	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE. ZIP CODE		
CALL							
Display Display Continued From page 67 Display	SALEM TE	ERRACE					
PREFIX TAG CAUTHOUSE CAUT			WINSTON	JALEWI, NC 2	1 121		
D921 Continued From page 67 the room where she could not access them from her bed to be able to reach the restroom. -Resident #5 had bragged to her that she "always ran off her roommates." Observation of Resident #4 and Resident #5's shared room on 2/14/18 at 10:20 am revealed a black line appearing to be drawn with a marker or crayon on the floor separating the room into two sections. Second interview on 02/14/18 at 11:30 am with Resident #4 revealed: -She was told by the Administrator that if she filled a restraining order she would be removed from the facility for "causing trouble." -She had been harassed at breakfast by Resident #5 who approached her table while she was eatingShe told staff Resident #5 was not supposed to be near her, and left the dining roomShe felf she was threatened by the Administrator, who told her she should never have gone to the ED and that Resident #4 was "trouble." Review of Resident #5's current FL2 dated 03/22/17 revealed: -Diagnoses included multiple falls, impaired mobility, and deep vein thrombosisShe was inson-ambulatory and required assistance with bathing, dressing, and feedingShe was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16.							
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Review on 02/15/18 of Resident #5's Resident		Review on 02/15/18 of	of Resident #5's Resident				

Division of Health Service Regulation

Notes revealed:

STATE FORM 6899 7GVN12 If continuation sheet 68 of 72

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	COMPLETED	
		HAL 024000	B. WING	B. WING		C	
		HAL034098	1		02/1	6/2018	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,			
SALEM T	ERRACE		SALISBURY R				
			SALEM, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
D921	Continued From page	e 68	D921				
	-An entry dated 02/10 between Resident #5 roommate. Staff were multiple occasionsAn entry dated 02/13 #5's physical aggress Resident #5 refused to psychiatric evaluationAn entry dated 02/14 #5 was finally transport or a psychiatric evaluationAn entry dated 02/15 #5 had been moved finew room with a difference of the second secon	and Resident #4, her new called to the room on white documented Resident ion toward Resident #4. The color of the hospital for the hospital f					
	Review of the police report for the incident on 02/13/18 revealed: -Officers responded to the facility on 02/13/18 at 11:10 pm for a report of simple assault. -Staff called law enforcement at 11:00 pm when they were alerted to Resident #4's injuries. -Officers questioned named resident as the offender in the assault. -Resident #5 laughed at officers and refused to speak to them until they threatened her with jail time. -Resident #4 was interviewed at the hospital and found to have injuries consistent with assault. -It was unknown whether Resident #5 assaulted Resident #4 with an object or her hands. -The incident was routed to the domestic violence unit for further investigation.						
	#4 revealed: -She was told by the a restraining order ag facility would discharge	Interview on 02/16/18 at 9:35 am with Resident #4 revealed: -She was told by the Administrator that if she filed a restraining order against Resident #5, the facility would discharge her and place her somewhere else rather than moving Resident #5.					

Division of Health Service Regulation

STATE FORM 6899 7GVN12 If continuation sheet 69 of 72

DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					R-C	
		HAL034098	B. WING		1	5/2018
					<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE	2609 OLD	SALISBURY R	OAD		
		WINSTON	I SALEM, NC 2	7127	_	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	I	COMPLETE DATE
IAG	REGOLATOR OR	is a second of the second of t	IAG	DEFICIENCY)	W/112	
D921	Continued From page	e 69	D921			
	discharged if she "cau	used trouble" by pursuing				
	charges against Resi	, . · ·				
		to press charges or file a				
	restraining order beca	ause she had just moved to				
	the facility and did no	t want to move again.				
	-She was afraid of ret	aliation by staff for talking				
	about this to anyone.					
	Interview on 02/14/18 at 10:20 am with Resident					
	#5 revealed:					
		erent roommates since				
	moving to the facility.					
		sed of hitting her roommate crystal salt shaker that she				
	had hidden under her	=				
	roommate "made it al	_				
		w Resident #4 was injured				
	because Resident #5	-				
	because resident no	was asieep.				
	Observation on 02/15	5/18 at 12:25 pm of an				
	interaction between a	-				
	Administrator reveale	d:				
	-The first shift MA req	uested to feed Resident #5				
	in her temporary roon	n per Resident #5's request				
	to avoid the dining roo	om.				
		eparating Resident #4 and				
		ninistrator stated, "There's no				
		ney don't have to be kept				
	•	#4 has a problem with				
	•	o the dining room, then we'll				
	deal with her (Reside	nt #4)."				
	Intoniow on 02/16/19	at 10:20 am with a first shift				
		revealed she knew of				
		nt behaviors and had written				
		orts before to send to the				
	PCP.	one belove to seria to the				
	. 5					
	Interview on 02/16/18	at 9:45 am with Resident				

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#5's primary care provider (PCP) revealed:

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Division o	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED	
					<u> </u>	2.0	
		1141 00 4000	B. WING			R-C	
		HAL034098			02	/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
		2609 OLI	SALISBURY R	OAD			
SALEM TERRACE WINSTO			N SALEM, NC 2	7127			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE	APPROPRIATE	DATE	
				DEFICIENCY)			
D921	Continued From page	e 70	D921				
	-He did not know Res	sident #5 had had any					
		ues before being contacted					
	by the hospital on 2/1						
		documentation that staff at					
	-	d him of any incidents other					
	than the unexplained	•					
	•	sident #5 in January 2018					
	and had not been info	ormed of any aggressive					
	behaviors.						
	-Resident #5 had nev	er mentioned any of her					
		or other residents and					
		and healthy for her age.					
	•	al order for Depakote, used					
	to treat agitation, at b	•					
	•	could see Resident #5					
	during his facility visit	t on Wednesday, 02/28/18.					
	Interview on 02/16/18	3 at 10:45 am with the					
	Administrator reveale						
		restraining order against					
		uld have to find placement					
		other facility because "she					
		and orderly discharge and					
	_	d take Resident #5 if they					
	knew her history." -Staff's normal respon	nee to Decident #5's					
	•	irect her or remove her from					
	the situation.	rectifier of femove fier from					
		keep Resident #4 and					
	-	ed and have Resident #5					
	"medicated" to avoid						
		cted by the hospital after					
		and told that the resident's					
		spital staff Resident #5 did					
		health issues, so they did					
	not perform a psychia						
		ought back to the facility					
		nave a choice to send her					
	anywhere else."						

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-She had moved residents around to separate

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDEN.	A. BUILDING: _	A. BUILDING:			
		HAL034098	B. WING	B. WING		C 6/ 2018	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA		. 02/1		
			SALISBURY R				
SALEM TE	ERRACE		SALEM, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D921	Continued From page	271	D921				
D921		ident #5 into rooms in two	D921				

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