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 03/08/2019

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 conducted an annual and follow-up survey 03/05/19 through 03/08/19.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the water temperatures were maintained at a maximum of 116 degrees Fahrenheit (F) for 5 of 5 sampled fixtures (sinks) in resident rooms on the 100 Hall. The findings are: Observation during the initial tour of the facility on 03/05/19 from 8:45am to 9:30am revealed hot water temperatures as follows: -At 9:02 am, the hot water temperature at the sink in room 103 was 119 degrees F. -At 9:08 am, the hot water temperature at the sink in room 106 was 120 degrees F. -At 9:12 am, the hot water temperature at the sink in room 107 was 121 degrees F. -At 9:20 am, the hot water temperature at the sink in room 112 was 121 degrees F.	D 113		

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D 113	Continued From page 1 -At 9:46 am, the hot water temperature at the sink in room 104 was 120 degrees F. Interview with a resident residing in room 104 on 03/05/19 at 8:48am revealed the water was not too hot for him because he was able to mix in cold water to adjust to his comfort level. Interview with a second resident residing in room 104 on 03/05/19 at 4:12pm revealed the hot water coming from the sink was not hot because he knew to mix in cold water. Interview with a resident in room 103 on 03/05/19 at 9:04am revealed she did not think the water coming from the faucet was hot because she turned on the cold water to make the water warm. Based on observations, interviews and record review, a second resident residing in room 103 was not interviewable. Interview with a resident residing in room 106 on 03/05/19 at 9:10am revealed he did not know if the water was hot because he always used cold water with the hot water for his comfort. Interview with a resident residing in room 107 on 03/05/19 at 9:15am revealed she always used cold water to mix with hot water and did not feel the water temperature was too hot. Interview with a resident residing in room 112 on 03/05/19 at 9:23am revealed she did not get burned by the hot water because she was able to adjust the hot water temperature to her comfort level. Interview with the Maintenance Director on 03/05/19 at 9:40am revealed:	D 113		

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D 113	Continued From page 2	D 113		

-He had worked at the facility since December 2018.
-He was told to check hot water temperatures monthly.
-He checked various locations throughout the facility on the same date every month and recorded the readings on the "Temperature Checklist."
-He did not know what the temperature ranges were required to be.
-The facility had two hot water tanks and he did not know which tanks controlled the 100 hallway.
-The thermometer given to him to check the hot water temperature was a meat thermometer.
-He would adjust both hot water tanks to reach the required temperature.

Review of the facility's monthly water temperature checklist for March 2019 revealed:
-There was one hot water temperature recorded for residents residing on the 100 hallway.
-The hot water temperature in room 114 was 118 degrees.

Interview with the Administrator on 03/05/19 at 9:45am revealed:
-She did not know the hot water temperatures in resident rooms on the 100 hallway were greater than 116 degrees F.
-She would post signs to warn residents to seek caution when using the hot water.

Calibration on 03/05/19 at 4:05pm of the surveyor thermometer and the Maintenance Director thermometer revealed:
-The surveyor thermometer calibrated at 30 degrees F, requiring two degrees to be added to obtain 32 degrees F.
-The Maintenance Director thermometer calibrated at 38 degrees requiring him to deduct

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D 113	Continued From page 3 six degrees to obtain 32 degrees F. A second recheck of the water temperature at the sink in resident room 104 on 03/05/19 at 4:10pm revealed the water temperature was 124 degrees F after running the hot water for one minute. Second interview with the Maintenance Director on 03/05/19 at 4:16pm revealed he had adjusted the wrong hot water tank he would make another adjustment to the hot water. A third recheck of the water temperature at the sink in resident room 104 on 03/05/19 at 5:26pm revealed the water temperature was 110 degrees F.	D 113		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 7 residents sampled (Resident #3) was tested upon admission for tuberculosis (TB) disease.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 234	Continued From page 4 The findings are: Review of Resident #7's current FL2 dated 06/27/18 revealed diagnoses included end stage renal disease, type two diabetes, neurogenic bladder, colostomy, bilateral amputation, and left arm paralysis. Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 02/05/18. Review of Resident #7's record revealed: -There was a documented TB skin test with no dated the dated was placed. -The TB skin test was read on 08/09/17 with negative results. -There was a second documented TB skin test that was placed on 02/07/18. -There was no documented result. Interview with Resident #7 on 03/07/19 at 9:52am revealed: -She moved into the facility on 02/05/18. -Prior to living at the facility she came from home. -A TB skin test was placed when she came to the facility, but she could not recall if the TB skin test was read. Interview with the medical records person and the Resident Care Director on 03/06/19 at 4:15pm revealed: -The Registered Nurse that placed Resident #7's TB skin test no longer worked at the facility. -They could not validate the TB skin test that was placed on 02/07/18 had been read.	D 234		

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D 273	Continued From page 5	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 4 of 7 sampled residents (Residents #2, #4, #6 and #7) related to not contacting the physician when a resident's blood sugar was greater than 400, when residents were out of the facility and missed medications and when residents refused medications of Novolog, Tylenol, Auryxia, gabapentin, linzess, refresh tears, and midodrine (#7), Sevelamer Carbonate (renvela) (#6), anti-inflammatory cream and an inhaled Fluticasone Propionate (#2), a podiatrist referral and contacting the physician regarding refusal of Ibuprofen (#4). The findings are: 1. Review of Resident #7's current FL2 dated 06/27/18 revealed diagnoses included end stage renal disease, type two diabetes, neurogenic bladder, colostomy, bilateral amputation, and left arm paralysis.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 6	D 273		

a. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for Novolog (fast-acting insulin to help control diabetes) sliding scale insulin subcutaneously with meals when FSBS ranged between 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, greater than 400 call the physician, and an order for fingerstick blood sugars (FSBS) before meals and at bedtime.

Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for Novolog sliding insulin subcutaneously when FSBS ranged between 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, greater than 400 call the physician, and an order for FSBS before meals and at bedtime.

Review of Resident #7's December 2018 electronic Medication Record Administration (eMAR) revealed:
-There was an entry for FSBS four times daily scheduled for 7:30am, 11:30am, 4:30pm and 8:00pm.
-There was documentation FSBS were greater than 400 on four occasions on 12/15/18 at 8:00pm FSBS was 422, 12/21/18 at 7:30am FSBS was 579, 12/21/19 at 4:30pm FSBS was 438, and 12/21/19 at 8:00pm FSBS was 443.
-There was no documentation the physician was notified the resident's FSBS was greater than 400.

Review of Resident #7's January 2019 eMAR revealed:
-There was an entry for FSBS four times daily scheduled for 7:30 am, 11:30 am, 4:30 pm and 8:00 pm.
-There were no documentation of FSBS greater

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D 273	Continued From page 7	D 273		

than 400 on the January eMAR.

Review of Resident #7's February 2019 eMAR revealed:
-There was an entry for FSBS four times daily scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation of FSBS greater than 400 on four occasions on 02/21/19 at 7:30am FSBS was 561, 02/24/19 at 7:30am FSBS was 457, 02/25/19 at 7:30am FSBS was 487, and on 02/27/19 FSBS was 487.
-There was no documentation the physician was notified the resident's FSBS was greater than 400.

Review of Resident #7's March 2019 eMAR revealed:
- There was an entry for FSBS four occasions daily scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation FSBS were greater than 400 on two occasions on 03/01/19 at 8:00pm FSBS was 491, and on 03/02/19 at 7:30am FSBS was 401.
- There was no documentation the physician was notified the resident's FSBS that were greater than 400.

Review of the facility's "SIC/MT Daily Report" for December 2018, January, February, and March 2019 revealed:
-The form required staff to document a resident's blood sugar results, date and time for each scheduled reading.
-The FSBS results for Resident #7 were not documented daily, per shift as required by the form.
-There were no documented FSBS results for Resident #7's FSBS that were greater than 400.

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	HAL034098	A. BUILDING: _____ B. WING _____	R 03/08/2019

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D 273	Continued From page 8 Review of Resident #7's "Nurse Notes" from 12/01/18 through 03/07/19 revealed there was no documentation Resident #7's physician had been notified regarding FSBS that were greater than 400. Interview with Resident #7 on 03/07/19 at 8:34am revealed: -She was a severe diabetic. -Her blood sugars were "All over the place." -The medication aides (MAs) checked her FSBS four times daily, excluding the times she was at dialysis. -When her blood sugar was above 400 she sometimes felt light-headed. -She had not seen the "Diabetes" doctor in several months. Interview with a first shift MA on 03/07/19 at 3:05pm revealed: -Sunday (02/20/19) Resident #7 had a FSBS greater than 400. -She called the on-call service and left a message. -When they called her back she was told to give the resident extra insulin, plus what was originally ordered. -She thought she "wrote a note", but could not recall if she had documented the communication with the on-call physician or the extra insulin administered. Interview with a MA on 03/07/19 at 3:58pm revealed: -A couple of times she called Resident #7's physician to inform of the FSBS that was greater than 400. -She was told to give the resident extra insulin. -She did not document the conversation with the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 9	D 273		

physician, she did not document the order to give more insulin and she did not document the units of insulin administered to the resident.

Interview with Resident #7's Endocrinologist on 03/07/19 at 11:14am revealed:
-The physician had not seen Resident #7 since August 2018.
-The resident had an appointment on 02/28/19, but was a no show.
-A search of the physician's records showed no documentation the facility had called and informed Resident #7 had FSBS greater than 400.
-Resident #7 was a brittle diabetic and the physician wanted to be notified when the FSBS was greater than 400 because there may need to be medication adjustments.
-The facility should call to get the resident in to see the physician as soon as possible.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed:
-The facility had a form titled "SIC/MT Daily Report," that MAs were to complete per shift for residents ordered FSBS.
-The MAs were to turn the form in to her at the end of each shift.
-She did not review the FSBS results.
-At the end of each day she should have reports with four FSBS for Resident #7.
-She did not review Resident #7's FSBS results.
-She did not check to ensure staff completed the form every day.
-She did not know that Resident #7 had FSBS greater than 400.
-The only staff that checked the form for FSBS outside of range was the facility's nurse.
-The nurse no longer worked at the facility.
-She did not know if the nurse followed-up with

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	HAL034098	A. BUILDING: _____ B. WING _____	R 03/08/2019

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D 273	Continued From page 10	D 273		

the physician regarding Resident #7's FSBS greater than 400.
-It was the facility's protocol that the MAs were responsible for checking Resident #7's FSBS.
-If the resident's FSBS was greater than 400, the MA should immediately notify the resident's physician.
-The MA who called the physician should document in the nurse notes the date, time and physician's response to the phone call.
-If the physician ordered additional insulin, that was considered a telephone order and there should be physician's signature for the order.
-If the MA did not document the physician was notified, then there was no way to validate the physician had been called.
-Weekly, she did a whole cart and eMAR audit reviewing the medications in the medication cart and the eMARs, she did not look at the FSBS results.

Interview with the Medical Records person on 03/08/19 at 12:47pm revealed:
-The MAs were required to document Resident #7's FSBS four times daily and give the documented FSBS to the RCC.
-The RCC should look at Resident #7's FSBS results and verify with the MA to ensure they followed-up with the resident's physician regarding FSBS greater than 400.
-The MAs had been continually reminded to document "happenings" for all residents, especially contact with the physician.

Interview the Administrator on 03/08/19 12:48pm revealed:
-The MAs were responsible to notify the physician when Resident #7's FSBS were greater than 400.
-The MAs were required to give FSBS sheets to the RCC daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 11	D 273		

-The RCC should have verified the MAs contacted Resident #7's physician for FSBS greater than 400 and made sure the physician was notified.
-There should be documentation in the resident's record to validate the physician was notified.

b. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for Novolog insulin four units subcutaneously once daily (used to lower elevated blood sugar levels) with the lunch meal.

Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for Novolog four units subcutaneously once daily with the lunch meal.

Review of Resident #7's December 2018 electronic Medication Record Administration (eMAR) revealed:
-There was an entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not administered sixteen of the thirty-one opportunities scheduled for 12:00pm between 12/01/18 through 12/31/18.
-There was documentation the resident was out of the facility, "Physically unable to take medications," or there was no documentation why the medication was not administered.
-There was no documentation the physician was notified the resident was not administered Novolog four units at 12:00pm.

Review of Resident #7's January 2019 eMAR revealed:
-There was an entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not

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D 273	Continued From page 12	D 273		

administered fourteen of the thirty-one opportunities scheduled between 01/01/19 through 01/31/19.
-There was documentation the resident was out of the facility at dialysis, "Physically unable to take medication," for the missed medication administration times from 12/01/18 through 12/31/18.
-There was no documentation the physician was notified the resident was not administered Novolog four units at 12:00pm.

Review of Resident #7's February 2019 eMAR revealed:
-There was an entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not administered thirteen of the twenty-eight opportunities scheduled between 02/01/19 through 02/28/19.
-There was documentation the resident was out of the facility, "Physically unable to take medication," or there was no documentation for missed medication.
-There was no documentation the physician was notified the resident was not administered Novolog four units at 12:00pm as ordered.

Review of Resident #7's March 2019 eMAR revealed:
-There was an entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not administered three of the six opportunities scheduled between 03/01/19 through 03/06/19.
-There was documentation the resident was out of the facility for all the missed medication administration times.
-There was no documentation the physician was notified the resident was not administered

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 03/08/2019

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 273	Continued From page 13	D 273		

Novolog four units at 12:00pm.

Review of Resident #7's nurse's notes revealed there was no documentation Resident #7's physician was notified of the 46 occasions the resident out of the facility at dialysis and Novolog was not administered as ordered from 12/01/18 to 03/06/19.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She was a severe diabetic and was ordered Novolog insulin three times daily along with Novolog sliding scale.
-She went to dialysis Monday, Wednesday and Fridays.
-When she went to dialysis she left the facility at 11:00am and sometimes did not return to the facility until almost 6:00pm.
-On Monday, Wednesday and Fridays she was never administered the 12:00pm Novolog insulin.
-At dialysis she was given a snack, but no one checked her FSBS or gave her insulin.
-About two months ago she used to take medications with her to dialysis, but that stopped.
-The facility staff told her that the staff at the dialysis center said they were not responsible for administering her medications.
-She did not know if the Endocrinologist knew she did not get Novolog insulin at 12:00pm or if they knew when she returned late from dialysis.
-Depending on the time she returned to the facility, staff sometimes did not give her Novolog insulin at all because she had missed the one hour window to administer medications.
-For example, if she returned to the facility at 5:45pm, staff would administer her 4:30pm Novolog insulin because she was outside one hour window.
-On dialysis days, the only Novolog insulin that

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 14	D 273		

she got was at breakfast.
-Sometimes her FSBS were greater than 400 and still staff did not give insulin because she was outside the one hour window.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:
-Resident #7 went to dialysis Monday, Wednesday and Friday from 11:00am to 5:00 or 6:00pm.
-When the resident was at dialysis she was not administered any medications scheduled during the time the resident was out of the facility.
-She circled her initials on the eMAR, and documented the resident was out of the facility or "Physically unable to take the medication" when the resident was not present during the scheduled administration times.
-She documented; physically unable to take the medication because the resident was not present in the facility.
-The facility staff used to send Resident #7's medications to the dialysis center to be administered, but the center informed the staff at the center were not allowed to administer medications to Resident #7.
-She had not contacted Resident #7's physician to information Novolog four units at lunch time was not administered Monday, Wednesday and Fridays.

Interview with Resident #7's Endocrinologist 03/07/19 at 11:14am revealed:
-The physician knew Resident #7 went to dialysis and thought the Novolog was administered while the resident was at dialysis.
-The Novolog insulin was ordered with meals, therefore regardless of the time, if Resident #7 had a meal or snack she should still be administered Novolog.

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 15	D 273		

-It did not matter what time Resident #7 returned to the facility, if the resident was offered a meal, Novolog insulin should still be administered.
-The facility staff should have called the physician's office to inform the resident was not getting the lunch time Novolog insulin as ordered.

Interview with the Resident Care Coordinator on 03/08/19 at 8:43am revealed:
-Resident #7 went to dialysis three days per week.
-The resident previously took medications with her the dialysis center, but the center informed the facility they were not going to be responsible for administering Resident #7's medications.
-No one at the facility had contacted Resident #7's physician to inform him Novolog insulin was not administered when the resident was out of the facility at dialysis.
-It was the facility's policy not to administer medications outside the one hour window, however the MA should call the physician and ask for instructions regarding the missed medication.

Interview the Administrator on 03/08/19 12:48pm revealed:
-She expected the MAs to notify the physician when Resident #7 was not administered medications as ordered.
-The MAs should have followed-up with Resident #7's physician to inquire what to do regarding medications ordered during the time when the resident was out of the facility at dialysis.
-The MAs should have obtained orders from the physician addressing medications ordered when the resident was at dialysis.

c. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for Auryxia 210mg (two tablets =420mg) (used to lower high

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 16	D 273		

blood phosphate levels) three times daily with meals.

Review of Resident #7's record revealed a physician's order sheet dated 12/04/18 with orders for Auryxia 210mg (two tablets =420mg) three times daily with meals.

Review of Resident #7's December 2018 electronic Medication Record Administration (eMAR) revealed:
-There was an entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm.
-There was documentation Auryxia was not administered fifteen of the ninety-three opportunities scheduled between 12/01/18 through 12/31/18 at 12:00pm on Monday, Wednesday and Friday.
-There was documentation the resident was out of the facility or physically unable to take medications.
-There was no documentation the physician was notified the resident was not administered Auryxia as ordered at 12:00pm on Monday, Wednesday and Friday.

Review of Resident #7's January 2019 eMAR revealed:
-There was an entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm.
-There was documentation Auryxia was not administered sixty-three of the ninety-three opportunities scheduled between 01/01/19 through 01/31/19 at 12:00pm on Monday, Wednesday and Friday.
-There was documentation the resident was out of the facility or physical unable to take the medication.

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 03/08/2019

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D 273	Continued From page 17 -There was no documentation the physician was notified the resident was not administered Auryxia as ordered at 12:00pm on Monday, Wednesday and Friday. Review of Resident #7's February 2019 eMAR revealed: -There was an entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm. -There was documentation Auryxia was not administered twenty-two of the eighty-four opportunities schedules between 02/01/19 through 02/28/19 at 12:00pm on Monday, Wednesday and Friday. -There was documentation the resident was out of the facility. -There was no documentation the physician was notified the resident was not administered Auryxia as ordered at 12:00pm on Monday, Wednesday and Friday. Review of Resident #7's March 2019 eMAR revealed: -There was an entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm. -There was documentation Auryxia was not administered four of the seventeen opportunities scheduled between 03/01/19 through 03/06/19 at 12:00pm on Monday, Wednesday and Friday. -There was documentation the resident was out of the facility. -There was no documentation the physician was notified the resident was not administered Auryxia as ordered at 12:00pm on Monday, Wednesday and Friday. Interview with Resident #7 on 03/07/19 at 8:34am revealed:	D 273		

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 03/08/2019

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D 273	Continued From page 18	D 273		

-She went to dialysis three days per week from 11:00am until almost 6:00pm.
-She was not administered Auryxia at 12:00pm on the days she went to dialysis.
-If she arrived at the facility after 6:00pm the 5:00pm dosage of Auryxia was not administered.
-She knew Auryxia was an iron medication and she needed the medication because she had dialysis.
-She did not know if the physician knew she did not get the medication as ordered.

Review of Resident #7's nurse's notes revealed there was no documentation the resident did not receive Auryxia 104 times from 12/01/18 through 03/07/19.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:
-Resident #7 went to dialysis Monday, Wednesday and Friday from 11:00am to 5:00 or 6:00pm.
-When the resident was at dialysis, the 12:00pm dosage of Auryxia was not administered.
-She had not contacted Resident #7's physician to information Auryxia was not administered three times daily on the dialysis days.

Interview with a second MA on 03/08/19 at 9:50am revealed:
-The dialysis center informed staff at the facility they would not be responsible for administering Resident #7's Auryxia.
-She did not know if Resident #7's physician was notified Auryxia was not administered three times daily when Resident #7 was at dialysis (Mondays, Wednesdays and Fridays).

Interview with the nurse at Resident #7's Nephrologist's office on 03/07/19 at 2:22pm

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 19	D 273		

revealed:
-No one at the facility had notified the physician that Resident #7 was not administered Auryxia three times daily as ordered.
-The medication should be administered with a meal or a snack.
-The physician knew that Resident #7 had dialysis three times per week, but did not know administering medications three times daily on dialysis was a problem.
-The facility staff should have contacted the physician for instructions if they were unable to administer the medication as ordered.

Interview the Administrator on 03/08/19 12:48pm revealed:
-She expected the MAs to notify the physician when Resident #7 was not administered medications as ordered.
-The MAs should have followed-up with Resident #7's physician to inquire what to do regarding medications ordered during the times when the resident was out of the facility at dialysis.
-The MAs should have obtained orders from the physician addressing medications ordered when the resident was at dialysis.

d. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for gabapentin 100mg two capsules (200mg) (used to treat diabetic nerve pain) four times daily.

Review of Resident #7's record revealed a physician's order sheet dated 12/04/18 with orders for gabapentin 100mg two capsules (200mg) four times daily.

Review of Resident #7's December 2018 eMAR revealed:
-There was an entry for gabapentin 100mg two

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 03/08/2019

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 273	Continued From page 20	D 273		

capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation gabapentin was not administered thirteen of the ninety-three opportunities scheduled between 12/01/18 through 12/31/18 at 12:00pm when the resident was at dialysis (Monday, Wednesday, and Friday).
-There was no documentation the physician was notified the medication was not administered as ordered at 12:00pm when the resident was at dialysis.

Review of Resident #7's January 2019 eMAR revealed:
-There was an entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation gabapentin was not administered fourteen of ninety-three opportunities scheduled between 01/01/19 through 01/31/19 at 12:00pm.
-There was no documentation the physician was notified the medication was not administered as ordered at 12:00pm.

Review of Resident #7's February 2019 eMAR revealed:
-There was an entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation gabapentin was not administered twelve of eighty-four opportunities scheduled between 02/01/19 through 02/28/19 at 12:00pm.
-There was no documentation the physician was notified the medication was not administered as ordered at 12:00pm.

Review of Resident #7's March 2019 eMAR

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 03/08/2019

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D 273	Continued From page 21	D 273		

revealed:
-There was an entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation gabapentin was not administered three of seventeen opportunities scheduled between 03/01/19 through 03/06/19 at 12:00pm when the resident at dialysis (Monday, Wednesday, and Friday).
-There was no documentation the physician was notified the medication was not administered as ordered at 12:00pm when the resident was at dialysis.

Review of Resident #7's nurse's notes revealed there was no documentation the physician was notified the resident did not receive gabapentin 42 times from 12/01/18 through 03/06/19.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She went to dialysis Monday, Wednesday and Fridays.
-On the days that she went to dialysis she left the facility at 11:00am.
-She sometimes did not return to the facility until almost 6:00pm.
-The gabapentin was administered four times daily and was administered four times daily excluding the days she went to dialysis.
-If she returned from dialysis after 5:30pm she was not administered the 4:00pm gabapentin, which meant she had to wait until 8:00pm to get the medication.
-Facility staff would not administer the medication after 5:00pm because she was outside the one-hour after the scheduled medication administration time.
-About two months ago she used to take her medications with her to dialysis, but that stopped.

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 03/08/2019

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D 273	Continued From page 22 -The facility staff told her that the staff at the dialysis center said they were not responsible for administering her medications. -She wished that she could have the 12:00pm gabapentin because it would help with her pain. Interview with a first shift MA on 03/07/19 at 3:05pm revealed: -Resident #7 went to dialysis Monday, Wednesday and Friday from 11:00am to 5:00 or 6:00pm. -On the days that the resident went to dialysis gabapentin was not administered at 12:00pm. -When Resident #7 returned to the facility, if it was after 5:00pm, then the 4:00pm gabapentin was not administered because it was past the one hour window. -She did not contact Resident #7's physician to inform gabapentin was not administered. -Gabapentin was scheduled for 12:00pm, she had not considered administering the medication one hour early at 11:00am before the resident left for dialysis. -It was the facility's protocol when a medication was not administered to notify the physician why the medication was not administered. -She had not contacted Resident #7's physician's about the medications not administered as ordered. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed: -Resident #7 went to dialysis three days per week (Monday, Wednesday and Friday). -Resident #7 did not take the gabapentin with her to the dialysis center because there was no one there to administer the medications to the resident. -She had not contacted Resident #7's physician's to inform the medication was not administered as	D 273		

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 03/08/2019

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 273	Continued From page 23	D 273		

ordered.

Interview with the Administrator on 03/08/19 at 12:48pm revealed:
-The MA should have contacted the physician and explained why Resident #7 was not administered gabapentin.
-The facility's process was to administer medications one hour before the scheduled time or one hour after the scheduled time.
-She did not know that Resident #7 was not getting medications as ordered because she was going to dialysis.

Interview with the nurse at Resident #7's primary care physician's (PCP) office on 03/08/19 at 2:45pm revealed:
-The physician did not know Resident #7 was not administered gabapentin four times daily as ordered.
-The medication should be administered when the resident went to dialysis.
-If there was a problem administering gabapentin while at dialysis the facility staff should have informed the physician the medication could not be administered and he would have made adjustments.

e. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for linzess 290mcg (used to treat constipation) every morning thirty minutes before breakfast.

Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for linzess 290mcg every morning thirty minutes before breakfast.

Review of Resident #7's December 2018 eMAR revealed:

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 03/08/2019

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 273	Continued From page 24 -There was an entry for linzess 290mcg every morning thirty minutes before breakfast was scheduled at 7:30am. -There was documentation linzess was not administered ten of the thirty-one opportunities from 12/07/18 through 12/31/18. -There was documentation Resident #7 refused linzess. -There was no documentation the physician was notified the resident refused the medication. Review of Resident #7's January 2019 eMAR revealed: -There was an entry for linzess 290mcg every morning thirty minutes before breakfast was scheduled at 7:30am. -There was documentation linzess was not administered twenty-one of the thirty-one opportunities from 01/01/19 through 01/31/19. -There was documentation Resident #7 refused linzess or was "Physically unable to take medication." -There was no documentation the physician was notified the resident refused linzess. Review of Resident #7's February 2019 eMAR revealed: -There was an entry for linzess 290mcg every morning thirty minutes before breakfast was scheduled at 7:30am. -There was documentation linzess was not administered twenty-five of twenty-eight opportunities scheduled between 02/01/19 through 02/28/19. -There was documentation Resident #7 refused linzess or was "Physically unable to take medication." -There was no documentation the physician was notified the resident refused linzess.	D 273		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 25	D 273		

Review of Resident #7's March 2019 eMAR revealed:
-There was an entry for linzess 290mcg every morning thirty minutes before breakfast was scheduled at 7:30am.
-There was documentation linzess was not administered six of six opportunities scheduled between 03/01/19 through 03/06/19.
-There was documentation Resident #7 refused linzess or was "Physically unable to take medication."
-There was no documentation the physician was notified the resident refused linzess.

Review of Resident #7's nurse's notes revealed there was no documentation the physician was notified the resident refused linzess 83 times from 12/07/18 through 03/06/19.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She had a colostomy, and sometimes it was difficult for her to use the bathroom.
-Linzess made intestines contract which cause her bowels to move easier.
-She also had an indwelling catheter, which caused her to have chronic urinary tract infections (UTI's).
-Last year the physician ordered a routine antibiotic to help with the frequent UTI's.
-The antibiotic caused her to have loose bowels, so she felt that she no longer needed linzess.
-When staff administered the linzess with the antibiotic it caused her to have severe diarrhea and she spent a lot of time cleaning herself up.
-She did not want the medication to be discontinued, but wanted the medication as needed.
-For the past two to three months she had repeatedly asked the MAs to get linzess changed

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 03/08/2019

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 273	Continued From page 26	D 273		

to an as needed medication.
-As of today's date (03/07/19), the MAs still tried to administer her linzess every morning at 7:30am.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:
-Resident #7 continually refused linzess.
-The resident had asked to have the medication changed to an as needed medication.
-She was going to contact Resident #7's physician, but had forgot.
-It was the facility's policy when a resident refused a medication the MA on duty was to complete the facility's "Physician notification of resident's refusal of medication or treatment form."
-The MA was to notify the physician, then give the form to the RCC, and document in the nurse notes.
-There was no documentation the form had been completed regarding Resident #7's refusal of linzess.
-The resident had refused the medication for a long time and the physician should have been notified, but was not.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed:
-The facility had a form that the MAs were to complete each time a resident refused a medication.
-If Resident #7 refused medications she should have forms to show the medication was refused.
-The MAs were to give the completed form to her and to document the contact with the physician in the nurse's notes.
-She did not have any medication refusal forms regarding Resident #7's refusal of linzess.
-Every Monday and Wednesday she performed a medication cart and eMAR audit.

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 27	D 273		

-The audit consisted of comparing the eMARs to the medications on hand to ensure the dosage and instructions were correct.
-She observed circled initials on the eMARs, but did not inquire why staff circled initials.
-The MA's were responsible for notifying the physician when a resident refused medications.
-She searched her paperwork and there were no medication refusal form submitted to her regarding Resident #7's refusal of linzess.

Interview with the nurse at Resident #7's PCP office on 03/08/19 at 2:55pm revealed:
-The physician did not know Resident #7 had refused linzess.
-One side effect of linzess is the medication can cause diarrhea.
-It was recommended if the diarrhea became severe the physician should immediately be notified.
-There was no documentation in their record the physician was contact regarding Resident #7's refusal to take the medication or that the medication caused the resident diarrhea.

Interview with the Administrator on 03/08/19 at 12:48pm revealed:
-The facility had forms for the MAs to document when a resident refused a medication.
-She expected the MAs to contact the physician after the first refusal of the medication and document on the form facility's medication refusal form.
-The form should be given to the RCC after each shift.
-The RCC should check to ensure the physician was notified.
-There should be documentation in the nurse's notes to show the physician was notified.

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 03/08/2019

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D 273	Continued From page 28	D 273		

f. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for midodrine hcl (used to treat low blood pressure) 5mg three times daily after meals.

Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for midodrine hcl 5mg three times daily after meals.

Review of Resident #7's December 2018 eMAR revealed:
-There was an entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm.
-There was documentation midodrine hcl 5mg was not administered seventeen of ninety-three opportunities scheduled between 12/01/18 through 12/31/18 at 1:00pm on Monday, Wednesday and Friday.
-There was documentation the resident was either out of the facility, refused the medication or "Physically unable to take medication."
-There was no documentation the physician was notified midodrine hcl was not administered at 1:00pm on Monday, Wednesday and Friday.

Review of Resident #7's January 2019 eMAR revealed:
-There was an entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm.
-There was documentation midodrine hcl 5mg was not administered sixteen of ninety-three opportunities scheduled between 01/01/19 through 01/31/19 at 1:00pm on Monday, Wednesday, and Friday.
-There was documentation the resident was either out of the facility, refused the medication or "Physically unable to take medication."

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 03/08/2019

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D 273	Continued From page 29 -There was no documentation the physician was notified midodrine hcl was not administered at 1:00pm on Monday, Wednesday and Friday. Review of Resident #7's February 2019 eMAR revealed: -There was an entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm. -There was documentation midodrine hcl 5mg was not administered sixteen of eighty-four opportunities scheduled between 02/01/19 through 02/28/19 at 1:00pm on Monday, Wednesday, and Friday. -There was documentation the resident was either out of the facility, refused the medication or "Physically unable to take medication." -There was no documentation the physician was notified midodrine hcl was not administered. Review of Resident #7's March 2019 eMAR revealed: -There was an entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm. -There was documentation midodrine hcl 5mg was not administered three of sixteen opportunities scheduled between 03/01/19 through 03/03/19 at 1:00pm on Monday, Wednesday, and Friday. -There was documentation the resident was either out of the facility. -There was no documentation the physician was notified midodrine hcl was not administered. Review of Resident #7's nurse's notes revealed there was no documentation the physician was notified the resident did not receive midodrine 51 times from 12/01/18 through 03/03/19.	D 273		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 30 Interview with Resident #7 on 03/07/19 at 8:34am revealed: -She went to dialysis Monday, Wednesday and Fridays. -When she went to dialysis she left the facility at 11:00am and sometimes did not return to the facility until almost 6:00pm. -On Monday, Wednesday and Fridays she was never administered the 1:00pm midodrine. -Previously she was allowed to take medications with her to dialysis, but that stopped. -The facility staff told her that the staff at the dialysis center said they were not responsible for administering her medications. -Her blood pressure was frequently checked Monday, Wednesday and Friday at dialysis. -The facility staff only checked her blood pressure, maybe once a month. -She had episodes of dizziness and light-headedness, but thought, it was related to other health issues. Interview with a first shift MA on 03/07/19 at 3:05pm revealed: -Resident #7 went to dialysis Monday, Wednesday and Friday from 11:00am to 5:00 or 6:00pm. -When the resident was at dialysis she was not administered any medications scheduled during the time the resident was out of the facility. -She circled her initials on the eMAR, and documented the resident was out of the facility or physically unable to take the medication. -She documented; physically unable to take the medication because the resident was not present in the facility. -The facility used to send Resident #7's medications to the dialysis center to be administered, but the center informed the facility staff that was not allowed.	D 273		

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 03/08/2019

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D 273	Continued From page 31	D 273		

-She had not contacted Resident #7's physician to inform midodrine was not administered at 1:00pm on Monday, Wednesday and Fridays.

Interview with the nurse at Resident #7's PCP office on 03/07/19 at 2:21pm revealed:
-The physician knew Resident #7 went to dialysis Monday, Wednesday, and Friday, but did not know the resident was not administered midodrine.
-The medication was ordered to be administered after meals, therefore if the resident consumed a meal or any food when she returned to the facility the medication should be administered.
-If facility staff needed clarification regarding the medication order, they should have contacted the physician.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed:
-Resident #7 went to dialysis three days per week.
-The resident previously took medications with her to the dialysis center, but the center informed the facility staff they were not going to be responsible for administering Resident #7's medications.
-Resident #7 had many physicians, she was not sure if the physician that ordered midodrine had been notified.
-She had not contacted Resident #7's PCP regarding the medication not being administered.
-More than likely, the physician was not notified because all physicians knew that Resident #7 went to dialysis three days per week.

Interview with the Administrator on 03/08/19 12:48pm revealed:
-She expected the MAs to notify the physician when Resident #7 was not administered

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 03/08/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 32	D 273		

medications as ordered.
-The MAs should have followed-up with Resident #7's physician to inquire what to do regarding medications ordered during the times when the resident was out of the facility at dialysis.
-The MAs should have obtained orders from the physician addressing medications ordered when the resident was at dialysis, and there should be documentation to show the physician was notified.

g. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for tylenol 500mg every eight hours for pain.

Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for tylenol 500mg every eight hours.

Review of Resident #7's December 2018 eMAR revealed:
-There was an entry for tylenol 500mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm.
-There was documentation tylenol 500mg was not administered twenty-one of the ninety-three opportunities scheduled between 12/01/18 through 12/31/18 on Monday, Wednesday, and Friday at 2:00pm while at dialysis.
-There was documentation the resident was either out of the facility, "Physically unable to take medication," or no documentation why the medication was not administered.
-There was no documentation the physician was notified tylenol was not administered every eight hours as ordered on Monday, Wednesday, and Friday while at dialysis.

Review of Resident #7's January 2019 eMAR

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 33	D 273		

revealed:
-There was an entry for tylenol 500mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm.
-There was documentation tylenol 500mg was not administered seventeen of ninety-three opportunities scheduled between 01/01/19 through 01/31/19 on Monday, Wednesday, and Friday at 2:00pm while at dialysis.
-There was documentation the resident was either out of the facility, "Physically unable to take medication," or no documentation why the medication was not administered.
-There was no documentation the physician was notified that tylenol was not administered every eight hours as ordered on Monday, Wednesday, and Friday while at dialysis.

Review of Resident #7's February 2019 eMAR revealed:
-There was an entry for tylenol 500mg every eight hours scheduled at 6:00am, 2:00pm, and 10:00pm.
-There was documentation tylenol 500mg was not administered twelve of eighty-four opportunities scheduled between 02/01/19 through 02/28/19 on Monday, Wednesday, and Friday at 2:00pm while at dialysis.
-There was documentation the resident was either out of the facility, "Physically unable to take medication," or no documentation why the medication was not administered.
-There was no documentation the physician was notified that tylenol was not administered every eight hours as ordered on Monday, Wednesday, and Friday at 2:00pm while at dialysis.

Review of Resident #7's March 2019 eMAR revealed:
-There was an entry for tylenol 500mg every eight

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 34	D 273		

hours scheduled at 6:00am, 2:00pm, and 10:00pm.
-There was documentation tylenol 500mg was not administered twelve of eighty-four opportunities scheduled between 03/01/19 through 03/07/19 on Monday, Wednesday, and Friday at 2:00pm while at dialysis.
-There was documentation the resident was either out of the facility "Physically unable to take medication," or no documentation why the medication was not administered.
-There was no documentation the physician was notified that tylenol was not administered every eight hours as ordered on Monday, Wednesday, and Friday at 2:00pm while at dialysis.

Review of Resident #7's nurse's notes revealed there was no documentation the physician was notified the resident did not receive Tylenol 71 times from 12/01/18 through 03/07/19.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She went to dialysis Monday, Wednesday and Fridays between 11:00am until almost 6:00pm.
-On dialysis days, she did not get her 2:00pm Tylenol.
-She wished that she did get tylenol because she was constantly in pain.
-The facility staff told her that the staff at the dialysis center said they were not responsible for administering her medications.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:
-When the resident was at dialysis she was not administered her 2:00pm tylenol for pain.
-The dialysis staff did not administer medications and there was no way for Resident #7 to be administered the Tylenol when at dialysis.

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 35	D 273		

-She had not contacted Resident #7's physician to inform tylenol was not administered three times daily as ordered.

Interview with the nurse at Resident #7's PCP office 03/08/19 at 2:45pm revealed:
-The physician knew Resident #7 went to dialysis Monday, Wednesday, and Friday, but did not know the resident was not administered medication as ordered.
-If facility staff needed clarification regarding the medication order, they should have contacted the physician to inquire what to do when the resident was at dialysis.
-A search of the PCP record did not show the PCP was notified the resident was not administered Tylenol when she was at dialysis.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed Resident #7 went to dialysis three days per week and to her knowledge the physician had not been notified Resident #7 was not administered tylenol when at dialysis.

Interview the Administrator on 03/08/19 12:48pm revealed:
-The MAs should have followed-up with Resident #7's physician when the resident missed scheduled dosages of tylenol because she was at dialysis.
-The MAs should document the physician notification in the nurse notes.
-Staff knew if they did not document, they could not prove they notified the physician.

2. Review of Resident #6's current FL2 dated 02/14/19 revealed:
-Diagnoses included Alzheimer's dementia, end state renal failure hypertension and diabetes

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 03/08/2019

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 273	Continued From page 36	D 273		

mellitus.
-A physician's order for Sevelamer Carbonate (renvela) 800mg two capsules (1600mg) twice daily with meals (used to control phosphorus levels in the blood), and a physician's order for sevelamer 800mg three capsules (3200mg) three times daily with meals.

Review of Resident #6's December 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily scheduled for 8:00am, 12:00pm, 5:00pm.
-There was a second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks.
-There was documentation sevelamer carbonate was not administered twenty-two of the one hundred and fifty-five opportunities scheduled between 12/01/18 through 12/31/18 at 12:00pm on dialysis days (Monday, Wednesday, and Friday).
-There was documentation the resident was out of the facility.
-There was no documentation the physician was notified the resident was not administered the medication at 12:00pm on dialysis days.

Review of Resident #6's January 2019 eMAR revealed:
-There was an entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily scheduled for 8:00am, 12:00pm, 5:00pm.
-There was a second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks.
-There was documentation sevelamer carbonate

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 03/08/2019

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 273	Continued From page 37	D 273		

was not administered thirty of one hundred and fifty-five opportunities scheduled between 01/01/19 through 01/31/19 at 12:00pm on dialysis days.
-There was documentation the resident was out of the facility or physical unable to take the medication.
-There was no documentation the physician was notified the resident was not administered the medication at 12:00pm on dialysis days.

Review of Resident #6's February 2019 eMAR revealed:
-There was an entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily scheduled for 8:00am, 12:00pm, 5:00pm.
-There was a second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks.
-There was documentation sevelamer carbonate was not administered thirty-two of one hundred and fifty-five opportunities scheduled between 02/01/19 through 02/28/19 at 12:00pm on dialysis days.
-There was documentation the resident was out of the facility.
-There was no documentation the physician was notified the resident was not administered Auryxia as ordered at 12:00pm on dialysis days.

Review of Resident #6's March 2019 eMAR revealed:
-There was an entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily scheduled for 8:00am, 12:00pm, 5:00pm.
-There was a second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks.

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 03/08/2019

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 273	Continued From page 38	D 273		

-There was documentation sevelamer carbonate was not administered nine of thirty-six opportunities scheduled between 03/01/19 through 03/08/19 at 12:00pm on dialysis days.
-There was documentation the resident was out of the facility.
-There was no documentation the physician was notified the resident was not administered sevelamer carbonate at 12:00pm on dialysis days.

Review of Resident #6's nurse's notes revealed there was no documentation the physician was notified of the 93 times Resident #6 was not administered sevelamer from 12/01/18 through 03/08/19.

Based on observation, interview and record review it was determined Resident #6 was not interviewable.

Interview with the nurse at Resident #6's Nephrologist office on 03/08/19 at 1:10pm revealed:
-The physician knew Resident #6 had dialysis, but did not know sevelamer carbonate was not administered as ordered.
-The medication should be administered anytime the resident consumed food and this included snacks.
-The physician did not know the medication was not being administered as ordered.
-The facility staff should notify the physician to discuss the administration of the medication, and what to do when the resident was at dialysis.

Interview on 03/08/19 at 2:40pm with Resident #6's power of attorney revealed:
-She thought Resident #6 was getting all medications ordered.

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 39	D 273		

-She had frequently had conversations with facility regarding the monitoring of Resident #6's fluid intake due to dialysis.
-No one at the facility had informed her Resident #6 missed medications due to the dialysis schedule.
-She could have notified the physician regarding Resident #6's missed medications.

Interview with the Memory Care Unit Coordinator (MCUC) on 03/08/19 at 2:05pm revealed:
-She knew that Resident #6 went to dialysis and did not get medications as ordered.
-When at dialysis Resident #6 was given a snack, but there was no way to give the resident medications ordered.
-She was responsible for notifying the physician when a resident was not administered medications as ordered.
-She had not notified Resident #6's Nephrologist regarding the resident not getting medications scheduled three times as ordered on Monday, Wednesday, and Fridays when the resident was at dialysis.
-She did not know that she needed to contact the resident's physician because the physician ordered the medication and the physician knew the resident had dialysis.

Interview with the Administrator on 03/08/19 at 12:48pm revealed:
-She expected the MAs to notify the physician when a resident was not administered medications as ordered.
-The MAs should have followed-up with Resident #6's physician to inquire what to do regarding medications ordered during the when the resident was out of the facility at dialysis.
-The MAs should have obtained orders from the physician addressing medications ordered when

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 40 the resident was at dialysis. 3. Review of Resident #2's current FL2 dated 01/3/19 revealed diagnoses included dementia, hypertension, hyperlipidemia, osteoarthritis, neuropathy, coronary artery disease, type II diabetes mellitus, chest pain, gastroesphageal reflux disease, constipation, anxiety, and allergic rhinitis. a. Review of Resident #2's current FL2 dated 01/3/19 revealed an order for diclofenac sodium (Voltaren Gel) 1%, (used to treat pain) apply 4 grams topically three times a day. Review of Resident #2's January 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Voltaren 1% Gel, apply 4 grams topically to affected areas three times a day scheduled at 9:00am, 3:00pm, and 9:00pm. -There was documentation Voltaren was not administered for 26 of 93 opportunities. -Voltaren was not documented as administered at 3:00pm on 01/24/19, 01/27/19, 01/29/19, and at 9:00pm on 01/18/19, 01/21/19-01/27/19, and on 01/29/19-01/31/19. -There was documentation Voltaren was not administered for the reason the resident refused. Review of Resident #2's February 2019 eMAR revealed: -There was an entry for Voltaren 1% Gel, apply 4 grams topically to affected areas three times a day scheduled at 9:00am, 3:00pm, and 9:00pm. -There was documentation Voltaren was not administered for 55 of 84 opportunities. -Voltaren was not documented as administered at 9:00am on 02/07/19, 02/09/19, 02/12/19, 02/14/19-02/15/19, 02/18/19-02/19/19, 02/23/19,	D 273		

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 03/08/2019

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D 273	Continued From page 41	D 273		

02/25/19-02/26/19 and on 02/28/19.
-Volatren was not documented as administered at 3:00pm on 02/01/19-02/03/19, 02/05/19-02/07/19, 02/09/19-02/10/19, 02/12/19-02/16/19, 02/18/19, and on 02/20/19-02/27/19.
-Voltaren was not documented as administered at 9:00pm on 02/01/19-02/02/19, 02/05/19-02/10/19, 02/12/19-02/16/19, 02/18/19-02/20/19, 02/22/19-02/24/19, and on 02/26/19-02/28/19.
-There was documentation Voltaren was not administered for the reason the resident refused.

Review of Resident #2's March 2019 eMAR revealed:
-There was an entry for Voltaren 1% Gel, apply 4 grams topically to affected areas three times a day scheduled at 9:00am, 3:00pm, and 9:00pm.
-There was documentation Voltaren was not administered for 10 of 15 opportunities.
-Voltaren was not documented as administered at 3:00pm on 03/01/19, and on 03/04/19.
-Voltaren was not documented as administered at 9:00pm on 03/01/19-03/02/19, and on 03/05/19.
-There was documentation Voltaren was not administered for the reason the resident refused.

Review of Resident #2's nurse's notes revealed:
-Documentation of resident refusal of Voltaren Gel on 02/09/19 and 02/10/19.
-There was no documentation staff notified the physician of the 91 times Voltaren gel was refused.

Interview with a Medication Aide (MA) on 03/07/19 at 9:45am revealed:
-She did not know if Resident #2 had refused Voltaren Gel.
-The provider should have been notified after the Voltaren was refused three times.

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 42 Interview with Resident #2 on 03/08/19 at 11:55am revealed: -She knew she was prescribed Voltaren for pain. -She refused the Voltaren frequently and wanted the order changed to as needed. -She did not ask for the Voltaren to be changed to as needed. Telephone interview with Resident #2's primary care provider on 03/08/19 at 10:50am revealed: -The facility did not notify her of Resident #2's refusal of Voltaren. -Resident #2 was prescribed Voltaren Gel for pain. -She expected the staff to notify her of the Voltaren refusals. -If the staff had notified her of the Voltaren refusals she would have changed the medication to as needed or discontinued the medication if not needed. -Resident #2 was last seen two weeks ago. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed: -She expected staff to administer Voltaren as ordered. -The MAs were responsible for provider notification after Resident #2 refused Voltaren. -The staff should have completed a refusal form after Resident #2 refused Voltaren and placed it in the box for the provider to review or fax the form to the provider. -No one was checking behind the MAs to make sure the form was completed and provider was notified regarding Resident #2's Voltaren refusals. Interview with the Memory Care Unit Coordinator (MCUC) on 03/08/19 at 12:00pm revealed: -She knew Resident #2 refused Voltaren. -She expected the MAs to notify the provider after	D 273		

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 03/08/2019

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 273	Continued From page 43	D 273		

Resident #2 refused Voltaren three times.
-The MAs were expected to complete the medication refusal form each time Resident #2 refused Voltaren and send to the provider for review.
-The refusal form was expected to be in Resident #2's record.

Interview with the Administrator on 03/08/19 at 2:50pm revealed.
-She did not know Resident #2 was refusing Voltaren Gel.
-She would expect the MA or RCC to notify the provider after Voltaren Gel was refused three consecutive times.
-The MA or RCC should complete the medication refusal form and send to the provider for review.

b. Review of Resident #2's current FL2 dated 01/3/19 revealed an order for Fluticasone Propionate (used to treat allergy symptoms) 50 mcg, one spray into each nostril daily.

Review of Resident #2's January 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Fluticasone Propionate 50mcg, one spray into each nostril daily scheduled at 9:00am.
- Fluticasone Propionate was not administered on 01/27/19 at 9:00pm and documented as refused.

Review of Resident #2's February 2019 eMAR revealed:
-There was an entry for Fluticasone Propionate 50mcg, one spray into each nostril daily scheduled at 9:00am.
-There was documentation Fluticasone Propionate was not administered for 9 of 28 opportunities.

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 03/08/2019

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 273	Continued From page 44	D 273		

- Fluticasone Propionate was not not administered at 9:00am on 02/07/19 at 9:00am on 02/09/19-02/10/19, 02/12/19, 02/14/19-02/15/19, 02/18/19, 02/23/19, and on 02/26/19.
-There was documentation Fluticasone Propionate was not administered for the reason the resident refused.

Review of Resident #2's nurse's notes revealed:
-There was documentation of resident refusal of Fluticasone Propionate on 02/09/19 and 02/10/19.
-There was no documentation staff notified the physician of the 10 times Fluticasone Propionate was refused.

Interview with a Medication Aide (MA) on 03/07/19 at 9:45am revealed:
-She did not know if Resident #2 had refused Fluticasone Propionate.
-The provider should have been notified after the Fluticasone Propionate was refused three times.
-She thought she had notified the physician regarding refusals but did not document the notification.

Interview with Resident #2 on 03/08/19 at 11:55am revealed:
-She knew she was prescribed Fluticasone Propionate.
-She refused the Fluticasone Propionate frequently because she did not know why it was prescribed.
-She did not report any allergy symptoms.

Telephone interview with Resident #2's primary care provider on 03/08/19 at 10:50am revealed:
-The facility did not notify her of Resident #2's refusal of Fluticasone Propionate.

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 03/08/2019

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 273	Continued From page 45 -Resident #2 was prescribed Fluticasone Propionate for allergic rhinitis. -She expected the staff to notify her of the Fluticasone Propionate refusals. -If the staff had notified her of the Fluticasone Propionate refusals she would have changed the medication to as needed or discontinued the medication if not needed. -Resident #2 was last seen two weeks ago. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed: -She expected staff to administer Fluticasone Propionate as ordered. -The MAs were responsible for provider notification after Resident #2 refused Fluticasone Propionate. -The staff should have completed a refusal form after Resident #2 refused Fluticasone Propionate and place it in the box for the provider to review or fax the form to the provider. -No one was checking behind the MA to make sure the form was completed and provider was notified regarding Resident #2's Fluticasone Propionate refusals. Interview with the Memory Care Unit Coordinator (MCUC) on 03/08/19 at 12:00pm revealed: -She did not know Resident #2 was refusing Fluticasone Propionate. -She expected the MAs to notify the provider after Resident #2 refused Fluticasone Propionate three times. -The MAs were expected to complete the medication refusal form each time Resident #2 refused Fluticasone Propionate and send to the provider for review. -The refusal form was expected to be in Resident #2's record.	D 273		

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 03/08/2019

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 273	Continued From page 46 Interview with the Administrator on 03/08/19 at 2:50pm revealed. -She did not know Resident #2 was refusing Fluticasone Propionate. -She would expected the MA or RCC to notify the provider after Fluticasone Propionate was refused three times. The -MA or RCC should complete the medication refusal form and send to the provider for review. 4. Review of the current FL2 dated 6/26/18 revealed diagnoses included diabetes mellitus, chronic hypoxic respiratory failure, chronic obstructive pulmonary disease, anxiety and depression, dementia, hypertension, hyperlipidemia, and macular degeneration. a. Review of Resident #4's Foot Care Plan dated 08/08/18 revealed: -Diagnoses included diabetes mellitus II, onychomycosis, and edema. -There was no documentation Resident #4's toe nails were trimmed on this date. -The care plan included nail debridement greater than every sixty one days to minimize pain/pressure/infection risk. Review of Resident #4's primary care physician (PCP) after visit summary dated 02/20/19 revealed: -There were instructions for an ambulatory referral to podiatry for diabetic foot, long toenail, and valgus deformity of both great toes. -There was documentation the PCP's office would arrange for a foot doctor consult. Review of nurse's notes for Resident #4 revealed there was no documentation of Resident #4's need for podiatry services or that she had received podiatry services.	D 273		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 47 Interview with Resident #4 on 03/07/19 at 10:55am revealed: -She did not see the podiatrist when he was last in the facility. -She could not wear shoes because her toenails push against the front of her shoes causing pain. -It had probably been three months since she had her toenails trimmed. -No one checked her toenails regularly. Observation of Resident #4 on 03/07/19 at 10:59am revealed: -Resident #4 was wearing socks but no shoes. -Resident #4's toenails on her left and right big toes extended approximately half an inch from her toes. -The toenails on the remaining four toes of the left and right feet were curved over the top of the toes. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:18am revealed: -Resident #4 was seen by a PCP outside of the facility. The personal care aides (PCA) were supposed to check resident's skin and feet when they assisted with baths. -She did not know Resident #4's toenails needed to be trimmed. -"She doesn't complain about them." -Residents who had an outside PCP were seen by the facility contracted podiatrist if the facility could get approval from the PCP. -She did not remember seeing a referral for a podiatry visit and did not know of any scheduled podiatry appointments for Resident #4. -The business office manager was responsible for making medical appointments outside of the facility.	D 273		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 48 Attempted telephone interview with Resident #4's PCP on 03/08/19 at 10:20am was unsuccessful. Interview with a medication aide (MA) on 03/08/19 at 11:51 am revealed: -MAs were responsible for checking residents' feet including need for a toenail trim. -If a resident needed to have their toenails trimmed, it should have been documented in the shift report and handed off to the RCC. -The RCC was responsible for making sure residents saw the podiatrist when needed by placing their names on the podiatrist list. -She knew Resident #4 needed her toenails trimmed. -She documented Resident #4 needed to have her toenails trimmed in the shift report book, but did not know when. -She did not know if Resident #4 was scheduled to have her toenails trimmed by a podiatrist. Interview with a PCA on 03/08/19 at 2:11pm revealed: -Her job responsibilities included assisting with feeding, incontinence care, bathing, and checking skin and toenails daily. -If a resident's toenails needed to be trimmed, the PCAs would report it to a MA. -She knew Resident #4's toenails needed to be trimmed and had reported it to a MA, but she did not remember when. -The facility contracted podiatrist saw residents at the facility about a month ago. -She thought Resident #4 was on this list to see the podiatrist, but she did not know if Resident #4 actually had her toenails trimmed by the podiatrist at that time. -There should be documentation in the nurse's notes of whether Resident #4 saw the podiatrist	D 273		

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 03/08/2019

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 273	Continued From page 49	D 273		

or not.

Attempted telephone interview with the PCP on 03/08/19 at 2:32pm was unsuccessful.

Interview with the Administrator on 03/08/19 at 2:48pm revealed:
-Residents' feet including toenails should be checked by PCAs when they assisted residents with baths.
-There was a contracted podiatrist who came to the facility for foot care and was able to see all residents.
-The podiatrist was last in the facility in January 2019, but she was not sure if the podiatrist saw Resident #4 or not.
-The podiatrist was scheduled to visit the facility again at the end of March.
-The medical records specialist was responsible for ensuring residents saw the podiatrist.
-Resident #4 would be seen when the podiatrist came back to the facility in March 2019.

Interview with the medical records specialist on 03/08/19 at 5:13pm revealed:
-Resident #4 was seen by the facility contracted PCP and service providers, but switched to an outside PCP.
-She last received podiatry services through the facility contracted podiatrist in August 2018 because of the change in her PCP.
-She had not seen the facility contracted podiatrist since August 2018.
-She made a referral to an outside provider for podiatry service on 03/05/19, but there was no scheduled appointment yet.
-She was waiting on a call back from the outside provider for podiatry services.
-She did not know if a referral for podiatry services was made by any staff member between

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 03/08/2019

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 273	Continued From page 50 August 2018 and 03/05/19. b. Review of Resident #4's current FL2 dated 06/26/18 revealed there was an order for motrin (Ibuprofen) 600 mg (a medication used to treat pain) one tablet every six hours. Review of Resident #4's physician's orders revealed: -There was a physician's order sheet dated 12/05/18 with an order for Ibuprofen every six hours not to exceed 3200 mg per day and an order for Ibuprofen 600 mg three times daily as needed for pain. -There was an order clarification sheet dated 12/13/18 which requested clarification on the order for Ibuprofen 600 mg three times a day and the order was clarified on 12/13/18. -There was one "Physician Notification of Resident's Refusal of Medications or Treatments" sheet which indicated Resident #4 refused to take Ibuprofen 600 mg on 02/25/19 and 02/26/19 because she was asleep and did not want to be awakened. Review of the nurse's notes for Resident #4 for December 2018 through March 2019 revealed: -There was documentation on 12/20/18, 12/25/18, 12/31/18, 1/9/19, 1/10/19, 01/14/19, 01/19/19, and 02/26/19 which indicated Resident #4 was refused to take her 12:00am and/or 6:00am scheduled Ibuprofen because she was sleep and did not want to be awakened. -There was no documentation Resident #4's primary care physician (PCP) was notified Ibuprofen was refused sixty eight times. Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2018 revealed:	D 273		

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 03/08/2019

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 273	Continued From page 51	D 273		

-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily with meals.
-There was an entry for Ibuprofen 600 mg tablet, take 1 tablet every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation Ibuprofen 600 mg was not administered twenty five of one hundred and twenty-four opportunities on the following dates: 12/06/18 at 6:00am; 12/10/18 at 6:00pm; 12/11/18 at 12:00pm; 12/12/18 at 12:00am and 6:00am; 12/13/18 at 12:00am; 12/14/18 at 12:00am; 12/14/18 at 12:00am; 12/15/18 and 6:00am and 12:00pm; 12/18/18 at 6:00am; 12/20/18 at 6:00 am; 12/24/18 at 12:00am and 6:00am; 12/26/18 at 12:00am and 6:00am; 12/27/18 at 12:00am and 6:00am; 12/28/18 at at 12:00am; 6:00am, and 12:00pm; 12/29/18 at at 12:00am and 6:00am; and 12/30/18 at 12:00pm.
-There was documentation Ibuprofen was not administered due to "resident refused," "physically unable to take."

Review of Resident #4's eMAR for January 2019 revealed:
-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily with meals.
-There was an entry for Ibuprofen 600 mg tablet, take 1 tablet every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation Ibuprofen 600 mg was not administered thirty two of one hundred and twenty-four opportunities on the following dates: 01/01/19 at 6:00am; 01/02/19 at 12:00am and 6:00am; 01/03/19 at 12:00am and 6:00am; 01/04/19 at 12:00am and 6:00am; 01/06/19 at 12:00am; 01/07/19 at 12:00am and 6:00am; 01/09/19 at 12:00am and 6:00am; 01/10/19 at 12:00am and 6:00am; 01/11/19 at 12:00am and

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 52	D 273		

6:00am; 01/12/19 at 12:00am; 01/15/19 at 12:00am; 01/16/19 at 6:00am; 01/17/19 at 6:00am; 01/18/19 at 12:00am and 6:00am; 01/20/19 at 12:00am; 01/21/19 at 6:00am; 01/23/19 at 12:00am and 6:00am; 01/24/19 at 6:00am; 01/25/19 at 6:00am; 01/26/19 at 12:00am and 6:00am; 01/27/19 at 12:00pm; and 01/31/19 at 6:00am.
-There was documentation Ibuprofen was not administered due to "resident refused".

Review of Resident #4's eMAR for February 2019 revealed:
-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily with meals.
-There was an entry for Ibuprofen 600 mg tablet, take 1 tablet every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation Ibuprofen 600 mg was not administered ten of one hundred and twelve opportunities on the following dates: 02/13/19 at 12:00am; 02/15/19 at 12:00am and 6:00am; 02/16/19 at 6:00pm; 02/18/19 at 12:00am; 02/20/19 at 12:00am and 6:00pm; 02/24/19 at 12:00pm; 02/26/19 at 6:00am; and 02/27/19 at 6:00am.
-There was documentation Ibuprofen was not administered due to "resident refused," "out of facility".

Review of Resident #4's eMAR for March 2019 revealed:
-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily with meals.
-There was an entry for Ibuprofen 600 mg tablet, take 1 tablet every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation Ibuprofen 600 mg was

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 53	D 273		

not administered one of twenty two opportunities on the following date: 03/03/19 at 12:00am.
-There was documentation Ibuprofen was not administered due to "resident refused."

Interview with Resident #4 on 03/07/18 at 10:55am revealed:
-She took medication at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-She did not what time she was administered Ibuprofen, but she knew Ibuprofen was not administered at 12:00am or 6:00am.
-She never refused any medication and she would know if she was awakened at 12:00am or 6:00am to take medication.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:26am revealed:
-She was responsible for checking the medications against the eMARS one or two times a month.
-The MA's were responsible for completing eMAR and cart audits on Mondays, Wednesdays, and Fridays.
-When she completed an eMAR audit, she did not audit for refusals because she reviewed Refusal Forms for each resident.
-If a resident refused medication, the MA was responsible for completing a Refusal Form to for the resident's physician to review and sign.
-Signed Refusal Forms should have been put in the resident's record and documented in the nurse's notes.
-If a medication was refused three times or more, the physician should have been contacted to get the medication ordered as needed or discontinued.
-She did not know Resident #4 consistently refused Ibuprofen as documented on the eMAR and did not know why Resident #4's PCP was not

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 03/08/2019

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D 273	Continued From page 54 notified. Interview with a MA on 03/08/19 at 11:51am revealed: -If a resident refused medication, it would be documented on the eMAR as not administered and a note should be put into the eMAR system as to why the medication was not administered. -Refusals should also be documented in the nurse's notes in the resident's record. -A Refusal Form should also be sent to the resident's physician. -If a resident kept refusing medication, MAs should contact the physician after three days of refusals. -The contact with the physician should be documented in the nurse's notes in the resident's record. -She did not remember documenting any refusals for Ibuprofen for Resident #4. Attempted telephone interview with the PCP on 03/08/19 at 2:32pm was unsuccessful. Interview with the Administrator on 03/08/19 at 2:48pm revealed: -The RCC and the pharmacy were responsible for eMAR audits. -An eMAR audit should include looking for holes in the eMAR as well as refusals. -When a medication was not administered, the MAs should document on the eMAR and in the nurse's notes why the medication was not administered. -She expected staff to complete a refusal form for the physician each time a medication was refused. -She expected MAs and the RCC to document and contact the resident's physician after 3 consecutive refusals.	D 273		

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 03/08/2019

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D 273	Continued From page 55 The facility failed to notify the physicians for 4 sampled residents related to orders to notify the physician when a resident's blood sugars were greater than 400 (Resident #7); insulin, pain, nerve, and constipation medications were not administered when a resident was out of the facility at dialysis (Resident #7), missed medications that aided with dialysis treatments (Residents #6 and #7), and refusal of medications (Residents #7, #2, #3 and #4). The facility's failure to notify the physician regarding missed medications was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility provided a Plan of Correction on 03/08/19 in accordance with G. S. 131D-24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 21, 2019.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	D 344		

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 03/08/2019

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D 344	Continued From page 56 record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure contact with the prescribing physician for clarification of orders for 2 of 7 sampled residents (Resident #6 and #7) related to orders to administer Novolog, Auryxia, gabapentin, midodrine, tylenol, refresh tears (#7) and sevelamer carbonate (#6) when residents were out of the facility at dialysis. The findings are: Review of Resident #7's current FL2 dated 06/27/18 revealed: -Diagnoses included end stage renal disease, type two diabetes, neurogenic bladder, colostomy, bilateral amputation, and left arm paralysis. a. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for Novolog four units subcutaneously once daily with the lunch meal. Review of Resident #7's record revealed a subsequent physician's order sheet signed by the physician on 12/04/18 with orders for Novolog four units subcutaneously once daily with the lunch meal. Review of Resident #7's December 2018 electronic Medication Record Administration	D 344		

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 03/08/2019

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D 344	Continued From page 57	D 344		

(eMAR) revealed:
-There was an order entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not administered sixteen times on the following dates due to the resident being at dialysis: 12/02/18, 12/03/18, 12/05/18, 12/07/18, 12/12/18, 12/14/18, 12/17/18, 12/18/18, 12/19/18, 12/20/18, 12/21/18, 12/23/18, 12/26/18, 12/28/18, 12/29/18, and 12/31/18.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's January 2019 eMAR revealed:
-There was an order entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not administered fourteen times on the following dialysis dates due to the resident being at dialysis: 01/02/19, 01/03/19, 01/04/19, 01/07/19, 01/09/19, 01/10/19, 01/11/19, 01/14/19, 01/16/19, 01/18/19, 01/21/19, 01/23/19, 01/25/19, 01/28/19, and 01/30/19.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's February 2019 eMAR revealed:
-There was an order entry for Novolog four units at lunch time scheduled for 12:00pm.
-There was documentation Novolog was not administered thirteen times on the following dates due to the resident being at dialysis: 02/01/19, 02/04/19, 02/05/19, 02/06/19, 02/08/19, 02/11/19, 02/13/19, 02/15/19, 02/18/19, 02/20/19, 02/22/19,

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D 344	Continued From page 58 02/25/19, and 02/27/19. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's March 2019 eMAR revealed: -There was an order entry for Novolog four units at lunch time scheduled for 12:00pm. -There was documentation Novolog was not administered three times on the following dates due to the resident being at dialysis: 03/01/19, 03/04/19, and 03/06/19. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Interview with Resident #7 on 03/07/19 at 8:34am revealed: -She was a severe diabetic and was ordered Novolog insulin three times daily along with Novolog sliding scale. -She went to dialysis Monday, Wednesday and Fridays. -When she went to dialysis she left the facility at 11:00am and sometimes did not return to the facility until almost 6:00pm. -On Monday, Wednesday and Fridays she was never administered the 12:00pm Novolog. Interview with a first shift MA on 03/07/19 at 3:05pm revealed: -Resident #7 went to dialysis Monday, Wednesday and Friday from 11:00am to 5:00 or 6:00pm. -When the resident was at dialysis she was not administered medications scheduled during the time the resident was out of the facility.	D 344		

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 03/08/2019

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D 344	Continued From page 59	D 344		

-Medication scheduled during the time Resident #7 was at dialysis she circled her initials on the eMAR, and documented the resident was out of the facility or "Physically unable to take the medication."
-Resident #7 left for dialysis at 11:00am, but was not given a meal, therefore she did not consider administering Novolog before the resident went to dialysis.

Interview with Resident #7's Endocrinologist 03/07/19 at 11:14am revealed:
-The physician knew Resident #7 went to dialysis and thought the Novolog was administered while the resident was at dialysis.
-It did not matter what time Resident #7 returned to the facility, if the resident was offered a meal, Novolog should still be administered.
-The facility staff should have contacted the physician to clarify what to do if they were unable to administer the medication as ordered.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed:
-Resident #7 went to dialysis three days per week, between 11:00am and 5:00 to 6:00pm.
-If Novolog was scheduled when the resident was at dialysis the medication was not administered.
-The MA should call the physician and ask for instructions regarding medications missed when Resident #7 was at dialysis.

b. Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for Auryxia 210mg (two tablets =420mg) (used to lower high blood phosphate levels) three times daily with meals.

Review of Resident #7's record revealed a subsequent physician's order sheet signed by the

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 03/08/2019

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D 344	Continued From page 60	D 344		

physician on 12/04/18 with orders for Auryxia 210mg (two tablets =420mg) three times daily with meals.

Review of Resident #7's December 2018 electronic Medication Record Administration (eMAR) revealed:
-There was an order entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm.
-There was documentation Auryxia was not administered fifteen times on the following dates due to the resident being at dialysis: 12/02/18 at 12:00pm, 12/03/18 at 12:00pm, and 5:00pm, 12/05/18 at 12:00pm, 12/12/18 at 12:00pm, 12/14/18 at 12:00pm, 12/19/18 at 12:00pm, 12/21/18 at 12:00pm, 12/23/18 at 12:00pm, 12/25/18 at 5:00pm, 12/26/18 at 12:00pm, 12/31/18 at 12:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's January 2019 eMAR revealed:
-There was an order entry for -There was documentation the resident was out of the facility, refused and was physically unable to take medication. 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm.
-There was documentation Auryxia was not administered sixty-three times on the following dates due to the resident being at dialysis: 01/02/19 at 12:00pm, 01/03/19 at 12:00pm, 01/04/19 at 12:00pm, 01/07/19 at 12:00pm, 01/09/19 at 12:00pm 01/10/19 at 12:00pm, 01/11/19 at 12:00pm, 01/14/19 at 12:00pm, 01/15/19 at 5:00pm, 01/16/19 at 12:00pm and

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 03/08/2019

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 344	Continued From page 61	D 344		

5:00pm, 01/17/19 at 5:00pm, 01/18/19 at 12:00pm and 5:00pm, 01/19/19 through 12:00pm 01/26/19,and no medications were administered 01/27/19 through 01/31/19.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis..

Review of Resident #7's February 2019 eMAR revealed:
-There was an order entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm.
-There was documentation Auryxia was not administered twenty-two times on the following dates due to the resident being at dialysis: 02/01/19 through 02/04/19, 02/06/19 at 12:00pm, 02/08/19 at 12:00pm, 02/11/19 at 12:00pm, 02/13/19 at 12:00pm, 02/15/19 at 12:00pm 02/18/19 at 12:00pm, 02/20/19 at 12:00pm, 02/22/19 at 12:00pm, 02/25/19 at 12:00pm, and 02/27/19 at 12:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis..

Review of Resident #7's March 2019 eMAR revealed:
-There was an order entry for Auryxia 210mg (two tablets= 420mg) three times daily with meals scheduled for 8:00am, 12:00pm, 5:00pm.
-There was documentation Auryxia was not administered four times on the following dates due to the resident being at dialysis: 03/01/19 at 12:00pm and 5:00pm, 03/04/19 at 12:00pm, and 03/06/19 at 12:00pm.
-There was no documentation the physician had been notified to clarify how to administer the

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 03/08/2019

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 344	Continued From page 62	D 344		

medication because the resident was out of the facility at dialysis.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She went to dialysis three days per week from 11:00am until almost 6:00pm.
-She was not administered Auryxia at 12:00pm.
-If she arrived at the facility after 6:00pm the 5:00pm dosage of Auryxia was not administered.
-She knew Auryxia was an iron medication and she needed the medication because she had dialysis.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:
-Auryxia was not administered to Resident #7 on Monday, Wednesday and Friday at 12:00pm when the resident was at dialysis.
-Medications could be administered one hour before the scheduled time or one hour after the scheduled time.
-Resident #7 left the facility at 11:00am for dialysis.
-She had not considered administering Auryxia at 11:00am before Resident #7 left for dialysis.
-She had not contacted Resident #7's physician to clarify administration of the medication on dialysis days (Monday, Wednesday, and Friday).

Interview with a second MA on 03/08/19 at 9:50am revealed:
-Several months ago the dialysis center informed they would not be responsible for administering Resident #7's Auryxia.
-Auryxia was ordered three times daily at 8:00am, 12:00pm and 5:00pm.
-Resident #7 was not administered the medication at 12:00pm when Resident #7 was at dialysis.

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 03/08/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 63	D 344		

-It had never been suggested to administer Auryxia at 11:00am before Resident #7 left the facility.
-She had not contacted Resident #7's physician regarding the medication not being administered due to the resident being at dialysis.

Interview with the nurse at Resident #7's Nephrologist's office on 03/07/19 at 2:22pm revealed:
-Auryxia was ordered three times daily with a meal or a snack.
-Auryxia was not to be a scheduled medication, anytime Resident #7 received a meal or snack regardless of the time the medication should be administered.
-The facility staff should have contacted the physician to clarify how to administer the medication when the Resident was at dialysis.

c. The current FL2 dated 06/27/18 revealed a physician's order for gabapentin 100mg two capsules (200mg) (used to treat diabetic nerve pain) four times daily.

Review of Resident #7's record revealed a subsequent physician's order sheet signed by the physician on 12/04/18 with orders for gabapentin 100mg two capsules (200mg) four times daily.

Review of Resident #7's December 2018 eMAR revealed:
-There was an order entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation gabapentin was not administered thirteen times on the following dates due to the resident being at dialysis: 12:00pm on 12/02/18, 12/03/18, 12/05/18, 12/07/18, 12/12/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 64 12/14/18, 12/17/18, 12/19/19, 12/21/18, 12/23/18, 12/26/18, 12/28/18 12/31/18, and one time at 4:00pm on 12/11/18. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's January 2019 eMAR revealed: -There was an order entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation gabapentin was not administered fourteen times on the following dates due to the resident being at dialysis: 12:00pm on 01/02/19, 01/03/19, 01/07/19, 01/09/19, 01/11/19, 01/14/19, 01/16/19, 01/18/19, 01/21/19, 01/23/19, 01/25/19, 01/28/19, and 01/30/19. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's February 2019 eMAR revealed: -There was an order entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation gabapentin was not administered twelve times on the following dates due to the resident being at dialysis: 12:00pm on 02/01/19, 02/04/19, 02/06/19, 02/08/19, 02/11/19, 02/13/19, 02/15/19, 02/18/19, 02/20/19, 02/22/19, 02/25/19, 02/27/19; and on 02/01/19 at 4:00pm, and 02/04/19 at 8:00am. -There was no documentation the physician had	D 344		

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 03/08/2019

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 344	Continued From page 65	D 344		

been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's March 2019 eMAR revealed:
-There was an order entry for gabapentin 100mg two capsules (200mg) four times daily was scheduled at 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation gabapentin was not administered three times on the following dates due to the resident being at dialysis: 12:00pm on 03/01/19, 03/04/19, and 03/06/19 and on 03/01/19 at 4:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She was a diabetic and constantly had nerve pain.
-The gabapentin was ordered four times daily for the pain.
-The gabapentin was scheduled four times a day, but was not administered four times a day on Monday Wednesday and Friday.
-She left the facility at 11:00am for dialysis and was not administered gabapentin at 12;00pm.
-Also, if she returned from dialysis after 5:00pm she was not administered the 4:00pm gabapentin, which meant she had to wait until 8:00pm to get the medication to help with pain.
-She wished that she could have the 12:00pm gabapentin because it would help with her pain.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:

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D 344	Continued From page 66	D 344		

-Resident #7 went to dialysis and was not administered the 12:00pm gabapentin.
-She had not considered administering the medication one hour early at 11:00am before the resident left for dialysis.
-She had not contacted Resident #7's physician to inform gabapentin was not administered at 12:00pm due to the resident being at dialysis.

Interview with the RCC on 03/08/19 at 8:43am revealed:
-Resident #7 went to dialysis three days per week (Monday, Wednesday and Friday).
-Resident #7 did not take the gabapentin with her to the dialysis center because there was no one there to administer the medications to the resident.
-The MA was responsible for contact the physician to obtain clarification how to administer the medication on days the resident out of the facility at dialysis.

Interview the Administrator on 03/08/19 12:48pm revealed:
-The MA should have contacted the physician and explained why Resident #7 was not administered gabapentin.
-She did not know that Resident #7 was not getting medications as ordered because she was going to dialysis.

Interview with the nurse at Resident #7's primary care physician's (PCP) office on 03/08/19 at 2:45pm revealed:
-The physician ordered gabapentin four times daily and did not know the medication was not administered as ordered.
-The medication should be administered before the resident went to dialysis.
-If the facility had contact the physician the

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D 344	Continued From page 67	D 344		

medication orders could have been changed to accommodate the dialysis schedule.

d. The current FL2 dated 06/27/18 revealed a physician's order for midodrine hcl (used to lower blood pressure) 5mg three times daily after meals.

Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for midodrine hcl 5mg three times daily after meals.

Review of Resident #7's December 2018 eMAR revealed:
-There was an order entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm.
-There was documentation midodrine hcl 5mg was not administered seventeen times on the following dates due to the resident being at dialysis: 12/02/18 at 1:00pm, 12/03/18 at 1:00pm, 12/05/18 at 1:00pm, 12/07/18 at 1:00pm, 12/12/18 at 1:00pm, 12/14/18 at 1:00pm, 12/17/18 at 1:00pm, 12/19/18 at 1:00pm, 12/21/18 at 1:00pm, 12/23/18 at 1:00pm and 6:00pm, 12/24/18 at 1:00pm, 12/25/19 at 6:00pm, 12/26/18 at 9:00am and 1:00pm, 12/28/18 at 1:00pm, 12/31/18 at 1:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's January 2019 eMAR revealed:
-There was an order entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm.
-There was documentation midodrine hcl 5mg

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D 344	Continued From page 68 was not administered sixteen times on the following dates due to the resident being at dialysis: 01/02/19 at 1:00pm, 01/04/19 at 1:00pm, 01/07/19 at 1:00pm, 01/09/19 at 1:00pm, 01/11/19 at 1:00pm and at 6:00pm, 01/14/19 at 1:00pm, 01/16/19 at 1:00pm, 01/18/19 at 1:00pm, 01/21/19 at 1:00pm, 01/23/19 at 1:00pm, 01/25/19 at 1:00pm, 01/28/19 at 1:00pm, 01/29/19 at 6:00pm, and 01/30/19 at 1:00pm and 6:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.. Review of Resident #7's February 2019 eMAR revealed: -There was an order entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm. -There was documentation midodrine hcl 5mg was not administered sixteen times on the following dates due to the resident being at dialysis: 02/01/19 at 1:00pm and 6:00pm, 02/04/19 at 9:00am and 1:00pm, 02/06/19 at 1:00pm, 02/08/19 at 1:00pm, 02/11/19 at 1:00pm, 02/13/19 at 1:00pm, 02/15/19 at 1:00pm, 02/18/19 at 1:00pm, 02/20/19 at 1:00pm, 02/22/19 at 1:00pm, 02/25/19 at 1:00pm, and 02/27/19 at 1:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.. Review of Resident #7's March 2019 eMAR revealed: -There was an order entry for midodrine hcl 5mg three times daily after meals was scheduled for 9:00am, 1:00pm, and 6:00pm.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 69 -There was documentation midodrine hcl 5mg was not administered three times on the following dates due to the resident being at dialysis: 03/01/19 at 1:00pm and 6:00pm, and 03/04/19 at 1:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Interview with Resident #7 on 03/07/19 at 8:34am revealed: -She went to dialysis three days per week and sometimes dialysis lowered her blood pressure and made her feel tired and drained. -She went to dialysis three days per week and midodrine was not administered at 1:00pm. -The facility staff checked her blood pressure once a month and never told her the results. Interview with a first shift MA on 03/07/19 at 3:05pm revealed: -Midodrine was not administered to Resident #7 on Monday, Wednesday and Friday at 1:00pm. -She circled her initials on the eMAR, and documented the resident was out of the facility or physically unable to take the medication. -She documented physically unable to take the medication because the resident was not present in the facility. -She had not contacted Resident #7's physician to inform midodrine was not administered at 1:00pm on Monday, Wednesday and Fridays. Interview with the nurse at Resident #7's PCP office on 03/07/19 at 2:21pm revealed: -The physician knew Resident #7 went to dialysis Monday, Wednesday, and Friday, but did not know the resident was not administered midodrine.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 70 -The medication should be administered anytime Resident #7 was served a meal or snack. e. The current FL2 dated 06/27/18 revealed a physician's order for tylenol 500mg every eight hours for pain. Review of Resident #7's record revealed a physician's order sheet signed by the physician on 12/04/18 with orders for tylenol 500mg every eight hours. Review of Resident #7's December 2018 eMAR revealed: -There was an order entry for tylenol 500mg every eight hours was scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation tylenol 500mg was not administered twenty-one times on the following dialysis dates due to the resident being at dialysis: 12/02/18 at 2:00pm, 12/03/18 at 2:00pm, 12/05/18 at 2:00pm, 12/07/18 at 2:00pm and 10:00pm, 12/09/18 at 10:00pm, 12/10/18 at 10:00pm, 12/11/18 at 10:00pm, 12/12/18 at 2:00pm and 10:00pm, 12/14/18 at 2:00pm, 12/17/18 at 2:00pm, 12/19/18 at 2:00pm, 12/21/18 at 2:00pm, 12/23/18 at 2:00pm 12/24/18 at 10:00pm, 12/26/18 at 2:00pm, 12/28/18 at 2:00pm, 12/29/18 at 10:00pm, 12/30/18 at 10:00pm, and 12/31/18 at 2:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's January 2019 eMAR revealed: -There was an order entry for tylenol 500mg every eight hours was scheduled at 6:00am, 2:00pm, and 10:00pm.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 71 -There was documentation tylenol 500mg was not administered seventeen times on the following dialysis dates due to the resident being at dialysis: 01/02/19 at 2:00pm, 01/03/19 at 6:00am, 01/04/19 at 2:00pm, 01/07/19 at 2:00pm, 01/09/19 at 2:00pm, 01/11/19 at 2:00pm, 01/14/19 at 2:00pm, 01/16/19 at 2:00pm, 01/18/19 at 2:00pm and 10:00pm, 01/20/19 at 10:00pm, 01/21/19 at 2:00pm, 01/23/19 at 2:00pm, 01/25/19 at 2:00pm 01/28/19 at 2:00pm, and 01/30/19 at 2:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's February 2019 eMAR revealed: -There was an order entry for tylenol 500mg every eight hours was scheduled at 6:00am, 2:00pm, and 10:00pm. -There was documentation tylenol 500mg was not administered twelve times on the following dates due to the resident being at dialysis: 02/01/19 at 2:00pm and 10:00pm, 02/02/19 at 2:00am, 02/04/19 at 2:00pm, 02/06/19 at 2:00pm, 02/08/19 at 2:00pm, 02/11/19 at 2:00pm, 02/13/19 at 2:00pm, 02/15/19 at 2:00pm, 02/20/19 at 2:00pm, 02/22/19 at 2:00pm, and 02/25/19 at 2:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's March 2019 eMAR revealed: -There was an order entry for tylenol 500mg every eight hours was scheduled at 6:00am, 2:00pm, and 10:00pm.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 344	Continued From page 72	D 344		

-There was documentation tylenol 500mg was not administered two times on the following dates due to the resident being at dialysis: 03/01/19 at 2:00pm and 03/04/19 at 2:00am.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-On dialysis days she did not get her 2:00pm Tylenol.
-She wished that did get Tylenol because she was constantly in pain.

Interview with a first shift MA on 03/07/19 at 3:05pm revealed:
-When the resident was at dialysis she was not administered her 2:00pm Tylenol for pain.
-She had not contacted Resident #7's physician to inform Tylenol was not administered three times daily as ordered.

Interview with the nurse at Resident #7's PCP office 03/08/19 at 2:45pm revealed:
-The physician knew Resident #7 went to dialysis Monday, Wednesday, and Friday, but did not know the resident was not administered medication as ordered.
-Had the facility staff called the medication could have been changed to accommodate the resident's dialysis schedule.

f. The current FL2 dated 06/27/18 revealed a physician's order for refresh tears 0.5% (used to treat eye irritation, dryness and discomfort) eye drops four times daily.

Review of Resident #7's record revealed a

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 03/08/2019

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D 344	Continued From page 73	D 344		

physician's order sheet signed by the physician on 12/04/18 with orders for refresh tears 0.5% eye drops four times daily.

Review of Resident #7's December 2018 eMAR revealed:
-There was an order entry for refresh eye drops four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation refresh eye drops was not administered fourteen times on the following dates due to the resident being at dialysis: 12/02/18 at 12:00pm, 12/03/18 at 12:00pm, 12/05/18 at 12:00pm, 12/07/18 at 12:00pm, 12/11/18 at 4:00pm, 12/12/18 at 12:00pm, 12/14/18 at 12:00pm, 12/17/18 at 12:00pm, 12/19/18 at 12:00pm, 12/21/18 at 12:00pm, 12/23/18 at 12:00pm, 12/26/18 at 12:00pm, 12/28/18 at 12:00pm, and 12/31/19 at 12:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's January 2019 eMAR revealed:
-There was an order entry for refresh eye drops four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-There was documentation refresh eye drops was not administered sixteen times on the following dates due to the resident being at dialysis: 01/02/19 at 12:00pm, 01/03/19 at 12:00pm, 01/04/19 at 12:00pm, 01/07/19 at 12:00pm, 01/09/19 at 12:00pm, 01/11/19 at 12:00pm, 01/14/19 at 12:00pm, 01/16/19 at 12:00pm, 01/18/19 at 12:00pm, 01/19/19 at 8:00am, 01/20/19 at 8:00am, 01/21/19 at 12:00pm, 01/23/19 at 12:00pm, 01/25/19 at 12:00pm, 01/28/19 at 12:00pm, and 01/30/19 at 12:00pm.

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 03/08/2019

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D 344	Continued From page 74 -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's February 2019 eMAR revealed: -There was an order entry for refresh eye drops four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation refresh eye drops was not administered fifteen times on the following dates due to the resident being at dialysis: 02/01/19 at 12:00pm and 4:00pm, 02/04/19 at 8:00am and 12:00pm, 02/06/19 at 12:00pm, 02/08/19 at 12:00pm, 02/11/19 at 12:00pm, 02/13/19 at 12:00pm, 02/15/19 at 12:00pm, 02/16/19 at 8:00am, 02/18/19 at 12:00pm, 02/20/19 at 12:00pm, 02/22/19 at 12:00pm, 02/25/19 at 12:00pm, and 02/27/19 at 12:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's March 2019 eMAR revealed: -There was an order entry for refresh eye drops four times daily scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation refresh eye drops was not administered eight times on the following dates due to the resident being at dialysis: 03/01/19 at 12:00pm and 4:00pm, 03/04/19 at 12:00pm, 03/05/19 at 8:00am, 4:00pm, and 8:00pm, and 03/06/19 at 8:00am and 12:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.	D 344		

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 03/08/2019

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D 344	Continued From page 75 Observation of Resident #7's medications on hand at the facility on 03/07/18 at 9:34am revealed: -Refresh tears were not available for administration. -The MA was observed ordering the eye drops on 03/07/19 at 9:40am. -The eMAR system showed the eye drop was lasted ordered on 01/21/19. Interview with Resident #7 on 03/07/19 at 8:34am revealed: -She was not administered refresh eye drops. -The medication had not been administered for the past three months. -She thought the medication had been discontinued. -She previously was administered refresh eye drops for dry eyes because sometimes her eyes were dry and became irritated. -She did not question why she did not get the medication, but thought it had been discontinued. Interview with a first shift MA on 03/07/19 at 8:38am revealed: -Refresh tears were not on the medication cart. -She administered the last dose this morning (03/07/19) and threw the medication bottle away. Interview with the pharmacist at the contact pharmacy on 03/07/19 at 10:12am revealed: -Refresh eye drop was last dispensed on 01/21/19. -One bottle of refresh tears would last "roughly" around six weeks. Interview with the nurse at Resident #7's Primary Care Physician's office 03/08/19 at 2:45pm revealed:	D 344		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 76	D 344		

-The physician did not know that Resident #7 did not receive refresh eye drops.
-There was no order to discontinue the medication.
-There was no documentation the facility staff had informed the physician the medication was not administered when the resident went to dialysis.

Interview with the Resident Care Coordinator on 03/08/19 at 8:43am revealed:
-Resident #7 went to dialysis three days per week and to her knowledge the physician had not been notified Resident #7 was not administered refresh tears when at dialysis.
-She did an audit of the medication cart and eMARs every Monday and Wednesday.
-If the refresh tears were not on the cart she would have re-ordered the eye drops.
-She did not specifically remember if she had observed Resident #7's refresh tears on the medication cart.

Interview with the Administrator on 03/08/19 at 12:48pm revealed:
-The MAs should have followed-up with Resident #7's physician when the resident was not administered refresh tears.
-No resident should run out of a medication.
-The RCC and MAs frequently did audits of the medication cart comparing medications on hand to the eMARs.
-She did not know if Resident #7 was administered refresh tears.

2. Review of Resident #6's current FL2 dated 02/14/19 revealed diagnoses included Alzheimer's dementia, end state renal failure hypertension and diabetes mellitus.
-A physician's order for sevelamer carbonate (renvela) 800mg two capsules (1600mg) twice

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 03/08/2019

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D 344	Continued From page 77 daily with meals (used to control phosphorus levels), and a physician's order for sevelamer 800mg three capsules (3200mg) three times daily with meals. Review of Resident #6's December 2018 electronic Medication Administration Record (eMAR) revealed: -There was an order entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily with meals was scheduled for 8:00am, 12:00pm, 5:00pm. -A second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks. -There was documentation sevelamer carbonate was not administered twenty-two times on the following dates due to the resident being at dialysis: 12/07/18 at 12:00pm and 2:00pm, 12/17/18 at 12:00pm, 12/19/18 at 12:00pm and 2:00pm, 12/20/19 at 5:00pm, 12/21/18 at 12:00pm and 2:00pm, 12/23/18 at 10:00am and 2:00pm, 12/24/18 at 10:00am, 12/26/18 at 12:00pm and 2:00pm, 12/28/18 at 10:00am, 12:00pm and 2:00pm, and 12/31/18 at 10:00am, 12:00pm, 2:00pm, and 12/31/18 at 5:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis. Review of Resident #7's January 2019 eMAR revealed: -There was an order entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily with meals was scheduled for 8:00am, 12:00pm, 5:00pm. -A second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks.	D 344		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 344	Continued From page 78 -There was documentation sevelamer carbonate was not administered thirty times on the following dates due to the resident being at dialysis: 01/02/19 at 2:00pm, 01/04/19 at 12:00pm and 2:00pm, 01/07/19 at 10:00am, 2:00pm, and 5:00pm, 01/09/19 at 12:00pm and 2:00pm, 01/11/19 at 10:00 and 12:00pm, 01/14/19 at 10:00am, 12:00pm and 2:00pm, 01/16/19 at 10:00am, 12:00pm and 2:00pm, 01/18/19 at 10:00am, 12:00pm, and 2:00pm, 01/21/19 at 10:00am, 12:00pm, and 2:00pm, 01/23/19 at 10:00am, 12:00pm, and 2:00pm, 01/25/19 at 10:00am, 12:00pm, 2:00pm, 01/28/19 at 10:00am, 12:00pm, and 2:00pm, 01/29/18 at 10:00am and 2:00pm, and 01/30/19 at 10:00am, 12:00pm and 2:00pm. -There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis Review of Resident #7's February 2019 eMAR revealed: -There was an order entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily with meals was scheduled for 8:00am, 12:00pm, 5:00pm. -A second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks. -There was documentation sevelamer carbonate was not administered thirty-two times on the following dates due to the resident being at dialysis: 02/01/19 at 12:00pm and 2:00pm, 02/03/19 at 2:00pm, 02/04/19 at 12:00pm and 2:00pm, 02/05/19 at 2:00pm, 02/06/19 at 12:00pm and 2:00pm, 02/08/19 at 10:00am, 2:00pm and 5:00pm, 02/11/19 at 12:00pm and 2:00pm, 02/13/19 at 10:00am, 12:00pm, and 2:00pm, 02/15/19 at 12:00pm and 2:00pm,	D 344		

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 03/08/2019

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D 344	Continued From page 79	D 344		

02/18/19 12:00pm and 2:00pm, 02/19/18 at 2:00pm, 02/20/18 at 2:00pm, 02/21/19 at 12:00pm and 2:00pm, 02/21/19 at 2:00pm, 02/22/19 at 12:00pm, 2:00pm, and 5:00pm, 02/25/19 at 12:00pm, 2:00pm, and 5:00pm, 12/27/19 at 12:00pm and 2:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis.

Review of Resident #7's March 2019 eMAR revealed:
-There was an order entry for sevelamer carbonate 800mg three capsules with meals (3200mg) three times daily with meals was scheduled for 8:00am, 12:00pm, 5:00pm.
-A second entry for sevelamer carbonate 800mg two capsules (1600mg) two times daily with snacks.
-There was documentation sevelamer carbonate was not administered four times on the following dates due the resident being at dialysis: 03/01/19 at 12:00pm and 2:00pm, 03/04/19 at 12:00pm and 2:00pm, 03/04/19 at 12:00pm and 2:00pm, 03/06/18 at 12:00pm, 03/08/19 at 12:00pm and 2:00pm.
-There was no documentation the physician had been notified to clarify how to administer the medication because the resident was out of the facility at dialysis

Based on observation, interview and record review it was determined Resident #6 was not interviewable.

Telephone interview with the nurse at Resident #6's Nephrologist office on 03/08/19 at 1:10pm revealed:
-The physician knew Resident #6 had dialysis,

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 03/08/2019

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 344	Continued From page 80	D 344		

but did not know sevelamer carbonate was not administered as ordered.
-The medication should be administered anytime the resident consumed food that included snacks.
-The physician did not know the medication was not being administered as ordered.
-The facility staff should notify the physician to discuss the administration of the medication, and what to do when the resident was at dialysis.

Interview on 03/08/19 at 2:40pm with Resident #6's power of attorney revealed:
-She thought Resident #6 was getting all medications ordered.
-She had frequently had conversations with facility staff, but no one at the facility had informed her that Resident #6 missed medications due to the dialysis schedule.
-She could have contacted the physician to clarify how to administer the medications when Resident #6 was at dialysis.

Interview with the memory care unit coordinator (MCC) on 03/08/19 at 2:05pm revealed:
-She knew that Resident #6 went to dialysis and did not get medications as ordered.
-Resident #6 was given a snack when at dialysis, but there was no way to give the resident medications ordered.
-She had not notified Resident #6's Nephrologist regarding the resident not getting medications scheduled three times, but not administered on Monday, Wednesday, and Fridays when the resident was at dialysis.

Interview the Administrator on 03/08/19 12:48pm revealed:
-She expected the MAs to notify the physician when a resident was not administered medications as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 344	Continued From page 81 -The MAs should have obtained orders from the physician addressing medications ordered when the resident was at dialysis.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 residents (Residents #1, #8, and #9) observed during the medication passes including errors with an anticonvulsant (#1), a carbonic anhydrase inhibitors and antifungal cream (#8) and alpha adrenergic agonists (#7); and for 2 of 7 residents sampled (Residents # 4 and #7) for record review related to Nobvolog insulin not administered as ordered (#7), and errors with a pain medication (#4).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 82 The findings are: The medication error rate was 13% as evidenced by 4 errors out of 29 opportunities observed during the 8:00 am medication pass on 03/05/19. 1. Review of Resident #1's current FL2 dated 04/18/18 revealed: -Diagnoses included bipolar disorder, type II diabetes, hypothyroid, gastroesophageal reflux disease, vitamin B12 deficiency, hypertension, and congestive heart failure. -An order for Topamax (used to treat seizures or migraines) 50mg twice a day. Observation of the 8:00am medication pass on 03/05/19 revealed: -At 8:45am Resident #1 was administered four oral medications by the medication aide (MA). -An entry for Topamax was not administered on 03/05/19. Review of Resident #1's March 2019 electronic medication administration record (eMAR) revealed: -Topamax 50mg twice a day and scheduled for administration at 8:00am and 8:00pm. -The medication was documented as administered. Review of Resident #1's medication on hand for administration on 03/05/19 at 1:11pm revealed Topamax 50mg was available for administration. Interview with the medication aide (MA) administering Resident #1's medications on 03/05/19 at 5:00pm revealed: -She had not administered medications since December 2018.	D 358		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 83 -She compared the eMAR to the medications available on the medication cart and pulled the medications due to administer. -The Topamax was available on the medication cart. -She must have overlooked the Topamax when pulling the medications to be administered. Interview with Resident #1 on 03/08/19 at 2:36pm revealed: -She knew she was prescribed Topamax but did not know if she received the Topamax during the morning medication pass on 03/05/19. -She did not know why the Topamax was prescribed. Interview with a representative from the facility contracted pharmacy on 03/05/19 at 4:20pm revealed: -She provided education regarding the medication pass and the eMAR system for staff at the facility. -The staff were taught to compare the medication labels to the eMAR. -Topamax was last dispensed 02/25/19 for 60 tablets. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed: -She expected all MAs to compare the eMAR to the medication labels and administer the medications due for their shift. -The MAs should read the directions carefully to assure the medication was given correctly. -If Resident #1 was not administered the medication, the MA should have documented not given on the eMAR. Interview with the Administrator on 03/08/19 at 2:50pm revealed:	D 358		

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 84	D 358		

-The MAs were expected to administer the medications due on their shift.
-MAs should compare the eMAR to the medication label on the bubble pack or the bottle and follow directions for medication administration.
-The MA should have administered all medications to Resident #1 during the morning medication pass on 03/05/19 as ordered.

Interview with Resident #1's primary care provider (PCP) on 03/06/19 at 2:00pm revealed:
-She expected staff to administer medications as ordered.
-She was not notified Resident #1 did not receive Topamax during the morning medication pass on 03/05/19.
-She was concerned staff were not administering medications as ordered.
-She was not concerned Resident #1 missed one dose of Topamax.

2. Review of Resident #8's current FL2 dated 04/26/18 revealed diagnoses included atrial fibrillation, coronary artery disease, chronic obstructive pulmonary disease, heart failure, hypertension, cerebrovascular accident, seizures, and glaucoma.

a. Review of Resident #8's current FL2 dated 04/26/18 revealed an order for dorzolamide 2% (used to treat high pressure behind the eye due to glaucoma) instill one drop into the right eye three times a day.

Observation of the 8:00am medication pass on 03/05/19 revealed:
-At 8:50am Resident #8 was administered four oral medications by the medication aide (MA).
-Dorzolamide 2%, one drop was administered to

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 03/08/2019

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 358	Continued From page 85 both eyes. Review of Resident #8's March 2019 electronic medication administration record (eMAR) revealed: -An entry for dorzolamide 2% instill one drop into the right eye three times a day for 30 days and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -The medication was documented as administered on 03/05/19. Observation of Resident #8's medication on hand for administration on 03/05/19 at 8:50am revealed dorzolamide 2%. Interview with the medication aide (MA) administering Resident #8's medications on 03/05/19 at 1:58pm revealed: -She did not normally administer Resident #8's medications. -She thought the dorzolamide was to be administered in both eyes. -She compared the dorzolamide with the directions listed in the eMAR but thought the dorzolamide was to be administered in both eyes. Interview with Resident #8 on 03/05/19 at 2:12 pm revealed: -He thought he was supposed to get dorzolamide in both eyes. -The dorzolamide 2% was always administered in both eyes. -He did not know why he was ordered dorzolamide. Interview with a representative from the facility contracted pharmacy on 03/05/19 at 4:20pm revealed: -She educated staff to compare the eMAR to the	D 358		

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 03/08/2019

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 358	Continued From page 86	D 358		

medication labels.
-She educated staff to follow directions on the eMAR and medication label.

Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed:
-She expected the MA to compare the eMAR to Resident #8's medication labels and administer the medications due for their shift.
-The MAs should read the directions carefully to assure the medication is given correctly.
-The MA should have administered according to the directions.

Interview with the Administrator on 03/08/19 at 2:50pm revealed:
-The MAs were expected to administer the medications due on their shift.
-MAs should compare the eMAR to the medication label on the bubble pack or the bottle and follow directions for medication administration.

Attempted telephone interview with Resident #8's primary care provider on 03/08/19 at 2:00pm was unsuccessful.

b. Review of Resident #8's physician orders dated 01/04/19 revealed an order for nystatin 100,000 ointment (used to treat antifungal infections) apply topically to penis two times a day until healed.

Observation of the 8:00am medication pass on 03/05/19 revealed:
-At 8:50am Resident #8 was administered four oral medications by the medication aide (MA).
-Nystatin ointment was not administered.

Review of Resident #8's March 2019 electronic

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 03/08/2019

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 358	Continued From page 87	D 358		

medication administration record (eMAR) revealed:
-An entry for nystatin 100,000 ointment apply topically to penis two time a day until healed and scheduled for administration at 8:00am and 8:00pm.
-The medication was not documented as administered on 03/05/19.

Observation of Resident #8's medication on hand for administration on 03/05/19 at 1:11pm revealed:
-Two tubes of nystatin was available for administration.
-Both nystatin tubes were half full.

Interview with the medication aide (MA) administering Resident #8's medications on 03/05/19 at 1:58pm revealed:
-She did not normally administer medications for Resident #8.
-She went back after the morning med pass and administered the nystatin ointment.
-The nystatin ointment was not kept on the medication cart; it was kept on the treatment cart.

Interview with Resident #8 on 03/05/19 at 2:12 pm revealed:
-He denied receiving nystatin ointment on 03/05/19.
-He did not know he was ordered the nystatin ointment or what it was used to treat.
-He denied ever receiving the nystatin ointment.

Interview with Resident #8's primary care provider (PCP) on 03/08/19 at 1:03 pm revealed:
-She expected the resident to receive the nystatin as ordered.
-Not receiving the nystatin ointment as ordered could cause delayed healing.

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 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 88 -The facility had not notified her the nystatin was not administered as ordered on 03/05/19. -She expected the staff to notify her of the missed nystatin. Interview with a representative from the facility contracted pharmacy on 03/05/19 at 4:20pm revealed: -She provided education regarding the medication pass and the eMAR system for staff. -The staff were taught to always compare the eMAR to the medication labels. -The nystatin ointment was dispensed on 01//4/19 for 30 grams and 02/11/19 for 30 grams. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed she expected the MA to compare the eMAR to Resident #8's medication labels and administer the medications due for their shift. Interview with the Administrator on 03/08/19 at 2:50pm revealed: -The MAs were expected to administer the medications due on their shift. -MAs should compare the eMAR to the medication label on the bubble pack or the bottle and follow directions for medication administration. 3. Review of Resident #9's current FL2 dated 04/04/18 revealed: -The diagnoses included hypertension, subarachnoid hemorrhage, epilepsy, general muscle weakness, and diabetes. -There was an order for alphagan 0.2% (used to treat glaucoma) instill one drop into the right eye three times a day. Observation of the 8:00am medication pass on	D 358		

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 03/08/2019

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D 358	Continued From page 89 03/05/19 revealed: -At 9:00am Resident #8 was administered four oral medications by the medication aide (MA). -Alphagan was not administered or offered. Review of Resident #9's March 2019 electronic medication administration record (eMAR) revealed: -An entry for Alphagan 0.2% instill one drop in both eyes two times a day and scheduled for administration at 8:00am and 8:00pm. -The medication was not documented as administered on 03/05/19. Observation of Resident #9's medication on hand for administration on 03/05/19 at 1:11pm revealed alphagan 0.2% was available for administration Interview with the medication aide (MA) administering Resident #9's medications on 03/05/19 at 1:58pm revealed: -She did not normally administer Resident #9's medications. -She administered only the medications due on her shift. -She compared the eMAR to the medications available on the cart. -Resident #9 always refused alphagan eye drops. Interview with Resident #9 on 03/05/19 at 2:07 pm revealed: -He was not administered eye drops during the 8:00 am medication pass on 03/05/19. -He did not refuse eye drops during the morning medication pass on 03/05/19. -He never refused his eye drops. Interview with a representative from the facility contracted pharmacy on 03/05/19 at 4:20pm revealed:	D 358		

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D 358	Continued From page 90 -She provided education regarding the medication pass and the eMAR system for the staff. -The staff were taught to compare the eMAR to the medication labels. -Alphagan was last dispensed 02/08/19 for 10 milliliter bottle. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 9:20am revealed: -She expected all MAs to compare the eMAR to the medication labels and administer the medications due for their shift. -The MAs should read the directions carefully to assure the medication was given correctly. -Resident #9 often refuse medications. -She expected the MA to attempt to administer the alphagan. -If Resident #9 refused the alphagan during the medication pass; the MA should document the medication was not administered on the eMAR and provide a reason the medication was not administered. Interview with the Administrator on 03/08/19 at 2:50pm revealed: -The MAs were expected to administer the medications due on their shift. -MAs should compare the eMAR to the medication label on the bubble pack or the bottle and follow directions for medication administration. -The MA should have attempted to administer all medications due for Resident #9. -If Resident #9 refused the alphagan during the medication pass; the MA was expected to document the medication was not administered. -The MA was also expected to document a reason the medication was not administered.	D 358		

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D 358	Continued From page 91	D 358		

Interview with Resident #9's primary care provider (PCP) on 03/06/19 at 2:00pm revealed:
-Resident #9 was prescribed alphagan 0.2% due to glaucoma.
-He expected staff to administer medications as ordered.
-He was not notified Resident #9 did not receive the alphagan 0.2% eye drops during the morning medication pass on 03/05/19.
-He was at the facility once a week.
-He was not concerned Resident #9 was not administered alphagan 0.2% eye drops during the morning medication pass.

4. Review of Resident #7's current FL2 dated 06/27/18 revealed:
-Diagnoses included end stage renal disease, type two diabetes, neurogenic bladder, colostomy, bilateral amputation, and left arm paralysis.

Review of Resident #7's current FL2 dated 06/27/18 revealed a physician's order for Novolog (fast-acting insulin to help control diabetes) sliding scale insulin subcutaneously when Fingerstick Blood Sugar (FSBS) ranged between 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, greater than 400 call the physician, and FSBS four times daily.

Review of Resident #7's record revealed a subsequent physician's order sheet signed by the physician on 12/04/18 with orders for Novolog sliding insulin subcutaneously when FSBS ranged between 201-250 give 1 unit, 251-300 give 2 units, 301-350 give 3 units, 351-400 give 4 units, greater than 400 call the physician, and FSBS four times daily.

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D 358	Continued From page 92	D 358		

Review of Resident #7's December 2018, January, February and March 2019 electronic Medication Record Administration (eMAR) revealed:
-There was an order entry for Novolog sliding scale scheduled for three times daily at 7:30am, 11:30am, and 4:30pm.
-There was a second entry for FSBS four times daily at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation FSBS required Novolog and no units of insulin was documented as administered:
-On 12/21/18 at 7:30am, FSBS was 438, required 4 units.
-On 02/21/19 at 7:30am, FSBS was 579, required 4 units.
-On 02/25/19 at 7:30am FSBS was 487, required 4 units.
-On 02/27/19 at 7:30am FSBS was 487, required 4 units.

Observation of Resident #7's medications on hand at the facility on 03/08/19 at 9:34am revealed Novolog was available for administration.

Interview with Resident #7 on 03/07/19 at 8:34am revealed:
-She was a severe diabetic and was ordered Novolog sliding scale insulin to reduce her high blood sugars.
-The medication aides (MAs) checked her FSBS four times daily, excluding the times she was at dialysis.
-She was administered Novolog sliding scale when her blood sugars were above 200.
-She could not remember the exact numbers the sliding scale range, and she did not ask staff how much insulin they administered.

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D 358	Continued From page 93 Interview with a first shift MA on 03/07/19 at 3:05pm revealed: -Resident #7 was ordered Novolog sliding scale three times daily based on FSBS results. -The units of Novolog administered were documented on the eMAR. -She did not know why there were FSBS results that required the administration Novolog and none was given. -There was an audit of the eMARs and medications on the cart two to three days per week. -The eMARs were checked for holes, but no one looked at the units of Novolog sliding scale documented. Interview with Resident #7's Endocrinologist 03/07/19 at 11:14am revealed: -Resident #7 was a severe diabetic. -The resident was ordered routine Novolog and Novolog sliding scale. -When a blood sugar was within range to administer the sliding scale Novolog the medication should be administered in conjunction with scheduled dose to control blood sugars. -A continued high blood sugar, greater than 400 was serious and could possibly cause the resident harm or death. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:43am revealed: -She did not know that Resident #7 had FSBS checks that required Novolog and the medication was not administered. -She audited the medication cart and the eMARs twice weekly but had not noticed there were some FSBS without documented units of Novolog administered. Interview the Administrator on 03/08/19 12:48pm	D 358		

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D 358	Continued From page 94	D 358		

revealed:
-The MAs should document the administration of all medications.
-The MAs and RCC did audits of the medication cart and medications on hand.
-The MAs and RCC should check to ensure Resident #7's Novolog sliding scheduled was administered as ordered.

5. Review of Resident #4's current FL2 dated 06/26/18 revealed:
-Diagnoses included diabetes mellitus, chronic hypoxic respiratory failure, chronic obstructive pulmonary disease, anxiety and depression, dementia, hypertension, hyperlipidemia, and macular degeneration.
-There was an order for motrin (Ibuprofen) 600 mg (a medication used to treat pain) one tablet every six hours.

Review of Resident #4's record revealed:
-There was a physician's order sheet signed by the physician on 12/05/18 with an order for Ibuprofen every six hours not to exceed 3200 mg per day and an order for Ibuprofen 600 mg three times daily as needed for pain.
-There was an order clarification sheet dated 12/13/18 which requested clarification on the order for Ibuprofen 600 mg three times a day as needed for pain (take with food) not to exceed 3200 mg per day.
-The physician gave clarification on the order clarification sheet dated 12/13/18 for Ibuprofen 600mg three times daily with meals.

Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2018 revealed:
-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily with meals.

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D 358	Continued From page 95 -There was an entry for scheduled Ibuprofen 600 mg tablet, take tablet by mouth every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm. -There was documentation scheduled Ibuprofen was administered at 12:00am, 6:00am, 12:00pm, and at 6:00pm from 12/01/18 through 12/5/18, 12/7/18 through 12/19/18, 12/16/18 through 12/17/18, 12/19/18, 12/21/18 through 12/22/18, and on 12/31/18. -There was documentation scheduled Ibuprofen 600 mg was not administered twenty five of one hundred and twenty-four opportunities on the following dates: 12/06/18 at 6:00am; 12/10/18 at 6:00pm; 12/11/18 at 12:00pm; 12/12/18 at 12:00am and 6:00am; 12/13/18 at 12:00am; 12/14/18 at 12:00am; 12/14/18 at 12:00am; 12/15/18 and 6:00am and 12:00pm; 12/18/18 at 6:00am; 12/20/18 at 6:00 am; 12/24/18 at 12:00am and 6:00am; 12/26/18 at 12:00am and 6:00am; 12/27/18 at 12:00am and 6:00am; 12/28/18 at at 12:00am; 6:00am, and12:00pm; 12/29/18 at at 12:00am and 6:00am; and 12/30/18 at 12:00pm. -There was documentation scheduled Ibuprofen was not administered due to "resident refused," "physically unable to take," or there was no documentation for the missed medication. -There was an entry for Ibuprofen 600 mg tablet, take one tablet by mouth three times daily as needed for pain and this entry was discontinued on 12/19/18. -There was an entry for Ibuprofen 600 mg tablet, take one tablet by mouth three times daily as needed with meals. -There was documentation Ibuprofen 600 mg three times daily as needed was administered once from 12/01/18 through 12/31/18. Review of the eMAR for January 2019 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 96 -There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily with meals. -There was an entry for scheduled Ibuprofen 600 mg tablet, take 1 tablet by mouth every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm. -There was documentation scheduled Ibuprofen was administered at 12:00 am, 6:00 am, 12:00 pm, and at 6:00 pm on 01/05/19, 01/09/19, 01/13/19, 01/14/19, 01/19/19, 01/22/19, and 01/28/19 through 01/30/19. -There was documentation scheduled Ibuprofen 600 mg was not administered thirty two of one hundred and twenty-four opportunities on the following dates: 01/01/19 at 6:00am; 01/02/19 at 12:00am and 6:00am; 01/03/19 at 12:00am and 6:00am; 01/04/19 at 12:00am and 6:00am; 01/06/19 at 12:00am; 01/07/19 at 12:00am and 6:00am; 01/09/19 at 12:00am and 6:00am; 01/10/19 at 12:00am and 6:00am; 01/11/19 at 12:00am and 6:00am; 01/12/19 at 12:00am; 01/15/19 at 12:00am; 01/16/19 at 6:00am; 01/17/19 at 6:00am; 01/18/19 at 12:00am and 6:00am; 01/20/19 at 12:00am; 01/21/19 at 6:00am; 01/23/19 at 12:00am and 6:00am; 01/24/19 at 6:00am; 01/25/19 at 6:00am; 01/26/19 at 12:00am and 6:00am; 01/27/19at 12:00pm; and 01/31/19 at 6:00am. -There was documentation scheduled Ibuprofen was not administered due to "resident refused" or there was no documentation for the missed medication. -There was an entry for Ibuprofen 600 mg tablet, take one tablet by mouth three times daily as needed with meals. -There was no documentation Ibuprofen 600 mg three times daily as needed was administered from 01/01/19 through 01/31/19. Review of the eMAR for February 2019 revealed:	D 358		

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D 358	Continued From page 97	D 358		

-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily.
-There was an entry for scheduled Ibuprofen 600 mg tablet, take 1 tablet by mouth every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation scheduled Ibuprofen was administered at 12:00 am, 6:00 pm, 12:00 pm, and 6:00 pm from 02/01/19 through 02/12/19, 02/14/19, 02/17/19, 02/19/19, 02/21/19 through 02/23/19, and 02/25/19.
-There was documentation scheduled Ibuprofen 600 mg was not administered ten of one hundred and twelve opportunities on the following dates: 02/13/19 at 12:00am; 02/15/19 at 12:00am and 6:00am; 02/16/19 at 6:00pm; 02/18/19 at 12:00am; 02/20/19 at 12:00am and 6:00pm; 02/24/19 at 12:00pm; 02/26/19 at 6:00am; and 02/27/19 at 6:00am.
-There was documentation scheduled Ibuprofen was not administered due to "resident refused," "out of facilty," or there was no documentation for the missed medication.
-There was an entry for Ibuprofen 600 mg tablet, take one tablet by mouth three times daily as needed with meals.
-There was no documentation Ibuprofen 600 mg 3 times daily as needed was administered from 02/02/19 through 02/28/19.

Review of the eMAR for March 2019 revealed:
-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily.
-There was an entry for Ibuprofen 600 mg tablet, take 1 tablet by mouth every six hours, not to exceed 3200 mg per day at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-There was documentation Ibuprofen was administered at 12:00am, 6:00pm, 12:00pm, and 6:00pm on 03/01/19, 03/02/19, 03/04/19, and

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D 358	Continued From page 98 03/05/19. -There was documentation Ibuprofen 600 mg was not administered one of twenty two opportunities on the following date: 03/03/19 at 12:00am. -There was documentation Ibuprofen was not administered due to "resident refused." -There was no documentation Ibuprofen 600 mg three times daily as needed was administered from 03/01/19 through 03/06/19. Observation of Resident #4's medications on hand at the facility on 03/07/19 at 9:58am revealed: -Ibuprofen every six hours was available on the medication cart for administration with a dispense date of 03/05/19. -The Ibuprofen medical label had directions for one tablet every six hours, do not exceed 3200 mg per day. -There was no Ibuprofen 600 mg three times daily as needed available on the medication care. Interview with Resident #4 on 03/07/18 at 10:55am revealed: -She was administered medication at 8:00am, 12:00pm, 5:00 pm, and 8:00 pm but did not know which ones. -She could not remember the last time she requested an as needed pain medication. Interview with a Medication Aide (MA) on 03/07/19 at 9:41am revealed: -The RCC was responsible for reviewing new orders and faxing them to the pharmacy. -She did not know there was an order for Ibuprofen to be administered three times daily with meals. -She administered medication according to what the eMAR indicated. -Ibuprofen, one tablet every six hours scheduled	D 358		

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D 358	Continued From page 99 was on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/08/19 at 8:26am revealed: -The RCC and MAs were responsible for reviewing new orders and faxing them to the pharmacy. -The facility recently changed the contracted pharmacy. -Sometimes doctor's offices faxed orders directly to the old pharmacy and facility staff would have to hunt the new orders down. -She did not know there was an order for Ibuprofen to be administered three times daily and did not know if the order had been faxed to the pharmacy. Interview with a MA on 03/08/19 at 11:51am revealed: -The RCC was responsible for reviewing new orders and faxing them to the pharmacy to be put on the eMAR. -New orders for medication had to be approved on the eMAR by the RCC before the medication could be administered. -The RCC was responsible for making sure medication orders match the order on the eMAR. Interview with a representative from the contracted pharmacy on 03/08/19 at 12:43pm revealed: -The pharmacy did not received the order dated 12/13/18 for Ibuprofen three times daily. -Had the pharmacy received the order dated 12/13/18 for Ibuprofen three times daily, the pharmacist would have clarified because the order was unclear. -Ibuprofen three times daily was not added to the eMAR.	D 358		

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D 358	Continued From page 100 Attempted interview with Resident #4's Primary Care Physician on 03/08/19 at 2:32pm was unsuccessful. Interview with the Administrator on 03/08/19 at 2:48pm revealed: -The RCC and the pharmacy were responsible for reviewing new orders when they came into the facility. -The order was sent to the pharmacy and the pharmacy uploaded to the orders to the eMAR. -She did not know there was an order dated 12/13/18 for Ibuprofen for Resident #4 to be administered 3 times daily. -She expected medication to be administered as ordered by the physician.	D 358		
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	D 367		

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	HAL034098	A. BUILDING: _____ B. WING _____	R 03/08/2019

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D 367	Continued From page 101 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the medication administration records (MARs) were accurate and complete for 1 of 7 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL2 dated 06/26/18 revealed: -Diagnoses included diabetes mellitus, chronic hypoxic respiratory failure, chronic obstructive pulmonary disease, anxiety and depression, dementia, hypertension, hyperlipidemia, and macular degeneration. -There was an order for to check finger stick blood sugars (FSBS) before meals. -There was an order for novolog (fast-acting insulin to help control diabetes) sliding scale insulin (SSI): FSBS 150-200 = 2 units; FSBS 201-250 = 4 units; FSBS 251-300 = 6 units; FSBS 301-350 = 8 units; FSBS 351-400 = 10 units; FSBS above 400 = 12 units and call the physician. Review of Resident #4's electronic Medication Administration Record (eMAR) for December 2018 revealed: -There was an entry for FSBS check before	D 367		

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D 367	Continued From page 102	D 367		

meals at 7:30 am, 11:30 am, and 4:30 pm.
-There was an entry for novolog SSI: FSBS 150-200 = 2 units; FSBS 201-250 = 4units; FSBS 251-300 = 6 units; FSBS 301-350 = 8 units; FSBS 351-400 = 10 units at 7:30 am, 11:30 am and 4:30 pm.
-There was an entry line to document the site of the injection under novolog SSI, but there was not an entry line to document the number of units given.
-Resident #4's blood sugars ranged from 76 to 269.

Review of Resident #4's eMAR for January 2019 revealed:
-There was an entry for FSBS check before meals at 7:30am, 11:30am, and 4:30pm.
-There was an entry for novolog SSI: FSBS 150-200 = 2 units; FSBS 201-250 = 4units; FSBS 251-300 = 6 units; FSBS 301-350 = 8 units; FSBS 351-400 = 10 units at 7:30 am, 11:30am and 4:30pm.
-There was an entry line to document the site of the injection under novolog SSI, but there was not an entry line to document the number of units given.
-Resident #4's blood sugars ranged from 74 to 380.

Review of Resident #4's eMAR for February 2019 revealed:
-There was an entry for FSBS check before meals at 7:30am, 11:30am, and 4:30pm.
-There was an entry for novolog SSI: FSBS 150-200 = 2 units; FSBS 201-250 = 4units; FSBS 251-300 = 6 units; FSBS 301-350 = 8 units; FSBS 351-400 = 10 units at 7:30 am, 11:30am and 4:30pm.
-There was an entry line to document the site of the injection under novolog SSI, but there was not

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D 367	Continued From page 103	D 367		

an entry line to document the number of units given.
-Resident #4's blood sugars ranged from 78 to 244.

Review of Resident #4's eMAR for March 2019 revealed:
-There was an entry for FSBS check before meals at 7:30am, 11:30am, and 4:30pm.
-There was an entry for novolog SSI: FSBS 150-200 = 2 units; FSBS 201-250 = 4units; FSBS 251-300 = 6 units; FSBS 301-350 = 8 units; FSBS 351-400 = 10 units at 7:30 am, 11:30 am and 4:30 am.
-From 03/01/19 through 03/05/19 at 11:30am, there was an entry line to document the site of the injection under novolog SSI, but there was not an entry line to document the number of units given.
-The novolog SSI order had been discontinued on the eMAR and a new novolog SSI order was entered on the eMAR which included an entry line to document the amount of insulin given according to the sliding scale.
-Resident #4's blood sugars ranged from 103 to 274.

Interview with a medication aide (MA) on 03/07/18 at 9:41am revealed:
-Resident #4 had orders for SSI.
-Insulin was administered to Resident #4 according to the sliding scale and should be documented on the eMAR.
-She documented SSI on the eMAR and completed a SSI sheet which was given to the Resident Care Coordinator (RCC).
-She did not realize Resident #4 did not a place to document SSI amount on her eMAR in December, January, February, and part of March 2019.

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D 367	Continued From page 104 -She thought the RCC completed eMAR audits twice a week. Interview with Resident #4 on 03/07/19 at 10:55am revealed: -She was diabetic and had FSBS three times daily. -She was administered SSI insulin three times daily, but did not know her blood sugar ranges or how much insulin was administered. Interview with the RCC on 03/08/19 at 9:18am revealed: -She was responsible for checking the medications against the eMARS one or two times a month. -The MA's were responsible for completing eMAR and cart audits on Mondays, Wednesdays, and Fridays. -When she reviewed eMARs she checked the medication, dosage, and directions. -SSI was automatically calculated in the eMAR system and should have been documented on the eMAR when given. -She did not know the SSI units given were not documented on the eMAR in December, January, February and part of March 2019. -The pharmacy was responsible for entering information on the eMAR. Interview with a MA on 03/08/19 at 11:51am revealed: -The RCC was responsible for completing MAR audits, but she did not how often. -She documented SSI for Resident #4 on the eMAR. -She did not know the SSI units given were not showing as documented on the eMAR in December, January, February, and part of March 2019.	D 367		

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D 367	Continued From page 105 Interview with a representative from the contracted pharmacy on 03/08/19 at 12:43pm revealed: -The pharmacy was responsible for entering orders on the eMAR. -The SSI order was updated on 03/05/19 to include an entry to document amount of insulin given. Attempted interview with Resident #4's the Primary Care Physician (PCP) on 03/08/19 at 2:32pm was unsuccessful. Interview with the Administrator on 03/08/19 2:48pm revealed: -The RCC and the pharmacy were responsible for eMAR audits. -She expected for eMAR audits to be completed once a week to check for accuracy. -Units of insulin given should be documented on the eMAR.	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	D912		

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D912	Continued From page 106 reviews, the facility failed to assure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 4 of 7 sampled residents (Residents #2, #4, #6 and #7) related to not contacting the physician when a resident's blood sugar was greater than 400, when residents were out of the facility and missed medications and when residents refused medications of Novolog, Tylenol, Auryxia, gabapentin, linzess, refresh tears, and midodrine (#7), Sevelamer Carbonate (renvela) (#6), anti-inflammatory cream and an inhaled Fluticasone Propionate (#2), a podiatrist referral and contacting the physician regarding refusal of Ibuprofen (#4). [Refer to Tag 273, .0902(b) Health Care (Type B Violation)].	D912		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device	D992		

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D992	Continued From page 107 may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure examination and screening for the presence of controlled substances for 1 of 6 sampled staff (B) who were hired after 10/01/13. The findings are: 1. Review of Staff B's personnel record revealed: -She was hired on 02/09/18 as the interim Administrator. -There was no documentation of examination and screening for the presence of controlled substances.	D992		

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D992	Continued From page 108 Interview with the Administrator on 03/05/19 at 5:01pm revealed: -She was pulled from the corporate office to work as part-time interim Administrator for the facility in February 2018. -She had a drug screen when she was hired by the corporate office, but did not have one when she started working in the facility. -She did not know if there was any documentation of her having had a drug screen. A second interview with the Administrator on 03/08/19 at 5:03pm revealed: -Drug screenings should be completed prior to orientation of new employees. -She completed a drug screening on 03/06/19 with negative results.	D992		