STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 10/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services conducted a follow-up survey and complaint investigation on October 23, 2018 through October 26, 2018. The complaint investigation was initiated by the Forsyth County Department of Social Services on September 5, 2018.	{D 000}		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure walls, ceilings, and floors were kept clean and in good repair in 4 of 11 resident bedrooms (107, 109, 113, and 115), 6 of 9 resident bathrooms (104, 105, 106, 107, 110, 113, and 115), and on the 500 hallway. The findings are: Observations of resident rooms on 10/23/18 between 9:40 am - 10:45 am revealed: -Room 104 had stained tiles around the toilet with small stained areas across the floor. -Room 105 had a reddish brown stained area 16	D 074	Rooms 104,105,106,110 the bathroom Floor will be replaced in each room, and Borders of each wall will be replaced or Cleaned. New caulking will be put down Around each toilet after floor is finished.	12/31/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John G Phillips — TITLE: ADMINISTRATOR — (X6) DATE: 11/27/18

Reviewed and Accepted 12-03-2018 Jo Scarlett, RN

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D 074	Continued From page 1 inches long by 3 inches wide to the right of the toilet. The linoleum had dirt build up in the crevices and a white substance along the border of the wall. -Room 106 had a stained bathroom floor with dark brownish red caulking with a black substance on it. There were 2 sets of holes in the wall from where a tissue holder used to hang. -Room 107 had a 2 inch by 2 inch area of missing tile located by the door and a 24 inch by 24 inch dirty grayish black stain on the left side of the room next to the wall. The bathroom had 2 sets of holes in the wall from where a tissue holder used to hang. -Room 109 had large blackened irregular shaped areas by each leg of the bed, some of which were scuff marks and there was a 4 foot by 4 foot area in the center of the room with multiple heavy black scuff marks. -Room 110 had a grayish black build-up on the bathroom floor. The caulking around the toilet was reddish brown and had a black substance on it. The wall to the right of the toilet had a set of holes where a tissue holder used to hang and multiple unpainted patched areas. Observation of the 500 hallway on 10/23/18 from 10:30 am - 10:45 am revealed: -The carpet had extensive staining around an air conditioning unit that had leaked. -The hallway had multiple patched areas that remained unpainted. -The ceiling around the lights had stains around the existing patched areas which remained unpainted. -The ceiling had a 12 inch irregular shaped crack by the light fixture. -There were stains on the ceiling around the exit lights.	D 074	Room 107 the 2in. X 2in. missing piece Of tile will be replaced with new tile. The 24x24 stain on wall has been removed And cleaned. New toilet paper holder will Cover existing holes in wall Room 106 new toilet paper holder will Cover holes in wall left by previous holder Room 109 the 4 foot by 4 foot area of tile Will be replaced with new tile, and bed feet Covers will be placed on each leg of the bed To prevent further scuffing of floor. Room 110 caulking will be put sown after floor Is replaced. New toilet paper holder will Cover existing holes. Steam Source has come back to clean all Carpets as of 11/28/2018. All patched areas will be repainted. Stains around multiple patched areas of Ceiling will be repainted, and cracks will Be repaired.	12/31/2018

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D 074	Continued From page 2 Interview with the residents residing in rooms 104, 105, 106, 107, 109, and 110 on 10/23/18 between 9:40 am and 10:45 am revealed: -Residents in rooms 104, 105, and 110 had not noticed the stained floor. -Residents in rooms # 104, 106, and 109 seen housekeeping staff sweep and mop daily. -The resident in room 107 had been missing her tissue holder for over a year and the holes had been there since she moved in. She set the tissue on the hand rail in the bathroom. -A resident in room # 109 had not seen any staff try to remove the black marks on the floor, but he had seen them mop the floor. -None of the residents had told staff. Observations of resident rooms on on the 100 hallway 10/25/18 between 7:10 am - 10:45 am revealed: -There was a crack in the ceiling in room 113 that was L shaped, one side was 4 feet long and the other side was 12 feet long. The ceiling had been patched and left unpainted in multiple areas. -There were multiple small scuff marks on the wall to the right of the room in room 115. The baseboard was missing from 2 walls in the room and the wall had been patched 8 inches above the floor and left unpainted. -Room 113 and 115 shared a common bathroom. -Sewage had seeped from under the toilet and formed a black build-up around the base and coated the surrounding tiles. -There was extensive staining around the entire toilet. -The wall behind the toilet had separated and crumbled 6 inches above the floor and spanned across the back wall leaving a huge gap and the base board leaning forward on the left side of the wall behind the toilet. -There was a 2 inch hole around the water line for	D 074	Room 113 renovations are in process and Should be completed by the end of December Room 115 has been completely repaired, and Renovated with the following: new flooring, paint, outlets, base boards, blind, and transition strips at bathroom door and room door. Administrator was made aware of The sewage issue in the common Bathroom of 113 and 115 on 10/25/18 The toilet was taken up and a new floor Was put down in the bathroom along with A new toilet with new seals and wax ring. The wall (sheet rock) has been replaced And the bathroom has been repainted. The completion of the bathroom was on 10/26/2018 the day after it was brought to The Administrators attention.	12/31/2018 11/16/2018 10/26/2018

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D 074	Continued From page 3 the toilet that was not covered. Interview with the residents residing in room 113 and 115 on 10/25/18 between 7:15 am - 7:40 am revealed: -Residents in rooms 113 and 115 said the bathroom was shared by 4 residents. -Residents in rooms 113 and 115 stated the shared bathroom floor was stained from sewage seeping from underneath the toilet. -A resident in room 113 stated the sewage had been coming from underneath the toilet over 4 months and the resident was told by maintenance staff it would be fixed. -A resident in room 115 had reported the sewage coming from underneath the toilet over a year ago. He was told by maintenance staff it would be fixed. -The sewage got on the resident's shoes in room 115 and on the wheels of his wheelchair, and would leave a trail when he rolled across the floor. -Two resident's used other bathrooms in the facility. -The ceiling in room 113 had been cracked and leaking over 4 months. The resident had reported the leak to maintenance staff and was told to use a bucket to catch the leaking water or he could find another place to stay. -The baseboard in room 115 had been missing several months because the wall had been patched but not completed. Interview with medical records assistant/medication aide on 10/25/18 at 9:05 am revealed: -She also worked in the facility as a medication aide. -She did not know about the shared bathroom floor between the residents rooms 113 and 115.	D 074		

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D 074	Continued From page 4 -The floor looked like it had been that way for a while. Interview with a personal care aide (PCA) on 10/25/18 at 9:17 am revealed: -She knew about the sewage seeping from underneath the toilet in the shared bathroom between rooms 113 and 115. -She did not know about the crumbling wall in the shared bathroom between rooms 113 and 115. -The bathroom floor had flooded in May 2018. Interviews with the resident care director (RCD) on 10/25/18 at 9:10 am and on 10/26/18 at 12:40 pm revealed: -She did not know about the sewage seeping from underneath the toilet in the shared bathroom between resident rooms 113 and 115. -When repairs were needed staff were supposed to fill out a repair ticket in the maintenance log. Interviews with the Housekeeping Director on 10/25/18 at 8:15 am and 10/26/18 at 12:20 pm revealed: -The floors in the facility were swept and mopped daily. -They had used multiple products over the past year and tried to remove the stains from the floors throughout the facility. -The machine used to strip and wax the floors had been broken for one year so they had not been able to strip and wax any of the floors. -He had requested the Administrator repair or replace the machine several months ago and the request was denied. -He knew about the sewage seeping from underneath the toilet in the shared bathroom for resident rooms 113 and 115 and knew the wall was crumbling and did not have any support in it so it would have to be torn out.	D 074		

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D 074	Continued From page 5 -He had reported the sewage seeping from underneath the toilet to maintenance staff one year ago. -He did not do repairs as he did not work in the maintenance department so the only thing he could do was try to clean the floor. Interview with the Maintenance Director on 10/26/18 at 12:35 pm revealed: -The shared bathroom between resident rooms 113 and 115 had been that way for at least a year. -He addressed small issues immediately and the bigger issues as soon as he could get to them. -He had to wait for the bigger issues to be addressed due to the need for monetary approval. -He was only one person and could only do so much. -The facility hired a part time staff to help with maintenance 6 months ago. Interviews with the Administrator on 10/25/18 at 8:10 am and 10/26/18 at 2:31 pm revealed: -The floors were swept and mopped daily. -She was aware of the toilet seeping sewage and knew the floor was stained. -Resident rooms 113 and 115 would be renovated in 4 months. -She did not know the deep cleaning schedule. -She asked the Housekeeping Director what he deep cleaned weekly. -The carpets was steam cleaned on 08/27/18 and would be cleaned quarterly. It would take a few visits to notice a difference with the stains on the carpet. -The Housekeeping Director used a Clorox mixture for cleaning but he had not been mixing it correctly so she obtained instructions for mixing from the health department. -She asked the Housekeeping Director for the	D 074	Housekeeping Director has given the Administrator a copy of his deep cleaning Schedule, and it has been addressed that The housekeeping supervisor will keep a Check off sheet verifying that the deep clean Has been done correctly. The carpets are scheduled to be steam cleaned Again the week of 11/26 – 11/30 It has been approved to rent a buffing machine to strip and wax the floors. Housekeeping Director is now using the state Guidelines on the Clorox mixing ratios.	11/1/2018

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D 074	Continued From page 6 information she needed so she could work on getting a machine to strip and wax the floors one week ago. -She would discuss with the owners about implementing a deep cleaning schedule. -She expected all cleaning and repairs to be done thoroughly, completely, efficiently, and according to state guidelines. _____ The facility failed to ensure walls, ceilings, and floors were kept clean and in good repair as evidenced by a cracked ceiling which could cause a fall hazard if water was on the floor in the residents room; a crumbling wall which could cause a fall hazard in the shared bathroom; and ongoing exposure to raw sewage in the shared bathroom increasing their risk of infection. This failure was detrimental to the health and safety of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/28/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 10, 2018.	D 074		
D 228	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:	D 228	Medical Records Clerk will ensure that all All new admits have a signed copy of the Resident Handbook, including the facility Smoking policy and discharge policy on File in their resident file.	11/16/2018

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D 228	Continued From page 7 (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule; (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident; (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 residents (# 7) was discharged for reasons related to endangering the safety of other residents, as evidenced by lacking documented incidents of prior smoking in the building and actions taken by the facility to decrease incidents of the resident smoking in the building. The findings are: Observations of the 500 hallway on 10/26/18 at 9:15 am revealed: -The resident's oxygen was in her room which measured 30 feet from the courtyard door. -The oxygen room where oxygen tanks were stored measured 83 feet from the courtyard door. Review of Resident #7's FL-2 dated 7/26/18 revealed diagnoses included cognitive communication deficit, muscle weakness, chronic	D 228	A smoking assessment will be completed Within 48 hours of admission by the Appropriate Care Coordinator to Determine the resident's ability to safely Smoke. All smoking will take place in the designated Smoking areas. Any resident caught violating This rule will be given a written warning and Re-educated regarding the facility smoking Policy. A copy of this warning will also go to The Responsible Party. An updated smoking Assessment will be completed by the care Coordinator after the second offense and The resident's smoking materials will be Removed from the resident per policy. In cases where there is an immediate Danger to resident's and staff, such as Smoking near the oxygen storage or With oxygen therapy in place, the resident Will immediately have their smoking Materials confiscated per the smoking Policy. Failure to comply will be Appropriately documented and reported To the facility Administrator. Any future immediate discharges will be Evaluated by the Administrator and the Facility RN for appropriateness and to ensure Proper documentation is on file, before Discharge is completed.	

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D 228	Continued From page 8 obstructive pulmonary disease (COPD), and anxiety disorder. Review of Resident #7's Resident Register on 10/25/18 revealed the resident was admitted to the facility on 08/30/18. Review of the Discharge Notice dated 10/16/18 revealed: -The date of discharge was 10/16/18. -The reason for discharge was marked as "The safety of the resident or other individuals in this facility is endangered". -The Administrator's signature was on the discharge notice. Review of Resident #7's Incident report dated 10/16/18 revealed the incident was described as: The resident was approached as she was sitting in her wheelchair in front of the 500 hall courtyard door with smoke coming from her mouth and a lit cigarette in her hand. She was informed that she could not smoke in the building. She took another puff, opened the door, and discarded the cigarette. The family member was notified. The Administrator was called and discharge notice completed. Review of Resident #7's admission documentation on 10/26/18 revealed: -There was not a smoking policy found in the resident agreement packet or admission paperwork. -There was not an initial smoking safety assessment upon admission. -There was a smoking safety assessment completed on 10/04/18 without any reports of incidents. Review of Resident #7's Nurse's Notes dated	D 228	The facility resident handbook and facility policy Manual will be updated to reflect the following Policy regarding immediate discharge: Responsible Parties will be notified in writing Upon admission that in the case of inappropriate Behaviors or danger to other residents, and staff A resident will be required to be transferred to the Hospital for evaluation before being allowed to Return to the facility. If the resident or responsible party refuses and evaluation, the responsible party Will be required to remove the resident from the Facility and a discharge will be initiated. The resident care coordinator for each unit will be Responsible for reviewing staff documentation of Behaviors or smoking violations for completeness And appropriate documentation. This will take Place weekly.	

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D 228	Continued From page 9 10/16/18 revealed: -The resident was found on the 500 hall sitting in her wheelchair smoking a cigarette. She was informed that there was no smoking in the building. She took another drag off the cigarette, opened the door, and threw it out. -The resident declined to give staff her lighter. -Staff notified the daughter and informed the family member it was a serious matter because the oxygen room is located on that hall. -The Administrator was then called and notified of the situation. -The Administrator instructed the staff to call the daughter and let her know the facility was issuing a 24 hour discharge because Resident #7 was putting the safety of the staff and resident in danger. -The daughter declined for Resident #7 to go to the hospital and both daughters picked Resident #7 up from the facility. Review of the Smoking Policy on 10/26/18 revealed: -The facility was designated as non-smoking but had a courtyard in which resident's were allowed to smoke. -Upon admission and at any time thereafter that there was a concern, individual residents would be assessed for their ability to comply with smoking policy rules, need for staff, volunteer, visitor or family supervision when smoking, and cognitive ability necessary to maintain smoking in a safe manner. -If a resident was non-compliant by choice or by inability to comply, all smoking materials would be maintained by staff and distributed upon request in a safe manner to be determined. -Staff members would make themselves available to monitor smoking by residents who required supervision.	D 228		

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D 228	Continued From page 10 -At no time could a resident retain lighters, matches, or any other inflammatory devices in a room where oxygen was present. Any source of ignition must be kept a minimum of 15 feet away from an oxygen enriched atmosphere such as a resident receiving oxygen. Review of the Smoking Safety Assessment Policy on 10/26/18 revealed: -Resident's whom smoked would be assessed within 24 hours of admission to determine whether they are capable of maintaining their own supply of smoking paraphernalia and/or smoking without supervision. -They will be reassessed with any noted changes in cognition, non-compliance to the smoking policy, visible burn holes in clothing and/or noted difficulty manipulating their smoking materials. -The smoking safety assessment included mental status, physical ability, and compliance with facility rules and regulations. Review of the Discharge Policy on 10/26/18 revealed: -Conditions for immediate and non-immediate discharge must meet the following conditions whether the discharge is immediate or not: 1) The facility cannot meet the needs of the resident. 2) The resident no longer requires services. 3) The resident's condition is such that he is a danger to himself or poses a direct threat to the health or safety of others. 4) The safety of individuals would otherwise be endangered. 5) The health of individuals would otherwise be endangered. -Reasons for an immediate discharge includes: the resident's condition is such that he is a danger to himself or poses a direct threat to the health or safety of others. Attempted interview with a family member on	D 228		

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D 228	Continued From page 11 10/25/18 at 9:41 am was unsuccessful. Interview with a staff member on 10/26/18 at 2:35 pm revealed: -On 10/16/18 a staff member informed other staff that Resident #7 was smoking in the hallway and she declined to give staff members her lighter and cigarettes. -Staff called the Administrator and informed her that the resident was non-compliant with giving her lighter and cigarettes to staff. -The Administrator instructed staff to call the family member and tell her the resident had to be discharged as a danger to staff and other residents due to her smoking in the building in front of the room that housed oxygen tanks. -Staff assisted the resident to pack her belongings and the resident threw cookies at her roommate and screamed at staff. -The resident's family declined for her to be taken for a psychiatric evaluation at the hospital. -Family picked up Resident #7. Interview with a Medication Aide (MA) on 10/26/18 at 2:55 pm revealed: -A personal aide (PCA) informed her Resident #7 was smoking in the building in front of the exit door. - She went to the resident and informed her smoking was not allowed in the building. -She took one last drag on the cigarette before throwing it out the door then declined to give her lighter and cigarettes to the MA. -A staff member called Resident #7's family and the family member did not believe staff. -She called the Administrator and was told if the resident did not relinquish the lighter to staff then the resident needed to be sent to the hospital for a psychiatric evaluation. - Family refused to have Resident #7 sent to	D 228		

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D 228	Continued From page 12 hospital. - Family came to facility to get resident and did not want to sign any paperwork for discharge. Resident #7 would not have been discharged if she had just given staff the lighter as requested. - Another MA prepared the resident's medications for discharge and she did the discharge paperwork. Family eventually signed the discharge paperwork when told that the resident may continue to be charged for the room if they did not. - She was not sure if the family took more oxygen tanks than the one on the resident's wheelchair. The family left the oxygen concentrator at the nurse's station rather than taking it with her. She did not know why family left the concentrator. - A MA told the resident's family member to take the concentrator and the family member said "no no no, that's fine" and left it at the nurses station. The MA left the oxygen concentrator up front for the family to pick up because she wasn't sure if the resident was coming back. - Resident #7 had the option to go to the hospital for a psychiatric evaluation or be discharged; family chose not to send her to the hospital; instead the family pick her up after she was discharged. Interview with the Resident Care Coordinator (RCC) on 10/26/18 at 12:40 pm revealed: -She was not at the facility the day Resident #7 was discharged. -When a resident had lots of behaviors they could be immediately discharged or sent to the hospital for psychiatric evaluation. -If the hospital did not find a reason for the behaviors they would be sent back to the facility. -She believed there was a policy for inappropriate discharge. -The resident had inappropriate behaviors on a	D 228		

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D 228	Continued From page 13 daily basis and she had the mindset of doing what she wanted to do. Interview with Medical Records Personnel on 10/26/18 at 12:50 pm revealed: -Discharges were noted on the last page of the resident register and on the transfer and discharge form. -For an immediate discharge, the resident would be transferred to the hospital for evaluation. -The Administrator decided when and if an immediate discharge was given. -The Administrator always tried to talk with residents to see why they were acting out to prevent discharges. Interview with the Administrator on 10/26/18 at 2:31 pm revealed: -When a resident was discharged, it was typically due to non-payment (usually 3 months) or resident safety. -When a 30 day discharge was issued it would be sent to the family via certified mail, the ombudsman would be listed, and appeals process would be listed. On day 31 the resident would be taken to the address on the discharge paper. -Resident #7 was discharged for a policy violation.	D 228		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270	All windows are unable to be opened More than 6in. up and down, and blocked From opening inward and outward on SCU. Increased supervision and proof of 15 min. Checks. Staff consistently redirecting resident. All windows are being checked weekly. Dining Room door remains locked when not in use. All Patio furniture has been removed from area of Accessibility to roof.	11/23/2018

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D 270	Continued From page 14 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled residents (Resident #8) which resulted in the resident attempting to climb onto the roof of the facility in the Special Care Unit (SCU) courtyard resulting in a fall and a second incident where the resident eloped from the SCU through an unsecured window. The findings are: Review of Resident #8's FL2 dated 09/27/18 revealed: -Diagnoses included dementia, hypothyroidism, osteoporosis, normocytic anemia, constipation, chronic bronchitis, diabetes mellitus II and history of alcohol abuse. -The Level of Care was marked as SCU. Review of the Resident Register for Resident #8 revealed the resident was admitted to the facility on 08/17/18. 1. Review of Resident #8's Incident and Accident report dated 09/04/18 revealed: -The incident occurred at 3:00 pm. -The resident was seen by another resident walking the outside grounds away from the facility. Observation of the dining room on 10/24/18 at 11:00 am revealed:	D 270		

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D 270	Continued From page 15 -The windows in the SCU dining room were not properly secured. -The window the resident was able to elope from had been secured with screws on each side of the window frame, but the screws were loose. -The window next to it had no visible screws in the window frame and was easy to push up; the window screen had been torn. -The facility was located 150 feet from a busy highway. Interview with Resident #8's Guardian on 09/05/18 at 2:20 pm revealed: -The hospital staff notified her of Resident #8's elopement through a window in the SCU at the facility and the resident being at the hospital for evaluation. -There was no communication from the facility staff about the elopement of the resident from the facility through an unsecured window in the SCU dining room. Interview with the Administrator on 09/05/18 at 2:30 pm revealed: -She was not in the facility during the elopement on 09/04/18. -The Dementia Care Coordinator (DCC) was notified by the staff about the elopement and told staff to be sure to notify the listed contacts. -There was no staff present in the SCU dining room where the elopement occurred through one of the windows that was unsecured. -The dining room was to remain locked when it was not being used and staff not available to supervise residents. -Resident #8's had been put on 15 minute checks when he returned from the hospital on 08/24/18. Interview with the Maintenance Supervisor on 09/24/18 at 3:30 pm revealed:	D 270		

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D 270	Continued From page 16 -The Maintenance Supervisor did not know there were any windows unsecured in the SCU. -He had not checked the windows in over a year. He did not know how often he was supposed to check the windows for security in the SCU. -He would have to check with the Fire Marshall as to what type of security could be done to the windows. -There were windows that had screws in them to keep the windows from being raised more than 6 inches and he was not aware of who could have put the screws in the windows. -He would check all the windows in the dining room to ensure they were properly secured. -Securing the windows would be a priority. -It never occurred to him to double check the windows in the SCU to ensure they were secure. Interview with the DCC on 10/26/18 at 1:00 pm revealed: -She was not working at the facility during the time of the elopement. -Since she had been in the facility, she had noticed as long as the Resident #8 was kept busy and had his cigarettes he was no trouble. -He had been put on 15 minute checks following his latest attempted elopement. Interview with the Receptionist on 10/26/18 at 3:20 pm revealed: -She was sitting at the front desk on 09/04/18 when a resident who had been sitting in front of the facility, came into the building and announced they had just seen a person walking from the side of the facility and the resident thought might be another resident. -She looked out the door and saw a man walking across the street from the facility and initially thought it could be a resident but was not sure. -She went to the SCU and asked if there was a	D 270		

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D 270	Continued From page 17 resident missing from the SCU. -She was initially told no but when she described the clothing the resident was wearing, one of the staff stated it was one of their residents and staff ran outside across the street where the resident went. -She, along with other staff also ran across the street to see if they could be of any assistance. -The resident was trying to walk fast to keep the staff from catching up with him, but eventually stopped and sat on a log. -Staff was able to talk the resident in returning back into the facility. -The staff who was able to redirect the resident back into the facility was no longer employed with the facility. -Emergency Medical Services (EMS) was called and the resident was transported to the hospital on 09/04/18. Attempted interview on 10/26/18 at 2:45 pm with a second staff who was working on 09/04/18 during Resident #8's elopement was unsuccessful. 2. Review of Resident #8's Incident and Accident report dated 08/24/18 revealed: -The incident occurred at 3:23 pm. -The resident was observed standing on a chair on top of a table attempting to climb on the roof of the facility. -The resident fell from the table when he was climbing down and hit his head on the outer wall of the facility. -Emergency Medical Services were notified and the resident was sent to the Emergency Department at a local hospital for evaluation. Interview with the Administrator on 09/05/18 at 2:30 pm revealed:	D 270		

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D 270	Continued From page 18 -There had been a prior attempt of an elopement with the same resident climbing onto the roof of the courtyard which was located within the SCU on 08/24/18. -The resident stacked chairs on top of a table in an attempt to climb on the roof on 08/24/18. -The incident of Resident #8 attempting to climb onto the roof was not considered an elopement due to the resident stating he was trying get into the office to get cigarettes. -She had the maintenance staff to remove the table the resident used. -Resident #8 was placed on 15 minute checks after the incident when he attempted to climb onto the roof on 08/24/18. -Since the incident, staff were supposed to supervise the resident when he went out to smoke or supervise the resident by watching him through the SCU windows overlooking the smoking area. Interview with a staff on 10/26/18 at 12:20 pm revealed: -She was in the Assisted Living (AL) side when she heard someone yell that a resident was trying to climb onto the roof in the courtyard of the SCU. -She went to the living room in the AL and observed the resident through the window. -Resident #8 had moved a table to the lower part of the roof and placed 2 chairs onto the table and climbed on the table. -The resident fell as he was being helped down by another staff. -The resident did not suffer any injuries and was sent to the hospital for evaluation. Interview with the DCC on 10/26/18 at 1:00 pm revealed: -Since she had been in the facility, she had noticed as long as the Resident #8 was kept busy	D 270		

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D 270	Continued From page 19 and had his cigarettes he was no trouble. -Staff were constantly keeping a lookout for him especially when he was in the courtyard smoking. -Staff did not have to physically be in the courtyard when the residents smoked. -The courtyard was surrounded by windows and staff were constantly looking at the residents through the window. -She had not been made aware of any other incidents involving Resident #8. Interview with a second staff on 10/26/18 at 3:30 pm revealed: -He was on duty at the time and went to the courtyard, after he heard yelling, to help Resident #8 off of the table. -The resident hit his head on the side of the building as he was being helped down by staff. -The resident did not sustain any injuries at the time but was sent out to the hospital as a precaution. -He did not know of any other incidents of other residents trying to leave the facility. -Resident #8 had been on 15 minute checks since 08/24/18 after he returned from the hospital. Interview with a third staff on 10/26/18 at 3:35pm revealed: -There was an incident on 08/24/18 where the resident attempted to climb onto a table in the SCU courtyard in order to climb onto the roof. -The incident happened at 12:00 pm and there were 2 other staff that witnessed the incident. The facility failed to provide adequate supervision for Resident #8, who resided in the SCU, resulting in Resident #8 attempting to climb onto the roof of the facility in the courtyard of the SCU, falling, and hitting his head on the side of the	D 270		

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D 270	Continued From page 20 facility; and during a second incident, opened an unsecured window in the dining room in the SCU, and climbed out, exiting the premises and crossed a busy highway. This failure placed residents at substantial risk of physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection on 10/24/18 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 25, 2018	D 270		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage;	D 278	The facility has contracted with a new Pharmacy, Medi-Pack, to provide Several services. The pharmacy has Agreed to meet with the corporate RN within the first two weeks of December to complete new LHPS Assessments on the entire facility. Each resident will receive an updated LHPS assessment at this time, and then Quarterly thereafter. The resident census Will divided into thirds, with a third of the Census being completed each month on a Rolling basis by the facility or corporate RN Resident records will be reviewed monthly By the care coordinator in conjunction with The Administrator to identify any overdue LHPS assessments or any needs for updates Due to new tasks being identified. These Findings will be communicated to the RN Who will then complete the assessment And appropriate staff competency. The Administrator will maintain a list of Residents identified for review the next Month to ensure LHPS assessment has been completed	12/31/2018

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D 278	Continued From page 21 (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic	D 278		

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D 278	Continued From page 22 devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a Licensed Health Professional Support (LHPS) assessment was completed on 1 of 3 sampled residents (Resident #3) in the special care unit (SCU) for the identified tasks of medication administration through injection and collecting and testing fingerstick blood samples. The findings are: Review of Resident #3's current FL2 dated 03/03/18 revealed diagnoses included Alzheimer's disease, Type 2 Diabetes Mellitus, coronary artery disease, hypertension, hyperlipidemia, and a history of breast cancer. Review of Resident #3's LHPS assessment dated 04/25/18 revealed LHPS tasks of medication administration through injection, and collecting and testing fingerstick blood samples. Observation on 10/26/18 at 11:30 am revealed	D 278		

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D 278	Continued From page 23 Resident #3 received fingerstick blood sugar (FSBS) testing and staff assisted her to stand using her walker. Based on observation, interviews, and record review, it was determined Resident #3 was not interviewable. Interview with the Dementia Care Coordinator (DCC) on 10/26/18 at 12:05 pm revealed: -Most of the residents on the special care unit (SCU) had LHPS tasks. -The nurse was responsible for completing the LHPS assessments, and they were supposed to be completed quarterly. -The nurse had completed about 10 residents in the SCU for their quarterly assessment at this time. -The nurse had told her "she was backed up and needed to catch up." -The administrator "had been on the nurse about getting the LHPS done." Interview with the facility Registered Nurse (RN) on 10/25/18 at 5:00 pm revealed: -She was responsible for completing the LHPS assessment quarterly for residents. -She was behind on LHPS assessments because when she started at the facility, the assessments had not been done for over a quarter, and every resident with LHPS tasks needed a quarterly assessment. -She had been trying to catch up all of the LHPS assessments and had completed all the assessments for the assisted living side of the facility, but had not completed the SCU yet. -She hoped to have them all completed by the end of the first week of November. Interview with the Administrator on 10/26/18 at	D 278		

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D 278	Continued From page 24 1:50 pm revealed: -LHPS assessments should have been done by the facility RN quarterly or with any significant changes in the residents. -She knew the LHPS assessments were not up to date. -The previous RN had not completed LHPS assessments in a timely manner so the current RN was "trying to catch them all up." -In the future, she would be auditing all records quarterly to assure the LHPS assessments were current.	D 278		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367	Continued on next page	

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D 367	Continued From page 25 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 1 of 7 sampled residents (Resident #5) related to documenting administration of a pain medication. The findings are: Review of Resident #5's current FL2 dated 09/12/18 revealed diagnosis included hypertension, Diabetes Mellitus Type II, Chronic Obstructive Pulmonary Disease (COPD), phantom limb syndrome with pain, depression, anxiety, scoliosis, and chronic low back pain. Review of Resident #5's Six Month Order Verification dated 9/12/18 revealed an order for norco 5/325mg (narcotic pain reliever) 1 tablet two times a day as needed for pain. Review of Resident #5's August 2018 medication administration record (MAR) revealed: -There was an entry for norco 5/325mg 1 tablet two times a day as needed for pain. -Norco was documented as administered 19 times from August 1 - 31, 2018. Review of the Controlled Substance Count Sheet (CSCS) for August 2018 revealed: -Norco was documented as administered 30 times from August 1 - 31, 2018. -A total of 19 doses were documented as administered on the MAR from August 1, 2018 - August 31, 2018 but 30 doses were documented as administered on the CSCS. Review of Resident #5's September 2018 MAR	D 367	The facility has contracted with a New pharmacy for pharmaceutical Services. A complete facility medication Audit has been completed by the Pharmacist to identify any medication Errors or inaccuracies on the MAR. the Facility will be transitioning to an Electronic MAR system on Dec. 1, 2018 The new pharmacy will be responsible For entering orders received by fax or Electronic transmission from the Providers into the electronic MAR. the Facility Care Coordinators will then be Responsible for reviewing the orders in The eMAR against the paper orders r Received for accuracy. Once verified, the Care Coordinators will activate the orders In the eMAR system for administration. All medications will be given according to The eMAR and documented appropriately On the eMAR. Safeguards have been built Into the eMAR system that require appropriate Documentation (such as route, site, amount, Efficacy, and reason) to be documented Before me MA can leave the screen or continue Documentation. EMARs will be reviewed Weekly for missed dosed or other issues With documentation by the Care Coordinators. A full review will be completed monthly By the RN and administrator. Pharmaceutical Reviews will be completed quarterly by the Contracted pharmacy. In-services and one-on-one Re-education will be provided to any MA Identified on audit as having more than 3 Medication or documentation errors or omissions in a month	12/31/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 10/26/2018

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

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D 367	Continued From page 26 revealed: -There was an entry for Norco 5/325mg 1 tablet two times a day as needed for pain. -Norco was documented as administered 26 times from September 1, 2018 through September 30, 2018. Review of the Controlled Substance Count Sheet (CSCS) for September 2018 revealed: -Norco was documented as administered 46 times from September 1, 2018 through September 30, 2018 -A total of 26 doses were documented as administered on the MAR from September 1, 2018 - September 30, 2018 but 46 doses were documented as administered on the CSCS log. Review of Resident #5's October 2018 MAR revealed: -There was an entry for norco 5/325mg 1 tablet two times a day as needed for pain. -Norco was documented as administered 9 times from October 1, 2018 through October 24, 2018. Review of the Controlled Substance Count Sheet (CSCS) for September 2018 revealed: -Norco was documented as administered 44 times from October 1, 2018 through October 24, 2018. -A total of 9 doses were documented as administered on the MAR from October 1, 2018 - October 24, 2018 but 44 doses were documented as administered on the CSCS. Observation of medications on hand 10/24/18 at 4:55 pm for Resident #5 revealed: -There was a supply of norco 5/325mg (60 tablets) dispensed on 09/26/18. -There were 8 of 60 tablets remaining in the bubble card.	D 367		

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D 367	Continued From page 27 -The number of norco tablets on hand reconciled with the CSCS log. Interview with Resident #5 on 10/24/18 at 3:40 pm revealed: -She knew norco 5/325mg was prescribed 2 times per day as needed for pain. -She had chronic pain and phantom pain from her right below the knee amputation. -She usually took the pills the medication aide (MA) placed in the cup without counting or looking at them. -She thought the norco was a little white or oval pill. -She usually took the norco twice daily, once in the morning and once of the evening. Interview with a MA on 10/24/18 at 4:45 pm revealed: -When a resident requested pain medication, she asked where their pain was and how bad it was. -She would then check the MAR for orders. -After administering the pain medication, she documented it on the front and back of the MAR, on the CSCS log, and in the progress notes. -MARs were supposed to be audited weekly by the Resident Care Coordinators (RCC). Interview with a second MA on 10/24/18 at 4:55 pm revealed: -She had administered norco to resident #5 previously. -When a resident requested pain medication, she was supposed to ask where the pain was and how bad it was. -She usually tried to document on the CSCS sheet and the front and back of the MAR. -Sometimes she forgot to go back and check her documentation for holes.	D 367		

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D 367	Continued From page 28 Interview with the Pharmacy staff on 10/25/18 at 10:15 am revealed that the norco CSCS sheets matched the amounts of norco that had been dispensed since August 2018. Interview with a third MA on 10/26/18 at 7:58 am revealed: -When a pain medication was administered, she asked how bad the pain was and where the pain was located. -She signed the medication out on the CSCS log and then took it to the resident. -After having administered it to the resident, the MAR's were signed on the front and the back. -The MA's then went back to ask the resident if the medication helped and documented effectiveness. -The MA's were supposed to check for holes on the MAR and make sure all the as needed medication were documented at the end of the shift. Interview with the RCC on 10/24/18 at 5:00 pm revealed: -She did not know Resident #5's norco had not been signed for on the MAR each time it had been administered. -MAs were supposed to ask where the resident's pain was at and how they would rate it when an as needed pain medication was requested. -When a narcotic was punched from the bubble packet, the MA was supposed to sign it out on the CSCS log. -The MAs would administer the medication and come back to the cart to document it on the front and the back of the MAR. -MAs were responsible for reviewing MARs after their shift for accuracy and completion. -She was responsible for random audits weekly. -It was her responsibility to ensure all medication	D 367		

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D 367	Continued From page 29 is documented appropriately. Interview with the Administrator on 10/24/18 at 5:10 pm revealed: -She did not know that Resident #5's norco had not been signed for on the MAR each time it had been administered. -Medication administration was supposed to be documented at the time the medication was administered. -All as needed medications required date, time, and how given. -The narcotics were supposed to be signed out on the CSCS log. -She did not know if MAR audits were being completed. -Going forward MAR audits would be completed by the RCC. -She was responsible for ensuring all regulations were followed.	D 367		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to	{D912}		

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{D912}	Continued From page 30 personal care and supervision and housekeeping and furnishings. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled resident (Resident #8) which resulted in the resident attempting to climb onto the roof of the facility in the Special Care Unit (SCU) courtyard resulting in a fall and a second incident where the resident eloped from the SCU through an unsecured window. [Refer to Tag 0269 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to ensure walls, ceilings, and floors were kept clean and in good repair in 4 of 11 resident bedrooms (107, 109, 113, and 115), 6 of 9 resident bathrooms {104, 105, 106, 107, 110, 113 and 115 (shared)}, and on the 500 hallway. [Refer to tag 0074 10A NCAC 13F .0306 (a)(1) Housekeeping and Furnishings (Type B Violation)].	{D912}		