STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		HAL034098	B. WING		R	8/2019
NAME OF PI	ROVIDER OR SUPPLIER		I RESS, CITY, STA	TE, ZIP CODE	1 03/0	0/2013
			SALISBURY R			
SALEM TE	ERRACE		SALEM, NC 2			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETE DATE
D 000	Initial Comments		D 000			
		sure Section conducted an survey 03/05/19 through				
D 113	10A NCAC 13F .0311	(d) Other Requirements	D 113			
	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.					
	failed to assure the w maintained at a maxin Fahrenheit (F) for 5 o in resident rooms on	ns and interviews, the facility vater temperatures were mum of 116 degrees of 5 sampled fixtures (sinks)				
	The findings are:					
	03/05/19 from 8:45an water temperatures a -At 9:02 am, the hot v in room 103 was 119 -At 9:08 am, the hot v in room 106 was 120 -At 9:12 am, the hot v in room 107 was 121	water temperature at the sink degrees F. water temperature at the sink degrees F. water temperature at the sink degrees F. water temperature at the sink				

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

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			25/25/110		R	
		HAL034098	B. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	SALEM TERRACE 2609 OLD WINSTON					
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE	
D 113	Continued From page 1		D 113			
	-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.					
		ns, interviews and record dent residing in room 103				
	03/05/19 at 9:10am re	ent residing in room 106 on evealed he did not know if cause he always used cold ter for his comfort.				
	03/05/19 at 9:15am re	ent residing in room 107 on evealed she always used hot water and did not feel e was too hot.				
	03/05/19 at 9:23am reburned by the hot was	ent residing in room 112 on evealed she did not get ter because she was able to emperature to her comfort				
	Interview with the Ma 03/05/19 at 9:40am re					

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Division of	of Health Service Regul	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	ETED
	!				<sub>F</sub>	
	ļ	HAL034098	B. WING		1	\ 08/2019
					1 00,0	10/2013
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	「E, ZIP CODE		
SALEM TE	FRRACE		SALISBURY RO			
<u></u>		WINSTON	N SALEM, NC 27	'127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG		200 IDENTIF TINO IN CLASS CHOOL	TAG	DEFICIENCY)	VIAI E	
7.440			+			
D 113	Continued From page 2		D 113			
	-He had worked at the	e facility since December				
	2018.	•				
	-He was told to check	k hot water temperatures				
	monthly.	·				
		locations throughout the				
	facility on the same da					
	_	s on the "Temperature				
	Checklist."					
		at the temperature ranges				
	were required to be.	to the stantantantand had				
		hot water tanks and he did				
		s controlled the 100 hallway.				
		ven to him to check the hot as a meat thermometer.				
		n hot water tanks to reach				
	the required temperat					
	1110 10441100 10	idio.				
	Review of the facility's	s monthly water temperature				
	checklist for March 20					
	-There was one hot w	vater temperature recorded				
	for residents residing					
	· ·	erature in room 114 was 118				
	degrees.					
		22/05/40				
		ministrator on 03/05/19 at				
	9:45am revealed:	e hot water temperatures in				
		e 100 water temperatures in e 100 hallway were greater				
	than 116 degrees F.	3 100 Hallway Wele greater				
		s to warn residents to seek				
	caution when using th					
	Calibration on 03/05/	19 at 4:05pm of the surveyor				
		Maintenance Director				
	thermometer revealed					
		ometer calibrated at 30				
	degrees F, requiring t	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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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL034098 B. WING		R 03/08/2019			
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/00/2010	
SALEM TE	ERRACE		SALISBURY ROSALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 113	Continued From page 3		D 113			
	six degrees to obtain 32 degrees F.					
	sink in resident room revealed the water term after running the horomorphisms. Second interview with on 03/05/19 at 4:16pr the wrong hot water to adjustment to the hot.  A third recheck of the sink in resident room.	the water temperature at the 104 on 03/05/19 at 4:10pm imperature was 124 degrees at water for one minute.  In the Maintenance Director imprevealed he had adjusted ank he would make another water.  water temperature at the 104 on 03/05/19 at 5:26pm imperature was 110 degrees				
D 234	Examination & Immur (a) Upon admission to resident shall be tested in compliance with the by the Commission for specified in 10A NCA subsequent amendment the rule are available the Department of Her Tuberculosis Control	unizatio  B Tuberculosis Test, Medical nizations to an adult care home, each ged for tuberculosis disease e control measures adopted	D 234			
	facility failed to assure	ews and interviews, the e 1 of 7 residents sampled sted upon admission for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DUILDING: _			.
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM T	ERRACE		SALISBURY R			
	Г		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 234	Continued From page 4		D 234			
	The findings are:					
	06/27/18 revealed diarenal disease, type two bladder, colostomy, but arm paralysis.  Review of Resident # revealed the resident on 02/05/18.  Review of Resident # -There was a docume dated the dated was pure -The TB skin test was negative results.  -There was a second that was placed on 02 -There was no docume linterview with Reside revealed:  -She moved into the first -A TB skin test was placed into the first revealed:  -Interview with the me Resident Care Director revealed:  -The Registered Nursing skin test no longer	ented TB skin test with no placed. Is read on 08/09/17 with Idocumented TB skin test 2/07/18. Inented result. Int #7 on 03/07/19 at 9:52am Idicality on 02/05/18. Idicality she came from home. Idical when she came to the not recall if the TB skin test Idical records person and the per on 03/06/19 at 4:15pm Idical the that placed Resident #7's reworked at the facility. Idia the TB skin test that was				

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PRINTED: 04/02/2019 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			SALISBURY R			
SALEM TERRACE			SALEM, NC 2			
040.15	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	d over	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From page 5		D 273			
D 273	10A NCAC 13F .0902(b) Health Care		D 273			
	•	Pealth Care Assure referral and follow-up And acute health care needs				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility far notification for 4 of 7 states (Residents #2, #4, #6 contacting the physical sugar was greater that out of the facility and when residents refused Tylenol, Auryxia, gabatears, and midodrine (renvela) (#6), anti-infinhaled Fluticasone P	and #7) related to not ian when a resident's blood an 400, when residents were missed medications and ed medications of Novolog, apentin, linzess, refresh (#7), Sevelamer Carbonate flammatory cream and an Propionate (#2), a podiatrist g the physician regarding				
	The findings are:					
	06/27/18 revealed dia renal disease, type tw	t #7's current FL2 dated agnoses included end stage vo diabetes, neurogenic bilateral amputation, and left				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034098	B. WING		R 03/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
D 273	06/27/18 revealed a procession of the procession	t #7's current FL2 dated obysician's order for Novolog help control diabetes) ubcutaneously with meals etween 201-250 give 1 unit, 301-350 give 3 units, greater than 400 call the er for fingerstick blood e meals and at bedtime.  7's record revealed a et signed by the physician ers for Novolog sliding insulin a FSBS ranged between 251-300 give 2 units, 351-400 give 4 units, the physician, and an order is and at bedtime.  7's December 2018 Record Administration  for FSBS four times daily and 11:30am, 4:30pm and station FSBS were greater	D 273			
	-There were no docur	nentation of FSBS greater				

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DIVISION	Division of Health Service Regulation					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		HAL034098	B. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			SALISBURY R			
SALEM TE	SALEM TERRACE					
		Winsto	N SALEM, NC 2	1121		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
IAO		,	IAG	DEFICIENCY)		
D 273	73 Continued From page 7		D 273			
	than 400 on the Janu	any eMAP				
	man 400 on the Janu	ary eman.				
	Pavious of Pacidont #	7's February 2019 eMAR				
	revealed:	7 S February 2019 eWAR				
		for FSBS four times daily				
	•					
		n, 11:30am, 4:30pm, and				
	8:00pm.	tation of ECDC arrestor their				
		tation of FSBS greater than s on 02/21/19 at 7:30am				
		1/19 at 7:30am FSBS was				
	457, 02/25/19 at 7:30am FSBS was 487, and on 02/27/19 FSBS was 487.					
		nentation the physician was				
		FSBS was greater than				
	400.					
	Davious of Davidant #	7's March 2019 eMAR				
		7 S March 2019 EMAR				
	revealed:	for ECDC form consists				
		for FSBS four occasions				
	_	30am, 11:30am, 4:30pm,				
	and 8:00pm.	t-ti				
		tation FSBS were greater				
	than 400 on two occa					
	•	91, and on 03/02/19 at				
	7:30am FSBS was 40					
		mentation the physician was				
		FSBS that were greater				
	than 400.					
	Davious of the feetitest	o "CIC/MT Doily Donort" for				
		s "SIC/MT Daily Report" for				
		uary, February, and March				
	2019 revealed:					
	-	aff to document a resident's				
		late and time for each				
	scheduled reading.	D ::   1/17				
		r Resident #7 were not				
	• •	er shift as required by the				
	form.					
	-There were no docur	mented FSBS results for	1			

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Resident #7's FSBS that were greater than 400.

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DIVISION	n nealth Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		03/08/2019
			1		1 00/00/2010
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	RRACE	2609 OLD	SALISBURY R	OAD	
		WINSTON	SALEM, NC 2	7127	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - )
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG			IAG	DEFICIENCY)	
D 0=0	2 2 11 15 2		D.070		
D 273	Continued From page	8	D 273		
	Review of Resident #	7's "Nurse Notes" from			
	12/01/18 through 03/0	07/19 revealed there was no			
	documentation Resid	ent #7's physician had been			
	notified regarding FSI	BS that were greater than			
	400.				
		nt #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				
	dialysis.	iding the times she was at			
	_	ar was above 400 she			
	sometimes felt light-h				
	-She had not seen the				
	several months.	Diabotoc doctor iii			
	Interview with a first s	shift MA on 03/07/19 at			
	3:05pm revealed:				
	-Sunday (02/20/19) R	lesident #7 had a FSBS			
	greater than 400.				
	-She called the on-ca	Il service and left a			
	message.				
		r back she was told to give			
		ulin, plus what was originally			
	ordered.	ote a note", but could not			
	•	mented the communication			
		cian or the extra insulin			
	administered.	olari or the extra mount			
	Interview with a MA o	n 03/07/19 at 3:58pm			
	revealed:				
	-A couple of times she	e called Resident #7's			
		the FSBS that was greater			
	than 400.	-			
	-She was told to give	the resident extra insulin.			

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-She did not document the conversation with the

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		1141 00 4000	B. WING		R	
		HAL034098			03/00	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY RO	OAD		
SALEM TE	ERRACE		N SALEM, NC 27			
	CLIMMADY CT					
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	<u> </u>	(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	<u> </u>	DATE
				DEFICIENCY)		
D 273	Continued From page 9		D 273			
0210	Continued From page 9		02/3			
	physician, she did not document the order to give more insulin and she did not document the units of insulin administered to the resident.					
		ent #7's Endocrinologist on				
	03/07/19 at 11:14am					
		ot seen Resident #7 since				
	August 2018.					
		appointment on 02/28/19,				
	but was a no show.	ining to a second about of no				
		sician's records showed no				
	documentation the facility informed Pesident #7	had FSBS greater than				
	400.	Hau robo greater than				
	-Resident #7 was a b	rittle diahetic and the				
		be notified when the FSBS				
		because there may need to				
	be medication adjustr					
		all to get the resident in to				
	see the physician as					
		•				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 03/08/19 at	t 8:43am revealed:				
	-The facility had a for	m titled "SIC/MT Daily				
	Report," that MAs we	ere to complete per shift for				
	residents ordered FS	BS.				
	-The MAs were to tur	n the form in to her at the				
	end of each shift.					
	-She did not review th					
		ay she should have reports				
	with four FSBS for Re					
		Resident #7's FSBS results.				
		ensure staff completed the				
	form every day.					
		at Resident #7 had FSBS				
	greater than 400.	and the form for ECDC				
	-	necked the form for FSBS				
	outside of range was	-				
		worked at the facility. the nurse followed-up with				
ļ	-Sile did flot know ii ti	The Hurse Tolloweu-up With				

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	IPLETED
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		HAL034098 B. WING		0.	3/08/2019	
		TIALOGIOGO				700/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
SALEM TE	-DDACE	2609 OLI	D SALISBURY RO	)AD		
OALLINITE	INVAOL	WINSTO	N SALEM, NC 27	127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page 10		D 273			
	greater than 400.  -It was the facility's presponsible for check.  -If the resident's FSBS MA should immediate physician.  -The MA who called the document in the nurse physician's response.  -If the physician order was considered a teles should be physician's.  -If the MA did not document in the many considered, then there was physician had been considered, then there was physician had been considered, she did a whole where we was the many considered and the	e notes the date, time and to the phone call. red additional insulin, that ephone order and there is signature for the order. Sument the physician was as no way to validate the				

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the RCC daily.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL034098	B. WING	B. WING		
SALEM TERRACE 2609 OLD			DRESS, CITY, STA SALISBURY RO SALEM, NC 2	OAD	03/08/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	ETE
D 273	greater than 400 and was notified.  -There should be door record to validate the  b. Review of Residen 06/27/18 revealed a pinsulin four units subot to lower elevated blocklunch meal.  Review of Resident # physician's order sheen on 12/04/18 with ordes subcutaneously once  Review of Resident # electronic Medication (eMAR) revealed:  -There was an entry flunch time scheduled -There was document administered sixteen opportunities schedul 12/01/18 through 12/3-There was document of the facility, "Physic medications," or there the medication was notified the resident with Novolog four units at Review of Resident # revealed:	re verified the MAs 7's physician for FSBS made sure the physician umentation in the resident's physician was notified.  It #7's current FL2 dated physician's order for Novolog cutaneously once daily (used and sugar levels) with the  7's record revealed a et signed by the physician ers for Novolog four units daily with the lunch meal.  7's December 2018 Record Administration  For Novolog four units at for 12:00pm. Itation Novolog was not of the thirty-one ed for 12:00pm between 31/18. Itation the resident was out ally unable to take was no documentation why of administered. Inentation the physician was was not administered 12:00pm.  7's January 2019 eMAR  Tor Novolog four units at	D 273			

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-There was documentation Novolog was not

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. DUILDING:		_	
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CALEMI	EDDACE	2609 OLI	SALISBURY R	OAD		
SALEM T	ERRACE	WINSTO	N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 12	D 273			
	administered fourteer opportunities schedul through 01/31/19.  -There was documen of the facility at dialys medication," for the madministration times of 12/31/18.  -There was no documentified the resident of Novolog four units at Review of Resident of the revealed:  -There was an entry of lunch time scheduled.  -There was documentified the facility, "Physic medication," or there missed medication.  -There was no documentified the resident of the facility, "Physic medication," or there missed medication.  -There was no documentified the resident of the	tation the resident was out sis, "Physically unable to take hissed medication from 12/01/18 through the nentation the physician was was not administered 12:00pm.  To Novolog four units at for 12:00pm. tation Novolog was not of the twenty-eight led between 02/01/19 tation the resident was out sally unable to take was no documentation for mentation the physician was was not administered 12:00pm as ordered.  To Novolog four units at for 12:00pm as ordered.  To Novolog four units at swas not administered 12:00pm as ordered.  To Novolog four units at for 12:00pm. tation Novolog was not string in the six opportunities 3/01/19 through 03/06/19. tation the resident was out				

Division of Health Service Regulation

notified the resident was not administered

STATE FORM 6899 1HE211 If continuation sheet 13 of 109

DIVISION	i rieaitii Service Regu	ialion			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
					R
		HAL034098	B. WING	<del></del>	03/08/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE 710 CODE	
NAIVIE OF FI	NOVIDER OR SUFFLIER				
SALEM TE	ERRACE		SALISBURY R		
		WINSTON	SALEM, NC 2	7127	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 273	Continued From page	. 13	D 273		
D 210	Continued From page	: 13	5275		
	Novolog four units at	12:00pm.			
	-	·			
	Review of Resident #	7's nurse's notes revealed			
	there was no docume	ntation Resident #7's			
		d of the 46 occasions the			
	•	cility at dialysis and Novolog			
		as ordered from 12/01/18			
	to 03/06/19.	45 6146164 116111 12761716			
	10 00/00/19.				
	Interview with Pecide	nt #7 on 03/07/19 at 8:34am			
		111 #7 011 03/07/19 at 0.34a111			
	revealed:				
		abetic and was ordered			
		times daily along with			
	Novolog sliding scale				
	•	Monday, Wednesday and			
	Fridays.				
		alysis she left the facility at			
	11:00am and sometime	nes did not return to the			
	facility until almost 6:0	00pm.			
	-On Monday, Wednes	sday and Fridays she was			
	never administered th	ne 12:00pm Novolog insulin.			
	-At dialysis she was g	jiven a snack, but no one			
	checked her FSBS or	gave her insulin.			
	-About two months ag				
	_	to dialysis, but that stopped.			
		her that the staff at the			
		ey were not responsible for			
	administering her med	•			
		he Endocrinologist knew she			
		nsulin at 12:00pm or if they			
	knew when she return				
		ne she returned to the			
		es did not give her Novolog			
		she had missed the one			
	hour window to admir				
		eturned to the facility at			
	5:45pm, staff would a				
	_	use she was outside one			
	hour window		1		1

Division of Health Service Regulation

-On dialysis days, the only Novolog insulin that

STATE FORM 6899 1HE211 If continuation sheet 14 of 109

Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE. ZIP CODE	,
			SALISBURY RO		
SALEM TE	ERRACE	WINSTO	N SALEM, NC 27	127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 14	D 273		
D 2/3	she got was at breakf -Sometimes her FSBS still staff did not give i outside the one hour i Interview with a first s 3:05pm revealed: -Resident #7 went to Wednesday and Frida 6:00pmWhen the resident w administered any med the time the resident v -She circled her initial documented the resid "Physically unable to the resident was not p scheduled administra -She documented; ph medication because t in the facility -The facility staff used medications to the dia	Sast. So were greater than 400 and insulin because she was window.  Shift MA on 03/07/19 at dialysis Monday, ay from 11:00am to 5:00 or as at dialysis she was not dications scheduled during was out of the facility. Is on the eMAR, and lent was out of the facility or take the medication" when bresent during the tion times. It is send that was not present during the tresident was not present during the tresident was not present during the the resident was not present during the total during the	D 2/3		
		ed Resident #7's physician			
	to information Novolo	g four units at lunch time Monday, Wednesday and			
	03/07/19 at 11:14am -The physician knew and thought the Novo the resident was at di -The Novolog insuling	Resident #7 went to dialysis log was administered while			

had a meal or snack she should still be

administered Novolog.

STATE FORM 6899 If continuation sheet 15 of 109 1HE211

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		J CONTIL	LILD
		HAI 024000	B. WING		F	
		HAL034098	B. W. TO		03/0	08/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SALEM T	ERRACE		SALISBURY ROSALEM, NC 2			
	OLIMANA DV. OT		<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 15	D 273			
D 213	-It did not matter what to the facility, if the re Novolog insulin shoul -The facility staff shouphysician's office to ingetting the lunch time Interview with the Res 03/08/19 at 8:43am re-Resident #7 went to weekThe resident previousher the dialysis center the facility they were for administering Resident to inform the dialysis center the facility they were for administering Resident #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the facility #7's physician to information in the state of the state of the facility #7's physician to information in the state of the state	t time Resident #7 returned esident was offered a meal, destill be administered. Utild have called the enform the resident was not envolog insulin as ordered.	<i>D</i> 273			
	facility at dialysisIt was the facility's pomedications outside t	olicy not to administer				
	however the MA shou	uld call the physician and ask ding the missed medication.				
	revealed: -She expected the May when Resident #7 was medications as ordered. The MAs should have #7's physician to inquired medications ordered resident was out of the The MAs should have physician addressing the resident was at discontinuous medications.	ed.  re followed-up with Resident lire what to do regarding during the time when the lire facility at dialysis.  re obtained orders from the medications ordered when				
		ohysician's order for Auryxia 420mg) (used to lower high				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 16 of 109

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		1141 024000	B. WING		R	
		HAL034098			03/08/2019	_
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SALEM TE	ERRACE		D SALISBURY RO			
			N SALEM, NC 27			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	Ē
D 273	Continued From page	e 16	D 273			
	blood phosphate leve meals.	els) three times daily with				
	Review of Resident # physician's order she	7's record revealed a et dated 12/04/18 with				
	orders for Auryxia 210 three times daily with	Omg (two tablets =420mg) meals.				
	(eMAR) revealed: -There was an entry f tablets= 420mg) three scheduled for 8:00am -There was documen administered fifteen of opportunities schedul through 12/31/18 at 1 Wednesday and Frida -There was documen of the facility or physi- medicationsThere was no docum	Record Administration for Auryxia 210mg (two e times daily with meals n, 12:00pm, 5:00pm. tation Auryxia was not of the ninety-three ed between 12/01/18 2:00pm on Monday, ay. tation the resident was out				
	and Friday.	m on Monday, Wednesday				
	revealed: -There was an entry fitablets= 420mg) three scheduled for 8:00am -There was documen administered sixty-thropportunities schedul through 01/31/19 at 1 Wednesday and Frida	tation Auryxia was not ree of the ninety-three ed between 01/01/19 2:00pm on Monday, ray. tation the resident was out				

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medication.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			74. 501251110.		R	
		HAL034098	B. WING		1	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	FE, ZIP CODE		
SALEM T	ERRACE		SALISBURY RO			
		WINSTON	N SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 17	D 273			
	notified the resident v	nentation the physician was was not administered Auryxia m on Monday, Wednesday				
	revealed: -There was an entry f tablets= 420mg) three scheduled for 8:00am -There was documen administered twenty-t opportunities schedul through 02/28/19 at 1 Wednesday and Frida -There was documen of the facilityThere was no docum notified the resident w	tation Auryxia was not two of the eighty-four es between 02/01/19 2:00pm on Monday,				
	revealed: -There was an entry f tablets= 420mg) three scheduled for 8:00am -There was documen administered four of t scheduled between 0 12:00pm on Monday, -There was documen of the facilityThere was no docum notified the resident w as ordered at 12:00pm and Friday.	for Auryxia 210mg (two etimes daily with meals n, 12:00pm, 5:00pm. tation Auryxia was not he seventeen opportunities 3/01/19 through 03/06/19 at Wednesday and Friday. tation the resident was out nentation the physician was was not administered Auryxia m on Monday, Wednesday				

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revealed:

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Division	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			_			
					F	2
		HAL034098	B. WING		03/0	8/2019
NAME OF D	DOVIDED OD OUDDUED	OTDEET AS	DDEGG OITY OTA	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	II E, ZIP CODE		
SALEM TI	FRRACE		SALISBURY R			
OALLIII II	INIOL	WINSTON	ISALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 273	Continued From page	. 10	D 273			
D 210	Continued From page	: 10	5275			
	-She went to dialysis	three days per week from				
	11:00am until almost	6:00pm.				
		tered Auryxia at 12:00pm on				
	the days she went to					
		acility after 6:00pm the				
		ryxia was not administered.				
		as an iron medication and				
		cation because she had				
		cation because sile nau				
	dialysis.					
		he physician knew she did				
	not get the medication	n as ordered.				
	D . (D , , ,	<del>-</del> 1				
		7's nurse's notes revealed				
		ntation the resident did not				
		mes from 12/01/18 through				
	03/07/19.					
	Interview with a first s	hift MA on 03/07/19 at				
	3:05pm revealed:					
	-Resident #7 went to	dialysis Monday,				
	Wednesday and Frida	ay from 11:00am to 5:00 or				
	6:00pm.					
	-When the resident w	as at dialysis, the 12:00pm				
	dosage of Auryxia wa	s not administered.				
		ed Resident #7's physician				
		was not administered three				
	times daily on the dia					
	annoo dany on the dia	yolo dayo.				
	Interview with a seco	nd MA on 03/08/19 at				
	9:50am revealed:	13 111 (OII OO/OO/ 10 at				
		nformed staff at the facility				
		ponsible for administering				
		. •				
	Resident #7's Auryxia					
		Resident #7's physician was				
	_	not administered three times				
		#7 was at dialysis (Mondays,				
	Wednesdays and Frid	days).				
	Interview with the nur					
	Nephrologist's office	on 03/07/19 at 2:22pm				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.125101.		R
		HAL034098	B. WING		03/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	-RRACE	2609 OLD	SALISBURY R	OAD	
OALLIN II		WINSTON	I SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 19	D 273		
	revealed:				
		had notified the physician			
	_	not administered Auryxia			
	three times daily as o				
		ıld be administered with a			
	meal or a snack.				
	-The physician knew				
	•	er week, but did not know tions three times daily on			
	dialysis was a probler	-			
	-	uld have contacted the			
		ons if they were unable to			
	administer the medica	ation as ordered.			
	Interview the Adminis revealed:	trator on 03/08/19 12:48pm			
		As to notify the physician			
	when Resident #7 wa	- · · · · ·			
	medications as ordere				
	-The MAs should hav	e followed-up with Resident			
		iire what to do regarding			
		during the times when the			
	resident was out of th				
		e obtained orders from the medications ordered when			
	the resident was at di				
		•			
		t #7's current FL2 dated			
	06/27/18 revealed a p				
	• . •	o capsules (200mg) (used pain) four times daily.			
	to treat diabetic nerve	pairi) iour uiries udily.			
	Review of Resident #	7's record revealed a			
		et dated 12/04/18 with			
		100mg two capsules			
	(200mg) four times da	aily.			
	Review of Resident #	7's December 2018 eMAR			

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-There was an entry for gabapentin 100mg two

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AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
		_		R	
	HAL034098	B. WING		1	3/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
SALEM TERRACE		SALISBURY RO			
		SALEM, NC 27			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273 Continued From page 20	0	D 273			
capsules (200mg) four tir at 8:00am, 12:00pm, 4:0  -There was documentative administered thirteen of topportunities scheduled through 12/31/18 at 12:0 was at dialysis (Monday, Friday).  -There was no document notified the medication wordered at 12:00pm whe dialysis.  Review of Resident #7's revealed:  -There was an entry for grapsules (200mg) four tir at 8:00am, 12:00pm, 4:0  -There was documentative administered fourteen of opportunities scheduled through 01/31/19 at 12:0  -There was no document notified the medication wordered at 12:00pm.  Review of Resident #7's revealed:  -There was an entry for grapsules (200mg) four tir at 8:00am, 12:00pm, 4:0  -There was documentative administered twelve of eigenvalues of eigenvalues and entry for grapsules (200mg) four tir at 8:00am, 12:00pm, 4:0  -There was documentative administered twelve of eigenvalues (200mg) four tires and entry for grapsules (200mg) four tires and en	imes daily was scheduled popm and 8:00pm. ion gabapentin was not the ninety-three between 12/01/18 popm when the resident was not administered as en the resident was at a January 2019 eMAR gabapentin 100mg two imes daily was scheduled popm and 8:00pm. ion gabapentin was not administered as en the resident was not f ninety-three between 01/01/19 popm. Intation the physician was was not administered as en the physician was not administered as a February 2019 eMAR gabapentin 100mg two imes daily was scheduled popm and 8:00pm. Intation the physician was was not administered as a february 2019 eMAR gabapentin 100mg two imes daily was scheduled popm and 8:00pm. Ion gabapentin was not eighty-four opportunities pol/19 through 02/28/19 at that intation the physician was not eighty-four opportunities pol/19 through 02/28/19 at that intation the physician was				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SI	
ANDILAN	JI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMILE	.120
					R	
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	FRRACE	2609 OLD 9	SALISBURY RO	OAD		
OALLIII II		WINSTON 9	SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
	capsules (200mg) fou at 8:00am, 12:00pm, -There was documen administered three of scheduled between 0 12:00pm when the re Wednesday, and Frid-There was no documnotified the medicatio ordered at 12:00pm with dialysis.  Review of Resident # there was no documenotified the resident of times from 12/01/18 to	tation gabapentin was not seventeen opportunities 13/01/19 through 03/06/19 at 15/01/19 through 03/06/19				
	FridaysOn the days that she facility at 11:00amShe sometimes did r almost 6:00pmThe gabapentin was daily and was administ excluding the days shif she returned from was not administered which meant she had the medicationFacility staff would not after 5:00pm because one-hour after the schadministration timeAbout two months ag	dialysis after 5:30pm she I the 4:00pm gabapentin, I to wait until 8:00pm to get ot administer the medication e she was outside the				

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					F	<b>)</b>
		HAL034098	B. WING		1	)8/2019
		TIAL034030			1 03/0	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CALEME	-DDAGE	2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IGIENCI)		
D 273	Continued From page	e 22	D 273			
		her that the staff at the				
	_	ney were not responsible for				
	administering her me					
		could have the 12:00pm				
	gabapentin because i	it would help with her pain.				
	Interview with a first a	shift MA on 03/07/19 at				
	3:05pm revealed:	SIIII WA ON 05/07/19 at				
	-Resident #7 went to	dialysis Monday				
		ay from 11:00am to 5:00 or				
	6:00pm.	ay Ironi 11.00ani to 5.00 oi				
		resident went to dialysis				
		idministered at 12:00pm.				
	• .	eturned to the facility, if it				
		en the 4:00pm gabapentin				
		because it was past the				
	one hour window.	·				
	-She did not contact F	Resident #7's physician to				
	inform gabapentin wa					
		eduled for 12:00pm, she				
	had not considered a	dministering the medication				
	one hour early at 11:0	00am before the resident left				
	for dialysis.					
	-It was the facility's pr	rotocol when a medication				
	was not administered	to notify the physician why				
	the medication was n	ot administered.				
	-She had not contacte	ed Resident #7's physician's				
	about the medications	s not administered as				
	ordered.					
		sident Care Coordinator				
	(RCC) on 03/08/19 at					
		dialysis three days per week				
	(Monday, Wednesday					
		take the gabapentin with her				
	•	because there was no one				
	there to administer th	e medications to the				
	resident.					

Division of Health Service Regulation

-She had not contacted Resident #7's physician's to inform the medication was not administered as

STATE FORM 6899 1HE211 If continuation sheet 23 of 109

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			, BOILDING		R
		HAL034098	B. WING		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
SALEM TI	ERRACE		SALISBURY R		
			N SALEM, NC 2		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 23	D 273		
	ordered.				
	12:48pm revealed: -The MA should have explained why Reside gabapentinThe facility's process medications one hour or one hour after the -She did not know the getting medications a going to dialysis.  Interview with the nur care physician's (PCF 2:45pm revealed: -The physician did no administered gabape orderedThe medication shouthe resident went to colf there was a proble while at dialysis the fainformed the physicia be administered and adjustments.	before the scheduled time scheduled time. at Resident #7 was not sordered because she was see at Resident #7's primary p) office on 03/08/19 at at know Resident #7 was not not not four times daily as all did be administered when lialysis. In administering gabapentin acility staff should have not			
		physician's order for linzess t constipation) every			
		et signed by the physician ers for linzess 290mcg every			
	Review of Resident #	7's December 2018 eMAR			

Division of Health Service Regulation

revealed:

STATE FORM 6899 1HE211 If continuation sheet 24 of 109

	or periornoles		OVO. MALILEIDI E	CONOTRUCTION	L(VO) DATE O	LIDVEV.
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
VIAD I TVIA	J. COMMEDITION	IDENTIFICATION NOWIDER.	A. BUILDING:		JOINI-L	
					F	.
		HAL034098	B. WING		1	8/2019
		TIALUUTUUU			1 03/0	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OLI	SALISBURY R	OAD		
SALEM TE	ERRACE		N SALEM, NC 2			
	0.11.11.42.52.4.57					
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,	1,7.0	DEFICIENCY)		
D 273	Continued From page	e 24	D 273			
	There was an entry f	for linzess 290mcg every				
	_	s before breakfast was				
	scheduled at 7:30am.					
		tation linzess was not				
		ne thirty-one opportunities				
	from 12/07/18 through					
	-There was documen	tation Resident #7 refused				
	linzess.					
	-There was no docum	nentation the physician was				
	notified the resident re	efused the medication.				
	Review of Resident #	7's January 2019 eMAR				
	revealed:					
	-There was an entry f	for linzess 290mcg every				
	<del>_</del>	s before breakfast was				
	scheduled at 7:30am.					
		tation linzess was not				
	administered twenty-					
		/01/19 through 01/31/19.				
	• •	tation Resident #7 refused				
	linzess or was "Physic	cally unable to take				
	medication."					
		nentation the physician was				
	notified the resident re	erusea iinzess.				
		7's February 2019 eMAR				
	revealed:					
	_	for linzess 290mcg every				
		s before breakfast was				
	scheduled at 7:30am.					
	-There was documen	tation linzess was not				
	administered twenty-f	five of twenty-eight				
		led between 02/01/19				
	through 02/28/19.					
	_	tation Resident #7 refused				
	linzess or was "Physic					
	medication."					
		nentation the physician was				
	notified the resident re					
	Houned the residefil I	Ciuscu IIII2633.				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 25 of 109

Division	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	,
		1141 00 4000	B. WING		F	
		HAL034098			03/0	18/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TI	ERRACE		N SALEM, NC 2			
	CUMMADVCT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 273	Continued From page	25	D 273			
52.0			52.0			
		7's March 2019 eMAR				
	revealed:					
		for linzess 290mcg every				
		s before breakfast was				
	scheduled at 7:30am					
		tation linzess was not				
		x opportunities scheduled				
	between 03/01/19 thr	•				
		tation Resident #7 refused				
	linzess or was "Physi	cally unable to take				
	medication."					
		nentation the physician was				
	notified the resident r	efused linzess.				
	Povious of Posidont #	7's nurse's notes revealed				
		entation the physician was				
		efused linzess 83 times from				
	12/07/18 through 03/0					
	12/07/10 tillough 03/0	00/19.				
	Interview with Reside	ent #7 on 03/07/19 at 8:34am				
	revealed:	ment on octors to de old fam				
		y, and sometimes it was				
	difficult for her to use	• •				
		nes contract which cause				
	her bowels to move e					
		welling catheter, which				
		hronic urinary tract infections				
	(UTI's).	,				
	-Last year the physici	ian ordered a routine				
	antibiotic to help with					
	· · · · · · · · · · · · · · · · · · ·	d her to have loose bowels,				
		o longer needed linzess.				
		ered the linzess with the				
	antibiotic it caused he	er to have severe diarrhea				
	and she spent a lot of	f time cleaning herself up.				
	-She did not want the					
	discontinued, but war	nted the medication as				
	needed.					
	-For the past two to the	hree months she had				
		MAs to get linzess changed				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 26 of 109

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	ľ
					R	
		HAL034098	B. WING		03/08/2019	
					1 00/00/2010	_
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SALEM TE	ERRACE		SALISBURY R			
_		WINSTOI	N SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - )	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		
				DEFICIENCY)		
D 273	Continued From page	26	D 273			
D 213	Continued From page	20	B 273			
	to an as needed med					
	•	3/07/19), the MAs still tried				
	to administer her linze	ess every morning at				
	7:30am.					
	Interview with a first s	shift MA on 03/07/19 at				
	3:05pm revealed:	SINIC WA ON 03/07/19 at				
	-Resident #7 continua	ally refused linzess				
		ked to have the medication				
	changed to an as nee					
	-She was going to co	ntact Resident #7's				
	physician, but had for	got.				
		olicy when a resident refused				
		on duty was to complete the				
	•	otification of resident's				
	refusal of medication					
	-	the physician, then give the				
	notes.	document in the nurse				
		nentation the form had been				
		Resident #7's refusal of				
	linzess.	rtosiaoni // o roladal ol				
	-The resident had ref	used the medication for a				
	long time and the phy	sician should have been				
	notified, but was not.					
		sident Care Coordinator				
	(RCC) on 03/08/19 at					
		m that the MAs were to				
	complete each time a medication.	resident refused a				
		ed medications she should				
		he medication was refused.				
		e the completed form to her				
	_	contact with the physician in				
	the nurse's notes.	,,,				
	-She did not have any	y medication refusal forms				
	regarding Resident #					
		Vednesday she performed a				

medication cart and eMAR audit.

STATE FORM 6899 If continuation sheet 27 of 109 1HE211

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI	
			A. BUILDING		_	
		HAL034098	B. WING		03/0	8/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	RRACE	WINSTON	I SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 27	D 273			
D 2/3	-The audit consisted of the medications on ha and instructions were -She observed circled did not inquire why st -The MA's were responsively because the paysician when a resignation refusal for regarding Resident #*  Interview with the nurroffice on 03/08/19 at 2-The physician did no refused linzess.  One side effect of linicause diarrhea.  -It was recommended severe the physician notified.  -There was no documphysician was contact refusal to take the memedication caused the Interview with the Adr 12:48pm revealed:  -The facility had forms when a resident refused to the first refusal of document on the form form.  -The form should be geshift.	of comparing the eMARs to and to ensure the dosage correct. d initials on the eMARs, but aff circled initials. Dosible for notifying the ident refused medications. Apperwork and there were norm submitted to her 7's refusal of linzess.  The seat Resident #7's PCP 2:55pm revealed: At know Resident #7 had  The diarrhea became should immediately be the entation in their record the ext regarding Resident #7's edication or that the line resident diarrhea.  The second of the MAS to document sed a medication.  As to contact the physician	D 273			
	shiftThe RCC should che was notified.	eck to ensure the physician sumentation in the nurse's				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 28 of 109

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			SURVEY PLETED	
			A. BOILDING.			_
		HAL034098	B. WING		03	R 3 <b>/08/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM T	EDDACE	2609 OLI	D SALISBURY ROA	<b>ND</b>		
SALEW I	ERRACE	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	28	D 273			
	06/27/18 revealed a p	treat low blood pressure)				
	' '	et signed by the physician ers for midodrine hcl 5mg				
	revealed: -There was an entry f times daily after meal 9:00am, 1:00pm, and -There was documen was not administered opportunities schedul through 12/31/18 at 1 Wednesday and Frida-There was documen either out of the facilit "Physically unable to -There was no docum	6:00pm. tation midodrine hcl 5mg seventeen of ninety-three ed between 12/01/18 :00pm on Monday, ay. tation the resident was y, refused the medication or				
	1:00pm on Monday, None Review of Resident # revealed: -There was an entry f times daily after meal 9:00am, 1:00pm, and -There was documen was not administered opportunities schedul through 01/31/19 at 1 Wednesday, and Frid-There was documen	Wednesday and Friday.  7's January 2019 eMAR  for midodrine hcl 5mg three s was scheduled for 6:00pm. tation midodrine hcl 5mg sixteen of ninety-three ed between 01/01/19 :00pm on Monday, ay. tation the resident was y, refused the medication or				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 29 of 109

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034098	B. WING		R <b>03/08/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEWI 1E	ERRAGE	WINSTON	I SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 29	D 273			
	notified midodrine hcl	nentation the physician was was not administered at Wednesday and Friday.				
	revealed: -There was an entry filmes daily after meal 9:00am, 1:00pm, and -There was documen was not administered opportunities schedul through 02/28/19 at 1 Wednesday, and Frid-There was documen either out of the facilit "Physically unable to -There was no documnotified midodrine hol Review of Resident # revealed:	6:00pm. tation midodrine hcl 5mg sixteen of eighty-four ed between 02/01/19 :00pm on Monday, lay. tation the resident was ty, refused the medication or take medication." nentation the physician was was not administered.				
	times daily after meal 9:00am, 1:00pm, and -There was documen was not administered opportunities schedul through 03/03/19 at 1 Wednesday, and Frid-There was documen either out of the facilit -There was no docum notified midodrine hcl	6:00pm. tation midodrine hcl 5mg three of sixteen ed between 03/01/19 :00pm on Monday, lay. tation the resident was ty. nentation the physician was was not administered.				
		entation the physician was lid not receive midodrine 51				

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times from 12/01/18 through 03/03/19.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	
SALEM TI	FRRACE	2609 OL	D SALISBURY ROA	ND.	
OALLIN II		WINSTO	N SALEM, NC 2712	27	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPL
D 273	Continued From page	e 30	D 273		
	revealed: -She went to dialysis FridaysWhen she went to di 11:00am and sometin facility until almost 6:0 -On Monday, Wednes never administered th -Previously she was a with her to dialysis, be -The facility staff told dialysis center said th administering her me -Her blood pressure w Monday, Wednesday -The facility staff only pressure, maybe onc -She had episodes of light-headedness, but other health issues.	sday and Fridays she was ne 1:00pm midodrine. allowed to take medications ut that stopped. her that the staff at the ney were not responsible for dications. was frequently checked and Friday at dialysis. checked her blood e a month.			

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.

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STATE FORM 6899 1HE211 If continuation sheet 31 of 109

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1141 024000	B. WING		R
		HAL034098	B. Wille		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM T	ERRACE				
			I SALEM, NC 2	1121	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG		,	IAG	DEFICIENCY)	
D 273	Continued From page	e 31	D 273		
	She had not contact	nd Posidont #7's physician			
		ed Resident #7's physician vas not administered at			
	1.00pm on wonday, v	Nednesday and Fridays.			
	Indominacy wide the comm	se at Resident #7's PCP			
	office on 03/07/19 at				
		Resident #7 went to dialysis			
	•	, and Friday, but did not			
	know the resident wa	s not administered			
	midodrine.				
		ordered to be administered			
		if the resident consumed a			
	•	en she returned to the facility			
	the medication should				
	-	d clarification regarding the			
		y should have contacted the			
	physician.				
		sident Care Coordinator			
	(RCC) on 03/08/19 at				
	-Resident #7 went to	dialysis three days per			
	week.				
	-	sly took medications with			
		nter, but the center informed			
	the facility staff they v	vere not going to be			
		istering Resident #7's			
	medications.				
		ny physicians, she was not			
		hat ordered midodrine had			
	been notified.				
		ed Resident #7's PCP			
		tion not being administered.			
		physician was not notified			
	because all physician	s knew that Resident #7			
	went to dialysis three	days per week.			
	Interview with the Adr	ministrator on 03/08/19			
	12:48pm revealed:				
		As to notify the physician			

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when Resident #7 was not administered

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWFLE	IED
		HAL034098	B. WING		R 03/08	/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE	2609 OLD 9	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	#7's physician to inquest medications ordered or resident was out of the The MAs should have physician addressing the resident was at didocumentation to shou notified.  g. Review of Resident 06/27/18 revealed a proposition of the physician's order sheet on 12/04/18 with orderight hours.  Review of Resident # revealed:  -There was an entry for hours scheduled at 6:10:00pm.  -There was document administered twenty-copportunities scheduled through 12/31/18 on for the friday at 2:00pm whill the facility medication," or no domedication was not at the facility medication was not at the facility of the facility medication was not at the facility of the facility medication was not at the facility of the facility medication was not at the facility of the facility o	ed. e followed-up with Resident lire what to do regarding during the times when the le facility at dialysis. e obtained orders from the medications ordered when alysis, and there should be low the physician was  t #7's current FL2 dated physician's order for tylenol purs for pain.  T's record revealed a let signed by the physician lers for tylenol 500mg every  To becember 2018 eMAR  For tylenol 500mg every eight letton of the ninety-three led between 12/01/18  Monday, Wednesday, and let at dialysis. Itation the resident was letton the resident was letton the resident was letton the physician was lot administered. Intentation the physician was lot administered every eight Monday, Wednesday, and list.	D 273			
		7's January 2019 eMAR				

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DIVISION	of Health Service Regu	liation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	=IED
		1141 00 4000	B. WING		R	
		HAL034098	D. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	RRACE					
		WINSTON	SALEM, NC 2	/12/		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NATE	DATE
				, , , , , , , , , , , , , , , , , , ,		
D 273	Continued From page	e 33	D 273			
	revealed:					
	-	for tylenol 500mg every eight				
	hours scheduled at 6	:00am, 2:00pm, and				
	10:00pm.					
	-There was documen	tation tylenol 500mg was not				
	administered sevente	en of ninety-three				
	opportunities schedul	led between 01/01/19				
		Monday, Wednesday, and				
	Friday at 2:00pm while at dialysis.					
		tation the resident was				
		ty, "Physically unable to take				
	medication," or no do					
	medication, or no do	•				
		nentation the physician was				
	•	as not administered every				
		d on Monday, Wednesday,				
	and Friday while at di	ialysis.				
		7's February 2019 eMAR				
	revealed:					
	-There was an entry f	for tylenol 500mg every eight				
	hours scheduled at 6	:00am, 2:00pm, and				
	10:00pm.					
	-There was documen	tation tylenol 500mg was not				
	administered twelve of	of eighty-four opportunities				
	scheduled between 0	2/01/19 through 02/28/19 on				
		, and Friday at 2:00pm while				
	at dialysis.					
	•	tation the resident was				
		ty, "Physically unable to take				
	medication," or no do					
	medication, or no do					
		nentation the physician was				
		as not administered every				
		ed on Monday, Wednesday,				
	and Friday at 2:00pm	i while at dialysis.				
		7's March 2019 eMAR				
	rovoolod:		1	I .		

Division of Health Service Regulation

-There was an entry for tylenol 500mg every eight

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AND PLAN OF CORRECTION IDEN	TIFICATION NUMBER:				
		A. BUILDING: _		COMPLE	TED
н	AL034098	B. WING		03/0	8/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
0.41 FM TERRA 0F	2609 OLD	SALISBURY RO	OAD		
SALEM TERRACE	WINSTON	SALEM, NC 27	7127		
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273 Continued From page 34		D 273			
hours scheduled at 6:00am, 2: 10:00pm.  -There was documentation tyle administered twelve of eighty-scheduled between 03/01/19 t Monday, Wednesday, and Fricat dialysis.  -There was documentation the either out of the facility "Physic medication," or no documentation notified that tylenol was not ad eight hours as ordered on Morand Friday at 2:00pm while at Review of Resident #7's nurse there was no documentation throtified the resident did not rectimes from 12/01/18 through 0  Interview with Resident #7 on revealed:  -She went to dialysis Monday, Fridays between 11:00am untiton dialysis days, she did not Tylenol.  -She wished that she did get tywas constantly in pain.  -The facility staff told her that the dialysis center said they were administering her medications.  Interview with a first shift MA on 3:05pm revealed:  -When the resident was at dial administered her 2:00pm tylenol.  -The dialysis staff did not administered her 2:00pm tylenol.	enol 500mg was not four opportunities hrough 03/07/19 on day at 2:00pm while entered was eally unable to take tion why the ed. the physician was ministered every aday, Wednesday, dialysis.  I's notes revealed the physician was beine Tylenol 71 3/07/19.  03/07/19 at 8:34am  Wednesday and I almost 6:00pm. Tylenol because she was the staff at the not responsible for the original of the physician was beine the staff at the not responsible for the original of the physician was beine the staff at the not responsible for the original of the physician was beine the staff at the not responsible for the original of the pain. The physician was not old for pain.	D 2/3			

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 35 of 109

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			D 14/11/0		R	
		HAL034098	B. WING		03/0	8/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF T	TOVIDER OR SOLT LIER		, ,	,		
SALEM TE	ERRACE		SALISBURY R			
		WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	JAIE	DATE
				DEI IOIENOT)		
D 273	Continued From page	e 35	D 273			
-	communication page	3 00				
	-She had not contacte	ed Resident #7's physician				
	to inform tylenol was	not administered three times				
	daily as ordered.					
	•					
	Interview with the nur	se at Resident #7's PCP				
	office 03/08/19 at 2:4	5pm revealed:				
		Resident #7 went to dialysis				
		, and Friday, but did not				
	know the resident wa					
	medication as ordere					
		d clarification regarding the				
		y should have contacted the				
		hat to do when the resident				
	was at dialysis.	mat to do when the resident				
	-	record did not show the				
	PCP was notified the					
	administered Tylenol	when she was at dialysis.				
		sident Care Coordinator				
	, ,	t 8:43am revealed Resident				
		ree days per week and to				
	her knowledge the ph	-				
		was not administered tylenol				
	when at dialysis.					
		trator on 03/08/19 12:48pm				
	revealed:					
	-The MAs should hav	e followed-up with Resident				
	#7's physician when t	the resident missed				
	scheduled dosages o	f tylenol because she was at				
	dialysis.					
	-The MAs should doc	ument the physician				
	notification in the nurs					
	-Staff knew if they did	I not document, they could				
	not prove they notified					
	in print and mounts				ľ	
	2 Review of Residen	t #6's current FL2 dated				
	02/14/19 revealed:	o o darront i L2 dated				
		Alzheimer's dementia, end				
		pertension and diabetes				
	state remai famule Hyp	שנונוואוטוו מווע עומטכנכא	I			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		ILED
		HAL034098	B. WING	B. WING		8/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	RRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 273	(renvela) 800mg two daily with meals (used levels in the blood), a sevelamer 800mg throtimes daily with meals Review of Resident # electronic Medication (eMAR) revealed: -There was an entry for 800mg three capsules times daily scheduled 5:00pmThere was a second carbonate 800mg two times daily with snack-There was document was not administered hundred and fifty-five between 12/01/18 throon dialysis days (Mon Friday)There was document of the facilityThere was no document of the facilityThere was no document of the facilityThere was an entry for the facility of the facilityThere was an entry for the facility of Resident # revealed: -There was an entry for 800mg three capsules times daily scheduled 5:00pmThere was a second carbonate 800mg two times daily with snack	or Sevelamer Carbonate capsules (1600mg) twice d to control phosphorus and a physician's order for ee capsules (3200mg) three s.  6's December 2018 Administration Record or sevelamer carbonate s with meals (3200mg) three for 8:00am, 12:00pm, entry for sevelamer carbonate twenty-two of the one opportunities scheduled ough 12/31/18 at 12:00pm aday, Wednesday, and tation the resident was out thentation the physician was was not administered them on dialysis days.  6's January 2019 eMAR or sevelamer carbonate s with meals (3200mg) three for 8:00am, 12:00pm, entry for sevelamer carbonate s with meals (3200mg) three for 8:00am, 12:00pm,	D 273			

Division of Health Service Regulation

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HAL034098  B. WING	STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 37  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.				A. BUILDING: _			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 37  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.			HAL034098	B. WING		1	
SALEM TERRACE  2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 37  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.	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 37  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.							
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 37  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.	SALEM TERRACE WINSTON			SALEM, NC 2	7127		
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.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
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.	D 273	Continued From page	e 37	D 273			
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	D 2/3	was not administered fifty-five opportunities 01/01/19 through 01/3 days.  -There was documen of the facility or physimedication.  -There was no documnotified the resident wimedication at 12:00pt  Review of Resident # revealed:  -There was an entry fi 800mg three capsule times daily scheduled 5:00pm.  -There was a second carbonate 800mg two times daily with snack-There was documen was not administered and fifty-five opportur 02/01/19 through 02/3 days.  -There was documen of the facility.  -There was no documnotified the resident was ordered at 12:00pt  Review of Resident # revealed:  -There was an entry fi 800mg three capsule times daily scheduled 5:00pm.	thirty of one hundred and scheduled between 31/19 at 12:00pm on dialysis tation the resident was out cal unable to take the nentation the physician was vas not administered the m on dialysis days.  66's February 2019 eMAR  for sevelamer carbonate swith meals (3200mg) three of for 8:00am, 12:00pm,  entry for sevelamer carbonate thirty-two of one hundred inities scheduled between 28/19 at 12:00pm on dialysis tation the resident was out nentation the physician was vas not administered Auryxia m on dialysis days.  66's March 2019 eMAR  for sevelamer carbonate swith meals (3200mg) three swith meals (3200mg),	D 273			

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times daily with snacks.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		D	
		HAL034098	B. WING		03/08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
041 514 51		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 38	D 273			
	-There was document was not administered opportunities schedul through 03/08/19 at 1 -There was document of the facilityThere was no document of the facilityThere was no document of the facilityThere was no document of the resident was evelamer carbonate days.  Review of Resident # there was no document of the 93 time administered sevelament of the 93 time administered sevelament of the 93 time administered sevelament of the was determined interview it was determined interview with the nurn Nephrologist office or revealed: -The physician knew but did not know seve administered as order the resident consument snacksThe physician did no not being administered -The facility staff should discuss the administration.	tation sevelamer carbonate nine of thirty-six ed between 03/01/19 2:00pm on dialysis days. tation the resident was out mentation the physician was was not administered at 12:00pm on dialysis  6's nurse's notes revealed entation the physician was as Resident #6 was not her from 12/01/18 through  and, interview and record ned Resident #6 was not see at Resident #6 was not ned Resident #6 was not ned Resident #6 was not see at Resident #6 was not ned Resident #6 had dialysis, elamer carbonate was not red.  Ild be administered anytime and food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included to the though the seed food and this included the though the seed food and the s				
	Interview on 03/08/19 #6's power of attorney -She thought Resider					

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medications ordered.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BOILDING.		_	
		HAL034098	B. WING		03/0	8/2019
NAME OF PROVIDER OR SUPPL	ER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TERRACE		2609 OLD	SALISBURY R	OAD		
WINSTON			SALEM, NC 2	7127		
PREFIX (EACH DE	ICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273 Continued Fro	n pag	e 39	D 273			
-She had frequence facility regarding fluid intake duento and the with the scheduleShe could have Resident #6's interview with the facility but there was a medications or she was respondered the medications as scheduled three weaking the facility but the facility but there was a medications as scheduled three wednesday, and the facility but the facility but the facility but there was a medications as scheduled three wednesday, and the facility but the facility but the facility but the facility but there was a scheduled three wednesday, and the facility but t	ently he to dia facility ication he Me 08/19 Residented by the control of the mass order of the the mass order of the Me dication he dicat	nad conversations with monitoring of Resident #6's alysis. If had informed her Resident inside to the dialysis fied the physician regarding it medications.  If medications. If medications is more than the physician revealed: If medications is more than to dialysis and inside as ordered. If medications is more than to dialysis and inside it mot give the resident is as ordered in mot administered medications is as ordered on Monday, than the physician mot administered more than the physician in the physician is as ordered in more than the physician more than the physician in and the physician in and the physician in and the physician in the physi				

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physician addressing medications ordered when

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DIVISION	n nealth Service Regu	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		` ′	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED	
			1			_	
			P WING		F		
		HAL034098	B. WING		03/0	08/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
		2609 OLD	SALISBURY R	OAD			
SALEM TERRACE WINSTON SALEM, NC 27127							
			JALLIN, NC 2				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE	
1,10		,	1,710	DEFICIENCY)			
			<del> </del>				
D 273	Continued From page	e 40	D 273				
	the resident was at di	alvsis					
		a., e.e.					
	3. Review of Residen	t #2's current FL2 dated					
	01/3/19 revealed diac	noses included dementia,					
		oidemia, osteoarthritis,					
		artery disease, type II					
	diabetes mellitus, chest pain, gastroesphageal reflux disease, constipation, anxiety, and allergic						
	rhinitis.						
	minus.						
	a. Review of Resident #2's current FL2 dated						
		order for diclofenac sodium					
		sed to treat pain) apply 4					
	grams topically three	lines a day.					
	Davious of Davidant #	21a January 2010 electronic					
		2's January 2019 electronic					
	Medication Administra	ation Record (eMAR)					
	revealed:						
		for Voltaren 1% Gel, apply 4					
		ected areas three times a					
	•	Dam, 3:00pm, and 9:00pm.					
		tation Voltaren was not					
	administered for 26 of	f 93 opportunities.					
	-Voltaren was not doo	cumented 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 documen	tation Voltaren was not					
	administered for the r	eason the resident refused.					
	Review of Resident #	2's February 2019 eMAR					
	revealed:						
	-There was an entry f	or Voltaren 1% Gel, apply 4					
		ected areas three times a					
		Dam, 3:00pm, and 9:00pm.					
	-	tation Voltaren was not					
	administered for 55 of						
		cumented as administered at					
	9:00am on 02/07/19,						

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02/14/19-02/15/19, 02/18/19-02/19/19, 02/23/19,

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING	B. WING		9
NAME OF P	ROVIDER OR SUPPLIER	2609 OLD	DRESS, CITY, STA SALISBURY RO SALEM, NC 2'	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	X5) PLETE ATE
D 273	3:00pm on 02/01/19-0 02/09/19-02/10/19, 02 and on 02/20/19-02/2 -Voltaren was not doo 9:00pm on 02/01/19-0 02/12/19-02/16/19, 02/02/21/19-02/16/19, 02/02/21/19-02/24/19, ar -There was documen administered for the revealed: -There was an entry figrams topically to affed day scheduled at 9:00 -There was documen administered for 10 or -Voltaren was not doo 3:00pm on 03/01/19, -Voltaren was not doo 9:00pm on 03/01/19-0 -There was documen administered for the review of Resident # -Documentation of resident of the resident of the plant of the 91 time fused.  Interview with a Medic 03/07/19 at 9:45am resident of the 91 time fused.	d on 02/28/19. cumented as administered at 02/03/19, 02/05/19-02/07/19, 2/12/19-02/16/19, 02/18/19, 7/19. cumented as administered at 02/02/19, 02/05/19-02/10/19, 02/18/19-02/20/19, nd on 02/26/19-02/28/19. tation Voltaren was not eason the resident refused.  2's March 2019 eMAR  or Voltaren 1% Gel, apply 4 exted areas three times a 0am, 3:00pm, and 9:00pm. tation Voltaren was not f 15 opportunities. cumented as administered at and on 03/04/19. cumented as administered at 03/02/19, and on 03/05/19. tation Voltaren was not eason the resident refused.  2's nurse's notes revealed: sident refusal of Voltaren 02/10/19. nentation staff notified the mes Voltaren gel was  cation Aide (MA) on exealed: Resident #2 had refused  thave been notified after the	D 273			

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					1 _	_
			D WING		F	
		HAL034098	B. WING		03/0	8/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	ATE ZIP CODE		
NAME OF F	NOVIDEN ON 3011 LIEN					
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				DEI IOIEI(OT)		
D 273	Continued From page	e 42	D 273			
	. •					
	Interview with Reside	nt #2 on 03/08/19 at				
	11:55am revealed:					
	-She knew she was p	rescribed Voltaren for pain.				
	-She refused the Volt	aren frequently and wanted				
	the order changed to	as needed.				
	_	he Voltaren to be changed to				
	as needed.	3 · · · · · · · · · · · · · · · · · · ·				
	Telephone interview v	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.	only her of Resident #25				
		- mile - d Maltana a Oal fan				
		scribed Voltaren Gel for				
	pain.					
	-She expected the sta	aff to notify her of the				
	Voltaren refusals.					
	-If the staff had notifie	ed her of the Voltaren				
	refusals she would ha	ave changed the medication				
	to as needed or disco	ontinued the medication if not				
	needed.					
	-Resident #2 was last	t seen two weeks ago.				
	Interview with the Re	sident Care Coordinator				
	(RCC) on 03/08/19 at					
		o administer Voltaren as				
	ordered.	danninister voltaren as				
	-The MAs were respon	anaible for provider				
	·	•				
		dent #2 refused Voltaren.				
		e completed a refusal form				
		used Voltaren and placed it				
	•	vider to review or fax the				
	form to the provider.					
	-No one was checking	g behind the MAs to make				
	sure the form was co	mpleted and provider was				
		sident #2's Voltaren refusals.				
	Interview with the Me	mory Care Unit Coordinator				
		at 12:00pm revealed:				
	-She knew Resident					
	S.IS INIGHT I CONCOLL		1	1		1

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-She expected the MAs to notify the provider after

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	EDDACE	2609 OL	SALISBURY R	OAD		
SALEWI II	ERRACE	WINSTO	N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 43	D 273			
D 273	Resident #2 refused \( \) -The MAs were experimedication refusal for refused Voltaren and reviewThe refusal form was #2's record.  Interview with the Adr 2:50pm revealedShe did not know Revoltaren GelShe would expect the provider after Voltaren consecutive timesThe MA or RCC shown refusal form and send b. Review of Residen 01/3/19 revealed and Propionate (used to the mcg, one spray into expect the was an entry of the following one spray into scheduled at 9:00ams Fluticasone Propion 01/27/19 at 9:00pm and Review of Resident # revealed:	Voltaren three times. cted to complete the rm each time Resident #2 send to the provider for s expected to be in Resident ministrator on 03/08/19 at esident #2 was refusing e MA or RCC to notify the n Gel was refused three uld complete the medication of to the provider for review.  It #2's current FL2 dated order for Fluticasone reat allergy symptoms) 50 each nostril daily.  It so January 2019 electronic ation Record (eMAR)  For Fluticasone Propionate to each nostril daily  ate was not administered on and documented as refused.  It's February 2019 eMAR	D 273			
	50mcg, one spray into scheduled at 9:00amThere was documen					

Division of Health Service Regulation

opportunities.

STATE FORM 6899 1HE211 If continuation sheet 44 of 109

Division of	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED	
					l R	,	
		HAL034098	B. WING			8/2019	
		HAE034098			03/0	0/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		2609 OLD	SALISBURY R	OAD			
SALEM TE	ERRACE	WINSTON	I SALEM, NC 2	7127			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE	
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
				DEFIGIENCY)			
D 273	Continued From page	e 44	D 273				
	- Fluticasone Propion	ate was not not					
		am on 02/07/19 at 9:00am					
	on 02/09/19-02/10/19						
		2/18/19, 02/23/19, and on					
	02/26/19.	,					
	-There was documen	tation Fluticasone					
	Propionate was not a	dministered for the reason					
	the resident refused.						
	Review of Resident #2's nurse's notes revealed: -There was documentation of resident refusal of						
	Fluticasone Propiona	te on 02/09/19 and					
	02/10/19.						
		nentation staff notified the					
	was refused.	nes Fluticasone Propionate					
	was refused.						
	Interview with a Medi	cation Aide (MA) on					
	03/07/19 at 9:45am re						
	-She did not know if F	Resident #2 had refused					
	Fluticasone Propiona						
		have been notified after the					
	•	te was refused three times.					
	•	I notified the physician					
		t did not document the					
	notification.						
	Interview with Reside	nt #2 on 03/08/19 at					
	11:55am revealed:	11t #2 011 03/00/19 at					
		rescribed Fluticasone					
	Propionate.						
	-She refused the Flut	icasone Propionate					
		ne did not know why it was					
	prescribed.	, , , , , , , , , , , , , , , , , , , ,					
	-She did not report ar	ny allergy symptoms.					
	•						
		vith Resident #2's primary					
		8/19 at 10:50am revealed:					
		otify her of Resident #2's					
	refusal of Fluticasone	Propionate.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEIVI II	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 45	D 273			
	-Resident #2 was pre Propionate for allergic -She expected the sta Fluticasone Propional -If the staff had notifie Propionate refusals s medication to as need medication if not need -Resident #2 was last  Interview with the Res (RCC) on 03/08/19 at -She expected staff to Propionate as ordered -The MAs were responotification after Resident -The staff should have after Resident #2 refu and place it in the box or fax the form to the -No one was checking sure the form was con notified regarding Res Propionate refusals.  Interview with the Me (MCUC) on 03/08/19 -She did not know Re Fluticasone Propional -She expected the MA Resident #2 refused I timesThe MAs were expected medication refusal for refused Fluticasone F provider for review.	scribed Fluticasone c rhinitis. aff to notify her of the te refusals. d her of the Fluticasone he would have changed the ded or discontinued the ded. t seen two weeks ago.  sident Care Coordinator 9:20am revealed: o administer Fluticasone d. nosible for provider dent #2 refused Fluticasone e completed a refusal form used Fluticasone Propionate of for the provider to review provider. g behind the MA to make mpleted and provider was sident #2's Fluticasone  mory Care Unit Coordinator at 12:00pm revealed: esident #2 was refusing te. As to notify the provider after Fluticasone Propionate three				

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#2's record.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R	
		HAL034098	B. WING		03/08/20	19
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SAI FM TI	SALEM TERRACE 2609 OLD			OAD		
WINSTON		WINSTON S	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COI	(X5) MPLETE DATE
D 273	Continued From page	<del>2</del> 46	D 273			
D 273	Interview with the Adr 2:50pm revealedShe did not know Re Fluticasone Propionar-She would expected provider after Fluticase three times. The -MA or RCC show refusal form and send 4. Review of the currer revealed diagnoses in chronic hypoxic respinobstructive pulmonary depression, demential hyperlipidemia, and management of the care plan included to onychomycosis, and compain/pressure/infection.  Review of Resident 4. There was no documnails were trimmed or an action of the care plan included than every sixty one compain/pressure/infection.  Review of Resident 4. (PCP) after visit summand values deformity and valgus deformity and	sident #2 was refusing te.  the MA or RCC to notify the sone Propionate was refused all complete the medication if to the provider for review.  ent FL2 dated 6/26/18 included diabetes mellitus, ratory failure, chronic y disease, anxiety and in hypertension, inacular degeneration.  It #4's Foot Care Plan dated diabetes mellitus II, redema. Inentation Resident #4's toe in this date. Inentation Resident #4's toe in this date. Inentation Resident #4's toe in this date. In this date in the provider of the property of the property of the provider of the provider of the property of the property of the provider toes.  It was refusing the provider of the	D 273			
		ntation of Resident #4's vices or that she had				

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STATE FORM 6899 1HE211 If continuation sheet 47 of 109

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		R
		HAL034098	B. W(0		03/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		2609 OLI	SALISBURY R	OAD	
SALEM TE	ERRACE		N SALEM, NC 2		
24.5.1=	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N 0.50
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	l l
				DEFICIENCY)	
D 273	Continued From page	. 47	D 273		
D 210	Continued From page	<del>,</del> 47	5275		
	Interview with Reside	nt #4 on 03/07/19 at			
	10:55am revealed:				
	-She did not see the	podiatrist when he was last			
	in the facility.				
		shoes because her toenails			
	-	t of her shoes causing pain.			
		three months since she had			
	her toenails trimmed.				
	-No one checked her	toenails regularly.			
		ent #4 on 03/07/19 at			
	10:59am revealed:				
		aring socks but no shoes.			
		ls on her left and right big			
		kimately half an inch from			
	her toes.				
		emaining four toes of the			
	<del>-</del>	e curved over the top of the			
	toes.				
	lintamijaith tha Da	sident Care Canadinator			
		sident Care Coordinator			
	(RCC) on 03/08/19 at				
		en by a PCP outside of the			
	facility.	des (PCA) were supposed to			
		and feet when they assisted			
	with baths.	and leet when they assisted			
		esident #4's toenails needed			
	to be trimmed.	Sident #43 tochans needed			
	-"She doesn't compla	in about them "			
		an outside PCP were seen			
		ted podiatrist if the facility			
	could get approval fro	•			
		er seeing a referral for a			
		not know of any scheduled			
	podiatry visit and did	-			
		manager was responsible			
	- 1116 003111699 011166 1	nanayer was responsible	1		

facility. Division of Health Service Regulation

for making medical appointments outside of the

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY
		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED
		_		R
	HAL034098	B. WING		03/08/2019
OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓE, ZIP CODE	
RRACE	2609 OLD	SALISBURY RO	DAD	
	WINSTON	SALEM, NC 27	<u>'127</u>	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
Continued From page	÷ 48	D 273		
PCP on 03/08/19 at 1 Interview with a media 03/08/19 at 11:51 am -MAs were responsib feet including need for a resident needed trimmed, it should have shift report and handed -The RCC was responsed to the residents saw the poor placing their names of she knew Resident at trimmed.  -She documented Reher toenails trimmed idd not know whenShe did not know if F	cation aide (MA) on revealed: le for checking residents' or a toenail trim. to have their toenails ve been documented in the ed off to the RCC. nsible for making sure diatrist when needed by on the podiatrist list. #4 needed her toenails esident #4 needed to have in the shift report book, but Resident #4 was scheduled			
Interview with a PCA revealed: -Her job responsibilitifeeding, incontinence skin and toenails daily-lf a resident's toenail PCAs would report it -She knew Resident trimmed and had repond remember whenThe facility contracte the facility about a moshe thought Resider the podiatrist, but she	on 03/08/19 at 2:11pm  es included assisting with e care, bathing, and checking y. Is needed to be trimmed, the to a MA. #4's toenails needed to be orted it to a MA, but she did ed podiatrist saw residents at onth ago. Int #4 was on this list to see ed did not know if Resident #4			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From page  Attempted telephone PCP on 03/08/19 at 1  Interview with a medic 03/08/19 at 11:51 am  -MAs were responsiblifeet including need fo -If a resident needed trimmed, it should have shift report and handed -The RCC was responsible to the resident saw the poor placing their names or she knew Resident for the resident saw the poor to have her toenails trimmed in the resident saw toenails to have her toenails to have her toenails to have her toenails to have her toenails daily.  Interview with a PCA or revealed:  -Her job responsibilities feeding, incontinence skin and toenails daily.  If a resident's toenails PCAs would report it to she knew Resident for the facility contracted the facility about a more she thought Resident to the podiatrist, but she in the podiatrist, but she in the property of the property of the podiatrist, but she in the property of the propert	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48  D 273  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 toenall trimIf a resident needed to have their toenails trimmed, it should have been documented in the shift report and handed off to the RCCThe RCC was responsible for making sure residents saw the podiatrist when needed by placing their names on the podiatrist listShe knew Resident #4 needed her toenails trimmedShe documented Resident #4 needed to have her toenails trimmed in the shift report book, but did not know whenShe 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 dailyIf a resident's toenails needed to be trimmed, the PCAs would report it to a MAShe knew Resident #4's toenails needed to be trimmed and had reported it to a MA, but she did not remember whenThe facility contracted podiatrist saw residents at the facility about a month agoShe 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD)  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 listShe knew Resident #4 needed her toenails trimmed.  -She din ont 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 MAShe 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 agoShe 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

-There should be documentation in the nurse's notes of whether Resident #4 saw the podiatrist

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Division of	<u>of Health Service Regu</u>	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL 024009	B. WING		R	
		HAL034098			03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OL	D SALISBURY R	OAD		
SALEM TI	ERRACE	WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE	
				DEI IGIENGI)		
D 273	Continued From page	e 49	D 273			
	or not.					
	Attampted talanhana	intensions with the DCD on				
		interview with the PCP on				
	03/08/19 at 2:32pm w	as unsuccessiui.				
	Interview with the Adr	ministrator on 03/08/19 at				
	2:48pm revealed:	Timistrator on 60/60/10 at				
	•	ding toenails should be				
		en they assisted residents				
	with baths.					
	-There was a contract	ted podiatrist who came to				
		e and was able to see all				
	residents.					
	-The podiatrist was la	st in the facility in January				
	2019, but she was no	t sure if the podiatrist saw				
	Resident #4 or not.					
	=	cheduled to visit the facility				
	again at the end of M					
		specialist was responsible				
	for ensuring residents	•				
	came back to the faci	e seen when the podiatrist				
	came back to the faci	illy in March 2019.				
	Interview with the me	dical records specialist on				
	03/08/19 at 5:13pm re					
		en by the facility contracted				
		viders, but switched to an				
	outside PCP.					
	-She last received po	diatry services through the				
	facility contracted poo	diatrist in August 2018				
	because of the chang					
	-She had not seen the					
	podiatrist since Augus					
		to an outside provider for				
		3/05/19, but there was no				
	scheduled appointme					
	_	a call back from the outside				
	provider for podiatry s					
	-She did not know if a					
	services was made by	y any staff member between				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		03	R 8/ <b>08/2019</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI		·	
SALEM T	ERRACE		N SALISBURT RO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 50	D 273			
	August 2018 and 03/	05/19.				
	06/26/18 revealed the (Ibuprofen) 600 mg (a pain) one tablet every Review of Resident # revealed: -There was a physicia 12/05/18 with an order hours not to exceed 3 order for Ibuprofen 60 needed for painThere was an order 12/13/18 which requeorder for Ibuprofen 60 the order was clarified There was one "Physical Resident's Refusal of sheet which indicated Ibuprofen 600 mg on	4's physician's orders an's order sheet dated er for Ibuprofen every six 3200 mg per day and an 00 mg three times daily as clarification sheet dated ested clarification on the 00 mg three times a day and d on 12/13/18.				
	December 2018 throu-There was documen 12/25/18, 12/31/18, 1 01/19/19, and 02/26/24 was refused to tak 6:00am scheduled lbs sleep and did not war	/9/19, 1/10/19, 01/14/19, 19 which indicated Resident re her 12:00am and/or uprofen because she was nt to be awakened. nentation Resident #4's n (PCP) was notified				
		4's electronic Medication d (eMAR) for December				

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Division of	<u>of Health Service Regu</u>	ılation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			_			
			B. WING		R	
		HAL034098	D. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
SALEM TE	ERRACE		D SALISBURY RO			
		WINSTO	N SALEM, NC 27	/12/		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( - )	
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		
IAG		200.122	IAG	DEFICIENCY)		
D 273	Continued From page	e 51	D 273			
		ntry for Ibuprofen 600 mg				
ļ		ee times daily with meals.				
ļ		for Ibuprofen 600 mg tablet,				
		x hours, not to exceed 3200				
	mg per day at 12:00a	am, 6:00am, 12:00pm, and				
	6:00pm.					
	-There was documen	tation Ibuprofen 600 mg was				
		nty five of one hundred and				
		ities on the following dates:				
	12/06/18 at 6:00am;					
		; 12/12/18 at 12:00am and				
	6:00am; 12/13/18 at					
		t 12:00am; 12/15/18 and				
		n; 12/18/18 at 6:00am;				
	-	12/24/18 at 12:00am and				
	· ·	12:00am and 6:00am;				
		and 6:00am; 12/28/18 at at				
		nd 12:00pm; 12/29/18 at at				
		n; and 12/30/18 at 12:00pm.				
		tation Ibuprofen was not				
	administered due to "	•				
	"physically unable to	take."				
	Review of Resident #	44's eMAR for January 2019				
	revealed:					
	-There was not an en	ntry for Ibuprofen 600 mg				
	tablet, one tablet thre	e times daily with meals.				
	-There was an entry f	for Ibuprofen 600 mg tablet,				
	take 1 tablet every six	x hours, not to exceed 3200				
		am, 6:00am, 12:00pm, and				
	6:00pm.					
	•	itation Ibuprofen 600 mg was				
		y two of one hundred and				
ļ		ities on the following dates:				
		01/02/19 at 12:00am and				
		12:00am and 6:00am;				
ļ		and 6:00am; 01/06/19 at				
ľ	<sub> </sub> 12:00am; 01/07/19 at	t 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

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STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TI	ERRACE		SALISBURY ROSALEM, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 273	6:00am; 01/25/19 at 6:12:00am and 6:00am 01/31/19 at 6:00am.  -There was documer administered due to "Review of Resident #revealed:  -There was not an entablet, one tablet thre-There was an entry fake 1 tablet every six mg per day at 12:00a 6:00pm.  -There was documen not administered tenopportunities on the 12:00am; 02/15/19 at 02/16/19 at 6:00pm; 02/20/19 at 12:00am; 02/26/19 at 6:00am.  -There was documen administered due to "facility".  Review of Resident #revealed:  -There was not an entablet, one tablet thre-There was an entry fake 1 tablet every six mg per day at 12:00a 6:00pm.	12:00am; 01/15/19 at 6:00am; 01/17/19 at 12:00am and 6:00am; 01/21/19 at 6:00am; and 6:00am; 01/24/19 at 6:00am; 01/26/19 at 6:00am; 01/26/19 at 7:01/27/19 at 12:00pm; and 6:01/27/19 at 12:00pm, and 6:00am, 12:00pm, and 6:00am; 12:00pm, and 6:00am; 12:00am and 6:00am;	D 273		

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Division of	of Health Service Regu	lation			
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE	
SALEM TI	EDDACE	2609 OL	D SALISBURY RO	DAD	
SALEINI II	ERRACE	WINSTO	N SALEM, NC 27	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	: 53	D 273		
	not administered one on the following date: -There was document administered due to "  Interview with Reside 10:55am revealed: -She took medication 5:00pm, and 8:00pm.	of twenty two opportunities 03/03/19 at 12:00am. tation Ibuprofen was not resident refused."  Int #4 on 03/07/18 at at 8:00am, 12:00pm,  e she was administered ew Ibuprofen was not			
	-She never refused a	ny medication and she s awakened at 12:00am or			
	(RCC) on 03/08/19 at -She was responsible medications against to a month.  -The MA's were responsible and cart audits on Month and cart audits on Month and cart audits on Month and cart audit for refusals of the resident refused responsible for complete resident's physicial-Signed Refusal Form	for checking the he eMARS one or two times onsible for completing eMAR andays, Wednesdays, and an eMAR audit, she did because she reviewed on resident.  In the MAR was eting a Refusal Form to for			
		efused three times or more, nave been contacted to get			

discontinued.

the medication ordered as needed or

-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

STATE FORM 6899 1HE211 If continuation sheet 54 of 109

Division of	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
					R
		HAL034098	B. WING		03/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE	
CALEMIT	EDDACE	2609 OL	D SALISBURY ROA	AD	
SALEM TE	ERRACE	WINSTO	N SALEM, NC 271	27	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
D 273	Continued From page	e 54	D 273		
	notified.				
	revealed: -If a resident refused documented on the e and a note should be as to why the medicar-Refusals should also nurse's notes in the re-A Refusal Form shouresident's physicianIf a resident kept refusalsThe contact with the documented in the nurecord.	using medication, MAs ysician after three days of physician should be urse's notes in the resident's er documenting any refusals			
	Attempted telephone 03/08/19 at 2:32pm w	interview with the PCP on ras unsuccessful.			
	2:48pm revealed: -The RCC and the pheMAR auditsAn eMAR audit should in the eMAR as well along the eMAR as well along the eMAR as well along the eMAR as should document nurse's notes why the administered.	was not administered, the at on the eMAR and in the emedication was not complete a refusal form for			

consecutive refusals.

-She expected MAs and the RCC to document and contact the resident's physician after 3

STATE FORM 6899 1HE211 If continuation sheet 55 of 109

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		HAL034098	B. WING		03/0	8/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEIVI II	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	: 55	D 273			
D 344	sampled residents relighysician when a resigneater than 400 (Residents) administered when a facility at dialysis (Residents #6 and #7 medications (Residents #6 and #7 medications) (Resident facility's failure to notimissed medications wand welfare of the resident Type B Violation.  The facility provided a 03/08/19 in accordance CORRECTION DATE	d with dialysis treatments ), and refusal of ts #7, #2, #3 and #4). The fy the physician regarding vas detrimental to the health idents and constitutes a  Plan of Correction on the with G. S. 131D-24.  FOR THE TYPE B HOT EXCEED APRIL 21,	D 344			
	10A NCAC 13F .1002 (a) An adult care hon	Medication Orders ne shall ensure contact with an or prescribing practitioner				
	resident are not dated of admission or readm (2) if orders are not cl (3) if multiple admission admission or readmis forms are not the sam The facility shall ensure	sion or readmission of the d and signed within 24 hours nission to the facility; ear or complete; or on forms are received upon sion and orders on the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			_		R
		HAL034098	B. WING		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
SALEM TI	ERRACE		SALISBURY RO		
			N SALEM, NC 27		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 56	D 344		
	record.				
	This Rule is not met	as syldeneed by:			
		as evidenced by. ns, interviews and record			
		iled to assure contact with			
		cian for clarification of orders			
		sidents (Resident #6 and #7) dminister Novolog, Auryxia,			
		e, tylenol, refresh tears (#7)			
		nate (#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:	and stage renal disease			
	type two diabetes, ne	end stage renal disease, urogenic bladder			
		mputation, and left arm			
	paralysis.				
	a. Review of Residen	t #7's current FL2 dated			
		physician's order for Novolog			
		ously once daily with the			
	lunch meal.				
	Review of Resident #	7's record revealed a			
		s order sheet signed by the			
	• •	B with orders for Novolog			
	four units subcutaned funch meal.	ously once daily with the			
	iuiicii iiiedi.				
	Review of Resident # electronic Medication	7's December 2018 Record Administration			

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COME	PLETED
						R
		HAL034098	B. WING		03	/08/2019
		TIALOGIOO			1 03	100/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY RO			
		WINSTO	N SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	e 57	D 344			
	(eMAR) revealed:					
		entry for Novolog four units				
	at lunch time schedul	•				
		tation Novolog was not				
		times on the following dates eing at dialysis: 12/02/18,				
		2/07/18, 12/12/18, 12/14/18,				
		2/19/18, 12/20/18, 12/21/18,				
	12/23/18, 12/26/18, 1	2/28/18, 12/29/18, and				
	12/31/18.					
		nentation the physician had				
		y how to administer the				
		the resident was out of the				
	facility at dialysis.					
	Review of Resident # revealed:	7's January 2019 eMAR				
	-There was an order of at lunch time schedul	entry for Novolog four units				
		tation Novolog was not				
		n times on the following				
	dialysis dates due to	•				
		/03/19, 01/04/19, 01/07/19,				
		01/11/19, 01/14/19, 01/16/19,				
	o1/18/19, 01/21/19, 0 and 01/30/19.	1/23/19, 01/25/19, 01/28/19,				
		nentation the physician had				
		y how to administer the				
		the resident was out of the				
	facility at dialysis.					
	Paviou of Posidont #	7's February 2019 eMAR				
	revealed:	7 3 1 CUIUAIY ZU 19 CIVIAR				
		entry for Novolog four units				
	at lunch time schedul	,				
		tation Novolog was not				
	administered thirteen	times on the following dates				
		eing at dialysis: 02/01/19,				
	02/04/19, 02/05/19, 0	2/06/19, 02/08/19, 02/11/19,				

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02/13/19, 02/15/19, 02/18/19, 02/20/19, 02/22/19,

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DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			D. MINO		R	
		HAL034098	B. WING		03/08	3/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDER OR SOLT LIER					
SALEM TE	RRACE		O SALISBURY R			
		WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIAIE	DATE
				DEI IOIENOT)		
D 344	Continued From page	e 58	D 344			
	02/25/19, and 02/27/					
	-There was no docum	nentation the physician had				
	been notified to clarify	y how to administer the				
	medication because t	he resident was out of the				
	facility at dialysis.					
	<b>, ,</b>					
	Review of Resident #	7's March 2019 eMAR				
	revealed:					
		entry for Novolog four units				
	at lunch time schedul	•				
		•				
		tation Novolog was not				
		nes on the following dates				
		eing at dialysis: 03/01/19,				
	03/04/19, and 03/06/					
	-There was no docum	nentation the physician had				
	been notified to clarify	y how to administer the				
	medication because t	he resident was out of the				
	facility at dialysis.					
	, ,					
	Interview with Reside	nt #7 on 03/07/19 at 8:34am				
	revealed:					
		abetic and was ordered				
		times daily along with				
	•					
	Novolog sliding scale					
		Monday, Wednesday and				
	Fridays.					
		alysis she left the facility at				
		nes did not return to the				
	facility until almost 6:0	00pm.				
	-On Monday, Wednes	sday and Fridays she was				
	never administered th	ne 12:00pm Novolog.				
	Interview with a first s	shift MA on 03/07/19 at				
	3:05pm revealed:	<del></del>				
	-Resident #7 went to	dialysis Monday				
		ay from 11:00am to 5:00 or				
		ay nom 11.00am to 5.00 or				
	6:00pm.					
		as at dialysis she was not				
		tions scheduled during the				
	time the resident was	out of the facility.				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
					F	₹
		HAL034098	B. WING		03/0	08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			SALISBURY R			
SALEM TE	RRACE		SALEM, NC 2			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRE	-CTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SH		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	'ROPRIATE	DATE
				DEI IOIEIVOT)		
D 344	Continued From page	e 59	D 344			
		d during the time Resident				
	_	e circled her initials on the				
		ted the resident was out of				
		ally unable to take the				
	medication."	lialysis at 11:00am but was				
		lialysis at 11:00am, but was refore she did not consider				
	_	g before the resident went to				
	dialysis.	g belove the resident went to				
	, <b>,</b>					
	Interview with Reside	nt #7's Endocrinologist				
	03/07/19 at 11:14am					
		Resident #7 went to dialysis				
	_	olog was administered while				
	the resident was at di	alysis. t time Resident #7 returned				
		sident was offered a meal,				
	Novolog should still b					
	•	uld have contacted the				
	physician to clarify wh	nat to do if they were unable				
	to administer the med	lication as ordered.				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 03/08/19 at	8:43am revealed:				
	-Resident #7 went to	dialysis three days per				
		am and 5:00 to 6:00pm.				
	_	duled when the resident was				
		ition was not administered.				
		he physician and ask for medications missed when				
	Resident #7 was at di					
	. toolgone irr was at a	, 5.5.				
	b. Review of Residen	t #7's current FL2 dated				
	06/27/18 revealed a p	physician's order for Auryxia				
	210mg (two tablets =	420mg) (used to lower high				
		els) three times daily with				
	meals.					
	Review of Resident #	7's record revealed a				

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subsequent physician's order sheet signed by the

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		03/08/2019	
					1 00/00/2010	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE		
SALEM TE	FRACE	2609 OLI	SALISBURY RO	DAD		
WINSTON SALEM, NC 27127						
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		Έ
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	MATE	
				,		
D 344	Continued From page	e 60	D 344			
	nhysician on 12/04/18	3 with orders for Auryxia				
		420mg) three times daily				
	with meals.	+20mg) three times daily				
	with meals.					
	Review of Resident #	7's December 2018				
		Record Administration				
	(eMAR) revealed:					
	,	entry for Auryxia 210mg (two				
		e times daily with meals				
	scheduled for 8:00am					
	-There was documen	tation Auryxia was not				
	administered fifteen ti	mes on the following dates				
	due to the resident be	eing at dialysis: 12/02/18 at				
	12:00pm, 12/03/18 at	12:00pm, and 5:00pm,				
	-	12/12/18 at 12:00pm,				
		12/19/18 at 12:00pm,				
		12/23/18 at 12:00pm,				
	12/25/18 at 5:00pm, 1					
	12/31/18 at 12:00pm.					
		nentation the physician had				
	•	how to administer the				
		he resident was out of the				
	facility at dialysis.					
	Paview of Pasident #	7's January 2019 eMAR				
	revealed:	7 3 January 2013 CWAR				
	-There was an order	entry for -There was				
		sident was out of the facility,				
	refused and was phys	•				
		wo tablets= 420mg) three				
		s scheduled for 8:00am,				
	12:00pm, 5:00pm.	·				
	-	tation Auryxia was not				
		ee times on the following				
	dates due to the resid					
	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

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STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND LAN OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COWI LL	-120
	HAL034098	B. WING		03/0	8/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TERRACE	2609 OLD S	SALISBURY RO	OAD		
OALLIN TERRORE	WINSTON S	SALEM, NC 27	7127		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344 Continued From page 61	1	D 344			
5:00pm, 01/17/19 at 5:00 12:00pm and 5:00pm, 02 01/26/19, and no medication been notified to clarify he medication because the facility at dialysis  Review of Resident #7's revealed: -There was an order entitablets= 420mg) three tirscheduled for 8:00am, 12-There was documentativadministered twenty-two dates due to the resident 02/01/19 through 02/04/202/08/19 at 12:00pm, 02 02/13/19 at 12:00pm, 02 02/18/19 at 12:00pm, 02 02/27/19 at 12:00pmThere was no documenteen notified to clarify he medication because the facility at dialysis  Review of Resident #7's revealed:	Opm, 01/18/19 at 1/19/19 through 12:00pm tions were administered 19. Intation the physician had ow to administer the resident was out of the  February 2019 eMAR  Try for Auryxia 210mg (two mes daily with meals 2:00pm, 5:00pm. To Auryxia was not to times on the following the being at dialysis: 19, 02/06/19 at 12:00pm, 2/11/19 at 12:00pm, 2/20/19 at 12:00pm, 2/25/19 at 12:00pm, 2/25/19 at 12:00pm, 2/25/19 at 00 pm, 2/25/19 at 12:00pm, 2/25/19 a	D 344			

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
			B. WING		R
		HAL034098	D. WING		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE	
		2609 OL	D SALISBURY R	OAD	
SALEM T	ERRACE		N SALEM, NC 2		
	CUMMADV CT		· ·	PROVIDER'S PLAN OF CORRECTIO	N 9.50
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 344	Continued From page	2.62	D 344		
D 044	Continued From page	5 02	5 544		
	medication because t	the resident was out of the			
	facility at dialysis.				
		ent #7 on 03/07/19 at 8:34am			
	revealed:				
		three days per week from			
	11:00am until almost	•			
		stered Auryxia at 12:00pm.			
		facility after 6:00pm the			
		ıryxia was not administered.			
	_	as an iron medication and			
		cation because she had			
	dialysis.				
	Interview with a first s	shift MA on 03/07/19 at			
	3:05pm revealed:	sime wire on object to de			
		ninistered to Resident #7 on			
	_	and Friday at 12:00pm			
	when the resident wa	•			
		e administered one hour			
	before the scheduled	time or one hour after the			
	scheduled time.				
	-Resident #7 left the t	facility at 11:00am for			
	dialysis.				
		red administering Auryxia at			
		dent #7 left for dialysis.			
		ed Resident #7's physician			
		on of the medication on			
	dialysis days (Monda	y, Wednesday, and Friday).			
		1111			
		nd MA on 03/08/19 at			
	9:50am revealed:	Alan diabasia annotaninfanna d			
		the dialysis center informed			
		sponsible for administering			
	Resident #7's Auryxia				
	12:00pm and 5:00pm	three times daily at 8:00am,			
	-Resident #7 was not	. auministereu trie			

dialysis.

medication at 12:00pm when Resident #7 was at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		03/08/2019
					1 00/00/2010
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
SALEM TERRACE			SALISBURY R		
		WINSTON	I SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 63	D 344		
	-It had never been sure Auryxia at 11:00am be facilityShe had not contactor regarding the medical due to the resident be linterview with the nur Nephrologist's office or revealed: -Auryxia was ordered meal or a snackAuryxia was not to be anytime Resident #7 regardless of the time administeredThe facility staff show physician to clarify he medication when the	efore Resident #7 left the ed Resident #7's physician tion not being administered eing at dialysis.  rse at Resident #7's on 03/07/19 at 2:22pm  I three times daily with a e a scheduled medication, received a meal or snack e the medication should be uld have contacted the			
	pain) four times daily.				
	physician on 12/04/18	7's record revealed and some sheet signed by the with orders for gabapentin (200mg) four times daily.			
	revealed: -There was an order two capsules (200mg scheduled at 8:00am 8:00pmThere was documen administered thirteen	entry for gabapentin 100mg four times daily was 12:00pm, 4:00pm and tation gabapentin was not times on the following dates ping at dialysis: 12:00pm on			

Division of Health Service Regulation

12/02/18, 12/03/18, 12/05/18, 12/07/18, 12/12/18,

STATE FORM 6899 1HE211 If continuation sheet 64 of 109

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CALEMI	EDDACE	2609 OLD	SALISBURY R	OAD	
SALEM TI	ERRACE	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 64	D 344		
	12/14/18, 12/17/18, 1 12/26/18, 12/28/18 12 4:00pm on 12/11/18. -There was no docum been notified to clarify medication because t facility at dialysis.	2/19/19, 12/21/18, 12/23/18, 2/31/18, and one time at nentation the physician had y how to administer the he resident was out of the 7's January 2019 eMAR			
	two capsules (200mg scheduled at 8:00am; 8:00pmThere was documen administered fourteer dates due to the resid 12:00pm on 01/02/19 01/09/19, 01/11/19, 0 01/21/19, 01/23/19, 0 01/30/19There was no documbeen notified to clarify	tation gabapentin was not in times on the following dent being at dialysis:			
	revealed: -There was an order of two capsules (200mg scheduled at 8:00am, 8:00pmThere was documen administered twelve to the resident be 02/01/19, 02/04/19, 002/13/19, 02/15/19, 002/25/19, 02/27/19; and 02/04/19 at 8:00am	tation gabapentin was not imes on the following dates eing at dialysis: 12:00pm on 2/06/19, 02/08/19, 02/21/19, 12/18/19, 02/20/19, 14:00pm,			

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STATE FORM 6899 1HE211 If continuation sheet 65 of 109

Division C	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			_		_	
			D WING		R	
		HAL034098	B. WING		03/0	8/2019
NAME OF DI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF F	TOVIDER OR SUFFLIER					
SALEM TE	FRRACE	2609 OLD	SALISBURY R	OAD		
O/ (		WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		<u></u>
D 344	Ozationed From poor	- 05	D 344			
D 344	Continued From page	3 00	D 344			ı .
	been notified to clarify	y how to administer the				ı .
	•	the resident was out of the				ı .
	facility at dialysis.					ı
						ı <b>,</b>
ļ	Poviou of Posident #	7's March 2019 eMAR			ļ	ı .
		7 S Maich 2019 GMAIN				ı .
	revealed:					ı
		entry for gabapentin 100mg				ı .
		j) four times daily was				ı
		, 12:00pm, 4:00pm and				ı
	8:00pm.					ı
	-There was documen	tation gabapentin was not				ı
	administered three tin	mes on the following dates				ı
	due to the resident be	eing at dialysis: 12:00pm on				ı
	03/01/19, 03/04/19, a	• •				ı
	03/01/19 at 4:00pm.					ı
		nentation the physician had				ı
		y how to administer the				ı
		the resident was out of the				ı
ļ		The resident was out or the			ļ	ı
ļ	facility at dialysis.				ļ	ı
	la company					ı
		ent #7 on 03/07/19 at 8:34am				ı
	revealed:					ı
		and constantly had nerve				ı
	pain.					ı
	-The gabapentin was	ordered four times daily for				ı
	the pain.					ı
	-The gabapentin was	scheduled four times a day,				ı
	but was not administe	ered four times a day on				ı
	Monday Wednesday	and Friday.				ı
		t 11:00am for dialysis and				ı
	_	I gabapentin at 12;00pm.				1
		from dialysis after 5:00pm				ı
	she was not administ	* · · · · · · · · · · · · · · · · · · ·				I
		eant she had to wait until				1
						1
		edication to help with pain.				I
		could have the 12:00pm				ı
	gabapentin because i	it would help with her pain.				1
	1					I

Division of Health Service Regulation

3:05pm revealed:

Interview with a first shift MA on 03/07/19 at

STATE FORM 6899 1HE211 If continuation sheet 66 of 109

Division of	<u>of Health Service Regu</u>	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			B. WING		R	
		HAL034098	B. WING		03/08/	2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE		SALEM, NC 2			
			JALEWI, NC 2			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
ind		,	IAG	DEFICIENCY)		
					<del></del>	
D 344	Continued From page	e 66	D 344			
	-Resident #7 went to	dialysis and was not				
	administered the 12:0					
	-She had not conside					
		early at 11:00am before the				
		•				
	resident left for dialys					
		ed Resident #7's physician				
		was not administered at				
	12:00pm due to the re	esident being at dialysis.				
	Intonvious with the BC	C on 03/08/19 at 8:43am				
		C 011 03/06/19 at 6.43a11				
	revealed:	dialysis three days nonyyout				
		dialysis three days per week				
	(Monday, Wednesday	• • • • • • • • • • • • • • • • • • • •				
		take the gabapentin with her				
		because there was no one				
	there to administer th	e medications to the				
	resident.					
	-The MA was respons					
		arification how to administer				
		ys the resident out of the				
	facility at dialysis.					
		tanton on 00/00/40 40:40:				
	revealed:	strator on 03/08/19 12:48pm				
		contacted the physician and				
		contacted the physician and				
		ent #7 was not administered				
	gabapentin.	1.5				
		at Resident #7 was not				
		s ordered because she was				
	going to dialysis.					
	Intonious with the	roo at Dagidant #7's primary				
		rse at Resident #7's primary				
		P) office on 03/08/19 at				
	2:45pm revealed:	ad archamantia farratia				
		ed gabapentin four times				
	_	w the medication was not				
	administered as orde					
		uld be administered before				
	the resident went to d					
	-If the facility had con	tact the physician the				

STATE FORM 6899 1HE211 If continuation sheet 67 of 109

DIVISION	of Health Service Regu	ilation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED	
					-	,	
		UAL 024009	B. WING		F		
		HAL034098			03/0	08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
		2609 OLD	SALISBURY R	OAD			
SALEM T	ERRACE		SALEM, NC 2				
	CUMMADY CT						
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE	
				DEFICIENCY)			
D 344	Continued From page	a 67	D 344				
D 011	Continued i Tom page	5 01	5044				
		uld have been changed to					
	accommodate the dialysis schedule.						
		ated 06/27/18 revealed a					
		midodrine hcl (used to lower					
	blood pressure) 5mg	three times daily after					
	meals.						
		7's record revealed a					
		et signed by the physician					
		ers for midodrine hcl 5mg					
	three times daily after	r meals.					
		(T) D					
		7's December 2018 eMAR					
	revealed:						
		entry for midodrine hcl 5mg					
	_	r meals was scheduled for					
	9:00am, 1:00pm, and						
		tation midodrine hcl 5mg					
		I seventeen times on the					
	9	o the resident being at 1:00pm, 12/03/18 at 1:00pm,					
	,	•					
	12/05/18 at 1:00pm,	•					
	12/12/18 at 1:00pm, 12/17/18 at 1:00pm, 1						
	1 /	' '					
		12/23/18 at 1:00pm and					
	T	1:00pm, 12/25/19 at 6:00pm,					
		and 1:00pm, 12/28/18 at					
	1:00pm, 12/31/18 at	nentation the physician had					
		y how to administer the					
	,	the resident was out of the					
	facility at dialysis.	the resident was out of the					
	idollity at ulalysis.						
	Review of Resident #	7's January 2019 eMAR					
	revealed:	7 5 Garidary 2019 GWAIN					
		entry for midodrine hcl 5mg					
		r meals was scheduled for					
	9:00am, 1:00pm, and						
		tation midodrine hcl 5mg					
			1	į		1	

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 68 of 109

Division o	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
			_			_
			B. WING			₹
		HAL034098	D. WING		03/0	08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLF	SALISBURY R	DAD.		
SALEM TE	RRACE		N SALEM, NC 2			
			TOALLIN, NO 2			1
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR		DATE
				DEFICIENCY)		
D 044	0 " 15	00	D 044			
D 344	Continued From page	e 68	D 344			
	was not administered	sixteen times on the				
		the resident being at				
	•	1:00pm, 01/04/19 at 1:00pm,				
	01/07/19 at 1:00pm, (	• • •				
	•	nd at 6:00pm, 01/14/19 at				
	•	1:00pm, 01/18/19 at 1:00pm,				
	01/21/19 at 1:00pm, (	•				
	01/25/19 at 1:00pm, (	•				
	•	and 01/30/19 at 1:00pm,				
		and 01/30/19 at 1.00pm and				
	6:00pm.	contation the physician had				
		nentation the physician had				
		y how to administer the				
		the resident was out of the				
	facility at dialysis					
	D	571- F-1				
	review of Resident #	7's February 2019 eMAR				
		entry for midodrine hcl 5mg				
		r meals was scheduled for				
	9:00am, 1:00pm, and					
		tation midodrine hcl 5mg				
	was not administered	S .				
		the resident being at				
	dialysis: 02/01/19 at 1	•				
	•	and 1:00pm, 02/06/19 at				
		1:00pm, 02/11/19 at 1:00pm,				
	02/13/19 at 1:00pm, (					
	02/18/19 at 1:00pm, (					
		02/25/19 at 1:00pm, and				
	02/27/19 at 1:00pm, 02/27/19 at 1:00pm.	02/25/19 at 1:00pm, and				
	•	nentation the physician had				
		y how to administer the				
		the resident was out of the				
	facility at dialysis					
	Peview of Posidont #	7's March 2019 eMAR				
	review of Resident #	1 5 Maich 2019 EMAR				
		ontry for midodrine half-ma				
		entry for midodrine hcl 5mg				
	unee umes daily atter	r meals was scheduled for				

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9:00am, 1:00pm, and 6:00pm.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		HAI 024000	B. WING		R	1/0040
		HAL034098			03/00	3/2019
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SALEM TE	ERRACE		SALISBURY R			
			I SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	e 69	D 344			
	-There was document was not administered dates due to the residual of the resi	tation midodrine hcl 5mg three times on the following lent being at dialysis: nd 6:00pm, and 03/04/19 at nentation the physician had y how to administer the he resident was out of the  nt #7 on 03/07/19 at 8:34am three days per week and wered her blood pressure				
	3:05pm revealed: -Midodrine was not at on Monday, Wedneso-She circled her initial documented the residual physically unable to tashe documented phymedication because to in the facilityShe had not contacte to inform midodrine was not accordance of the statement of the stateme	lent was out of the facility or				
	office on 03/07/19 at -The physician knew	Resident #7 went to dialysis , and Friday, but did not				

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midodrine.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY	
						R
		HAL034098	B. WING		03	/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
SALEM T	ERRACE	2609 OLD	SALISBURY RO	OAD		
		WINSTON	N SALEM, NC 27	127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	e 70	D 344			
	-The medication sho Resident #7 was ser	uld be administered anytime ved a meal or snack.				
		ated 06/27/18 revealed a tylenol 500mg every eight				
	physician's order she	#7's record revealed a et signed by the physician ers for tylenol 500mg every				
	revealed: -There was an order every eight hours wa 2:00pm, and 10:00pr -There was documer administered twenty-dialysis dates due to dialysis: 12/02/18 at 12/05/18 at 2:00pm, 10:00pm, 12/09/18 a 10:00pm, 12/11/18 at 2:00pm and 10:00pm, 12/21/18 at 2:00pm, at 10:00pm, 12/26/18 2:00pm, 12/29/18 at 10:00pm, and 12/31/-There was no docur been notified to clarif	ntation tylenol 500mg was not one times on the following the resident being at 2:00pm, 12/03/18 at 2:00pm, 12/07/18 at 2:00pm and to 10:00pm, 12/10/18 at 10:00pm, 12/12/18 at 10:00pm, 12/12/18 at 10:23/18 at 2:00pm, 12/23/18 at 2:00pm, 12/24/18 at 2:00pm, 12/23/18 at 2:00pm, 12/28/18 at 10:00pm, 12/30/18 at				
	Review of Resident # revealed: -There was an order	#7's January 2019 eMAR entry for tylenol 500mg s scheduled at 6:00am,				

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2:00pm, and 10:00pm.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	or dortheorion	BENTH IGATION NOWBER.	A. BUILDING: _		OOWII EI	LILD
		HAI 024000	B. WING		R 02/0	
		HAL034098			1 03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•		
SALEM T	ERRACE		SALISBURY R SALEM, NC 2			
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	J	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	e 71	D 344			
	-There was documen	tation tylenol 500mg was not				
		een times on the following				
	dialysis dates due to	the resident being at 2:00pm, 01/03/19 at 6:00am,				
	01/04/19 at 2:00pm, (	•				
	01/09/19 at 2:00pm, (					
	01/14/19 at 2:00pm, 0					
		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.					
		nentation the physician had				
		y how to administer the				
		the resident was out of the				
	facility at dialysis.					
	Review of Resident # revealed:	7's February 2019 eMAR				
	-There was an order	entry for tylenol 500mg				
	every eight hours was 2:00pm, and 10:00pm	s scheduled at 6:00am,				
		tation tylenol 500mg was not				
		imes on the following dates				
		eing at dialysis: 02/01/19 at				
	· ·	i, 02/02/19 at 2:00am,				
	02/04/19 at 2:00pm, (02/08/19 at 2:00pm, (	•				
	02/13/19 at 2:00pm, 0					
		02/22/19 at 2:00pm, and				
	02/25/19 at 2:00pm.					
		nentation the physician had			ĺ	
		y how to administer the the resident was out of the			ĺ	
	facility at dialysis.	and resident was out of the				
		7's March 2019 eMAR				
	revealed: -There was an order	entry for tylenol 500mg			ĺ	
		s scheduled at 6:00am,				

Division of Health Service Regulation

2:00pm, and 10:00pm.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING		 	,
		HAL034098	B. WING		ı	8/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
			SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	272	D 344			
	-There was document administered two time due to the resident be 2:00pm and 03/04/19 -There was no documbeen notified to clarify medication because to facility at dialysis.  Interview with Reside revealed: -On dialysis days she TylenolShe wished that did ywas constantly in pair Interview with a first some 3:05pm revealed: -When the resident was administered her 2:00 -She had not contacted to inform Tylenol was times daily as ordered Interview with the nur office 03/08/19 at 2:45 -The physician knew Monday, Wednesday know the resident was medication as ordered -Had the facility staff of have been changed to	tation tylenol 500mg was not es on the following dates sing at dialysis: 03/01/19 at at 2:00am. Identation the physician had by how to administer the he resident was out of the he resident was at dialysis she was not high Tylenol for pain. He resident #7's physician not administered three dialysis and Friday, but did not so not administered dialysis called the medication could be accommodate the				
	physician's order for r	ted 06/27/18 revealed a refresh tears 0.5% (used to rness and discomfort) eye				

Division of Health Service Regulation

Review of Resident #7's record revealed a

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Division of	of Health Service Regu	lation			TORWIATT	TOVED
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
		HAL034098	B. WING		R 03/08/201	9
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	SALEM TERRACE 2609 OL					
WINSTON			SALEM, NC 2	7127		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLETE DATE
D 344	Continued From page	e 73	D 344			
	on 12/04/18 with orde	et signed by the physician ers for refresh tears 0.5%				
		7's December 2018 eMAR				
		entry for refresh eye drops				
	four times daily sched 4:00pm, and 8:00pm.	duled at 8:00am, 12:00pm,				
		tation refresh eye drops was teen times on the following				
	dates due to the resid	<u> </u>				
	12/05/18 at 12:00pm,	12/07/18 at 12:00pm,				
	12/11/18 at 4:00pm, 1 12/14/18 at 12:00pm,	12/12/18 at 12:00pm, 12/17/18 at 12:00pm,				
	•	12/21/18 at 12:00pm, 12/26/18 at 12:00pm,				
	12/28/18 at 12:00pm,	and 12/31/19 at 12:00pm.				
	been notified to clarify	nentation the physician had you how to administer the				
	medication because t facility at dialysis.	he resident was out of the				
	Review of Resident #	7's January 2019 eMAR				
	-There was an order	entry for refresh eye drops duled at 8:00am, 12:00pm,				
	4:00pm, and 8:00pm.					
	not administered sixte	een times on the following				
	dates due to the resid					

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, 01/28/19 at 12:00pm, and 01/30/19 at 12:00pm.

STATE FORM 6899 1HE211 If continuation sheet 74 of 109

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R	
		HAL034098	B. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE	2609 OLD	SALISBURY R	OAD		
OALLIN II	WINSTON			7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
D 344	Continued From page	e 74	D 344			
	-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.					
	revealed: -There was an order four times daily sched 4:00pm, and 8:00pmThere was documen not administered fifte dates due to the resid 02/01/19 at 12:00pm 8:00am and 12:00pm, 02/08/19 at 12:00pm, 02/13/19 at 12:00pm, 02/16/19 at 8:00am, 02/20/19 at 12:00pm, 02/25/19 at 12:00pm	tation refresh eye drops was en times on the following dent being at dialysis: and 4:00pm, 02/04/19 at 1, 02/06/19 at 12:00pm, 02/11/19 at 12:00pm, 02/15/19 at 12:00pm, 02/22/19 at 12:00pm, and 02/27/19 at 12:00pm. nentation the physician had				
	-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					

Division of Health Service Regulation

facility at dialysis.

STATE FORM 6899 1HE211 If continuation sheet 75 of 109

Division of	of Health Service Regu	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETI	ED
					R	
		HAL034098	B. WING		03/08/	2010
		11AE034090			1 03/06/	2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
041 514 55		2609 OLD	SALISBURY RO	OAD		
SALEM TE	ERRACE	WINSTON	I SALEM, NC 27	7127		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
	<del> </del>		+	,		
D 344	Continued From page	e 75	D 344			
	Observation of Resid	ent #7's medications on				
	hand at the facility on					
	revealed:	103/01/10 at 3.34am				
	-Refresh tears were r	not available for				
	administration.	iot available lei				
		ed ordering the eye drops on				
	03/07/19 at 9:40am.	<b>Ju 0.0</b> 2 <b>3</b> 2, 2 2, 2 2, 2				
		howed the eye drop was				
	lasted ordered on 01/					
	Interview with Reside	ent #7 on 03/07/19 at 8:34am				
	revealed:					
		stered refresh eye drops.				
		not been administered for				
	the past three months					
	-She thought the med	dication had been				
	discontinued.					
		administered refresh eye				
		ecause sometimes her eyes				
	were dry and became					
	•	why she did not get the				
	medication, but thoug	ght it had been discontinued.				
	Interview with a first s	shift MA on 03/07/19 at				
	8:38am revealed:	SHIIL WA OH OS/OF 15 at				
		not on the medication cart.				
		e last dose this morning				
		the medication bottle away.				
		,				
	Interview with the pha	armacist at the contact				
	pharmacy on 03/07/1	9 at 10:12am revealed:				
	-Refresh eye drop wa	as last dispensed on				
	01/21/19.					
	-One bottle of refresh	tears would last "roughly"				
	around six weeks.					
	Interview with the nur	rse at Resident #7's Primary				

revealed:

Care Physician's office 03/08/19 at 2:45pm

STATE FORM 6899 1HE211 If continuation sheet 76 of 109

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					<sub>D</sub>
		1141 024000	B. WING		R
		HAL034098	B. Wille		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM TE	ERRACE		SALEM, NC 2		
		WINSTON	JALEWI, NC 2	1121	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
1710		,	1,710	DEFICIENCY)	
D 344	Continued From page	e 76	D 344		
	The physician did no	t know that Resident #7 did			
	not receive refresh ey				
	-There was no order f				
		to discontinue the			
	medication.	contation the facility staff had			
		nentation the facility staff had			
		n the medication was not			
	administered when th	e resident went to dialysis.			
		sident Care Coordinator on			
	03/08/19 at 8:43am re				
		dialysis three days per week			
	_	the physician had not been			
		vas not administered refresh			
	tears when at dialysis				
		ne medication cart and			
	eMARs every Monday				
		ere not on the cart she			
	would have re-ordere	·			
	<ul> <li>She did not specifica</li> </ul>	ally remember if she had			
	observed Resident #7	7's refresh tears on the			
	medication cart.				
	Interview with the Adr	ministrator on 03/08/19 at			
	12:48pm revealed:				
	-The MAs should hav	e followed-up with Resident			
	#7's physician when t	he resident was not			
	administered refresh	tears.			
	-No resident should re	un out of a medication.			
	-The RCC and MAs fi	requently did audits of the			
		aring medications on hand			
	to the eMARs.				
	-She did not know if Resident #7 was				
	administered refresh				
	2. Review of Residen	t #6's current FL2 dated			
	02/14/19 revealed dia				
		i, end state renal failure			
	hypertension and dial				
		or sevelamer carbonate			
	ripiny siciality of delile	or obvolution ourboliate	1	1	1

Division of Health Service Regulation

(renvela) 800mg two capsules (1600mg) twice

STATE FORM 6899 1HE211 If continuation sheet 77 of 109

DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		_
			D WING		R
		HAL034098	B. WING	<del></del>	03/08/2019
	20,4252 02 0422452	070557.40		TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	EDDACE	2609 OLD	SALISBURY R	DAD	
SALEW II	ERRACE	WINSTON	I SALEM, NC 2	7127	
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	I.D.	PROVIDER'S PLAN OF CORRECTION	V (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( )
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 344	Continued From page	<del>2</del> 77	D 344		
	1.9				
		d to control phosphorus			
		an's order for sevelamer			
	800mg three capsules	s (3200mg) three times daily			
	with meals.				
	Review of Resident #	6's December 2018			
		Administration Record			
		7 diffinistration (Coola			
	(eMAR) revealed:				
	-There was an order e				
	_	ee capsules with meals			
	(3200mg) three times	-			
	scheduled for 8:00am	ı, 12:00pm, 5:00pm.			
	-A second entry for se	evelamer carbonate 800mg			
	-	g) two times daily with			
	snacks.	g,eee ca,a.			
		tation sevelamer carbonate			
		twenty-two times on the			
	•	the resident being at			
	dialysis: 12/07/18 at 1				
	•	12/19/18 at 12:00pm and			
	2:00pm, 12/20/19 at 5	5:00pm, 12/21/18 at			
	12:00pm and 2:00pm	, 12/23/18 at 10:00am and			
	2:00pm, 12/24/18 at 1	10:00am. 12/26/18 at			
	• •	, 12/28/18 at 10:00am,			
	·	. and 12/31/18 at 10:00am.			
		,			
		d 12/31/18 at 5:00pm.			
		nentation the physician had			
		y how to administer the			
		he resident was out of the			
	facility at dialysis.				
	Review of Resident #	7's January 2019 eMAR			
	revealed:	•			
	-There was an order	entry for sevelamer			
	_	ee capsules with meals			
		daily with meals was			
	scheduled for 8:00am				
	-A second entry for se	evelamer carbonate 800mg			

Division of Health Service Regulation

snacks.

two capsules (1600mg) two times daily with

STATE FORM 6899 1HE211 If continuation sheet 78 of 109

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034098	B. WING		R 03/08/2019	
		HAL034090			03/06/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
CALEME	DDACE	2609 OLI	SALISBURY R	OAD		
SALEM TE	RRACE	WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	$\overline{}$
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JAIE DAIE	
				,		
D 344	Continued From page	e 78	D 344			
	-There was documen	tation sevelamer carbonate				
		thirty times on the following				
	dates due to the resid					
		01/04/19 at 12:00pm and				
	•	10:00am, 2:00pm, and				
	•	12:00pm and 2:00pm,				
	• '	d 12:00pm, 01/14/19 at				
		nd 2:00pm, 01/16/19 at				
		nd 2:00pm, 01/18/19 at				
	·	ind 2:00pm, 01/21/19 at				
		ind 2:00pm, 01/23/19 at				
	•	ind 2:00pm, 01/25/19 at				
	10:00am, 12:00pm, 2	•				
	•	and 2:00pm, 01/29/18 at				
		, and 01/30/19 at 10:00am,				
	12:00pm and 2:00pm					
		nentation the physician had				
		y how to administer the				
		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 thre	ee capsules with meals				
		daily with meals was				
	scheduled for 8:00am	• •				
	_	evelamer carbonate 800mg				
		g) two times daily with				
	snacks.					
		tation sevelamer carbonate				
		thirty-two times on the				
	•	the resident being at				
	dialysis: 02/01/19 at 1	•				
		02/04/19 at 12:00pm and				
	2:00pm, 02/05/19 at 2					
		, 02/08/19 at 10:00am,				
		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,

STATE FORM 6899 If continuation sheet 79 of 109 1HE211

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _		_	
		HAL034098	B. WING		R 03/08	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE		SALISBURY R			
	OUR MARK OT		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	<del>2</del> 79	D 344			
D 344	02/18/19 12:00pm and 2:00pm, 02/20/18 at 2 12:00pm and 2:00pm, 02/22/19 at 12:00pm, 02/25/19 at 12:00pm, 12/27/19 at 12:00pm -There was no documbeen notified to clarify medication because to facility at dialysis.  Review of Resident # revealed: -There was an order of carbonate 800mg three (3200mg) three times scheduled for 8:00am -A second entry for set two capsules (1600m snacksThere was document was not administered dates due the resider at 12:00pm and 2:00pm, 03/04/18 03/06/18 at 12:00pm, 2:00pmThere was no documbeen notified to clarify	d 2:00pm, 02/19/18 at 2:00pm, 02/21/19 at , 02/21/19 at 2:00pm, and 5:00pm, 2:00pm, and 5:00pm, and 2:00pm.  nentation the physician had y how to administer the he resident was out of the 7's March 2019 eMAR entry for sevelamer ee capsules with meals daily with meals was	D 344			
	Based on observation	n, interview and record ned Resident #6 was not				
	#6's Nephrologist officerevealed:	vith the nurse at Resident ce on 03/08/19 at 1:10pm Resident #6 had dialysis,				

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				_	R
		HAL034098	B. WING	B. WING	
			DE00 0171/ 074	TE 7/2 0025	03/08/2019
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA		
SALEM TI	SALEM TERRACE 2609 OLD				
	Г	WINSTON	SALEM, NC 2	/12/	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 80	D 344		
	but did not know sever administered as order -The medication shouthe resident consume -The physician did no not being administere -The facility staff shoud discuss the administration what to do when the rule of the could have controlled the could have controlled administration or decidity staff, but no or informed her that Resmedications due to the -She could have controlled -The medications due to the -She could have controlled -The medications due to the -She could have controlled -The medication staff, but no or informed her that Resmedications due to the -She could have controlled -The medication staff, but no or informed her that Resmedications due to the -She could have controlled -The medication staff.	elamer carbonate was not red.  Ild be administered anytime and food that included snacks. It know the medication was and as ordered.  Ild notify the physician to action of the medication, and resident was at dialysis.  In at 2:40pm with Resident by revealed:  Int #6 was getting all the action and resident #6 missed			
	(MCC) on 03/08/19 ar -She knew that Resid did not get medication -Resident #6 was give but there was no way medications orderedShe had not notified regarding the residen scheduled three times Monday, Wednesday resident was at dialys Interview the Adminis revealed:	lent #6 went to dialysis and his as ordered. en a snack when at dialysis, to give the resident  Resident #6's Nephrologist to not getting medications is, but not administered on and Fridays when the sis.  trator on 03/08/19 12:48pm  As to notify the physician			

Division of Health Service Regulation

medications as ordered.

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Division of	Division of Health Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED		
					R			
		HAL034098	B. WING		1	8/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE. ZIP CODE				
			D SALISBURY RO					
SALEM TERRACE WINSTON		N SALEM, NC 27						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	OULD BE COMPLETE			
D 344	Continued From page	e 81	D 344					
	-The MAs should hav	e obtained orders from the medications ordered when						
D 358	3 10A NCAC 13F .1004(a) Medication Administration		D 358					
	This Rule is not met Based on observation reviews, the facility fa	ns, interviews, and record						

(#4).

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

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_		_	
			D MINO		R	
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
			, ,	,		
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JAIL	DATE.
				,		
D 358	Continued From page	e 82	D 358			
	1 0					
	The findings are:					
		rate was 13% as evidenced				
	-	opportunities observed				
	during the 8:00 am m	edication pass on 03/05/19.				
	<ol> <li>Review of Residen</li> </ol>	t #1's current FL2 dated				
	04/18/18 revealed:					
	-Diagnoses included	bipolar disorder, type II				
	diabetes, hypothyroid	, gastroesophageal reflux				
		deficiency, hypertension,				
	and congestive heart					
	•	x (used to treat seizures or				
	migraines) 50mg twic	The state of the s				
	migrames, comg two	o a day.				
	Observation of the 8:0	00am medication pass on				
	03/05/19 revealed:	obain medication pass on				
		#1 was administered four				
		#1 was administered four				
	•	ne medication aide (MA).				
		x was not administered on				
	03/05/19.					
		41.14. 1.0040 1.4.				
		1's March 2019 electronic				
	medication administra	ation record (eMAR)				
	revealed:					
		e a day and scheduled for				
	administration at 8:00	am and 8:00pm.				
	-The medication was	documented as				
	administered.					,
	Review of Resident #	1's medication on hand for				
	administration on 03/0	05/19 at 1:11pm revealed				,
		available for administration.				,
						,
	Interview with the me	dication aide (MA)				,
		nt #1's medications on				
	03/05/19 at 5:00pm re					
		tered medications since				

Division of Health Service Regulation

December 2018.

STATE FORM 6899 1HE211 If continuation sheet 83 of 109

DIVISION	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	TED
		1141 00 4000	B. WING		R	(00.40
		HAL034098			03/08	/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLF	SALISBURY RO	<b>ΠΑ</b> Π		
SALEM TE	ERRACE		N SALEM, NC 27			
			T SALLIVI, NO 21			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From page	e 83	D 358			
	-She compared the el	MAR to the medications				
		cation cart and pulled the				
	medications due to ac					
		vailable on the medication				
	cart.	valiable of the medication				
		ooked the Topamax when				
	pulling the medication					
	pulling the medication	is to be administered.				
	Interview with Peside	nt #1 on 03/08/10 at 2:36nm				
	Interview with Resident #1 on 03/08/19 at 2:36pm revealed:					
		rescribed Topamax but did				
		red the Topamax during the				
	morning medication p					
	-She did not know wh	y trie Topamax was				
	prescribed.					
	Interview with a repre	sentative from the facility				
		on 03/05/19 at 4:20pm				
	revealed:	011 03/03/19 at 4.20pm				
	-She provided educat	ion regarding the				
		the eMAR system for staff				
	at the facility.	the emait system for stall				
	•	t to compare the medication				
	labels to the eMAR.	to compare the medication				
		spensed 02/25/19 for 60				
	tablets.	3pended 02/23/10 for 00				
	tableto.					
	Interview with the Res	sident Care Coordinator				
	(RCC) on 03/08/19 at					
	` ,	s to compare the eMAR to				
	the medication labels					
	medications due for the					
		d the directions carefully to				
	assure the medication					
	-If Resident #1 was no	•				
		nould have documented not				
		iodia navo accumentos not				
	given on the eMAR.					

Division of Health Service Regulation

2:50pm revealed:

Interview with the Administrator on 03/08/19 at

STATE FORM 6899 1HE211 If continuation sheet 84 of 109

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE S	LIDVEV.
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPLE	
			A. BUILDING:			
					R	
		HAL034098	B. WING		03/0	8/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDER OR SOLT LIER		, ,	,		
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	/12/		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
		,		DEFICIENCY)		
D 250	O	- 04	D 358			
D 358	Continued From page	2 84	D 356			
	-The MAs were expec	cted to administer the				
	medications due on the	neir shift.				
	-MAs should compare	e the eMAR to the				
	medication label on the	ne bubble pack or the bottle				
	and follow directions	for medication				
	administration.					
	-The MA should have	administered all				
	medications to Reside	ent #1 during the morning				
	medication pass on 0	3/05/19 as ordered.				
		nt #1's primary care provider				
	(PCP) on 03/06/19 at	The state of the s				
		administer medications as				
	ordered.					
		Resident #1 did not receive				
	Topamax during the r 03/05/19.	norning medication pass on				
	-She was concerned	staff were not administering				
	medications as ordered					
		ned Resident #1 missed one				
	dose of Topamax.					
	2. Daview of Decider	at #Ola augustat ELO datad				
		nt #8's current FL2 dated				
		agnoses included atrial artery disease, chronic				
	•	y disease, heart failure,				
		ovascular accident, seizures,				
	and glaucoma.	ovasculai accident, seizures,				
	ana gladooma.					
	a. Review of Residen	t #8's current FL2 dated				
		order for dorzolamide 2%				
		essure behind the eye due to				
	` .	drop into the right eye three				
	times a day.					
	•					
		00am medication pass on				
	03/05/19 revealed:					
		#8 was administered four				
		ne medication aide (MA).				
	-Dorzolamide 2%, on	e drop was administered to				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 85 of 109

DIVISION	of Health Service Regu	1811011 1			T
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAI 024000	B. WING		
		HAL034098			03/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OI F	SALISBURY R	DAD	
SALEM TE	ERRACE				
		WINSTOR	SALEM, NC 2	7127	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(* /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
IAG	REGOEMONT ON E	DEIVIN TING IN GIAWATION,	TAG	DEFICIENCY)	W. (1) E
D 358	Continued From page	e 85	D 358		
	both eyes.				
		8's March 2019 electronic			
	medication administra	ation record (eMAR)			
	revealed:				
	-An entry for dorzolan	nide 2% instill one drop into			
	the right eye three tim	nes a day for 30 days and			
	scheduled for adminis	stration at 8:00am, 2:00pm,			
	and 8:00pm.				
	-The medication was	documented as			
	administered on 03/0				
	Observation of Reside	ent #8's medication on hand			
		03/05/19 at 8:50am revealed			
	dorzolamide 2%.	ooroor to at o.ooani revealed			
	doizolamide 270.				
	Interview with the me	dication aide (MA)			
		nt #8's medications on			
	03/05/19 at 1:58pm re				
	-	administer Resident #8's			
	medications.				
	-She thought the dorz				
	administered in both	•			
	-She compared the do				
		e eMAR but thought the			
	dorzolamide was to b	e administered in both eyes.			
		nt #8 on 03/05/19 at 2:12			
	pm revealed:				
		upposed to get dorzolamide			
	in both eyes.				
		was always administered in			
	both eyes.				
	-He did not know why	he was ordered			
	dorzolamide.				
	Interview with a repre	sentative from the facility			
		on 03/05/19 at 4:20pm			

Division of Health Service Regulation

revealed:

-She educated staff to compare the eMAR to the

STATE FORM 6899 1HE211 If continuation sheet 86 of 109

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		HAL034098	B. WING		R 03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE		SALISBURY R			
	I		N SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 86	D 358			
	medication labelsShe educated staff to eMAR and medication	o follow directions on the n label.				
	(RCC) on 03/08/19 at -She expected the M/Resident #8's medicathe medications due f -The MAs should read assure the medication -The MA should have the directions.	A to compare the eMAR to tion labels and administer for their shift. If the directions carefully to a is given correctly. If administered according to ministrator on 03/08/19 at				
	medications due on the -MAs should compare medication label on the and follow directions that administration.	e the eMAR to the ne bubble pack or the bottle				
		interview with Resident #8's on 03/08/19 at 2:00pm was				
	dated 01/04/19 revea 100,000 ointment (use	t #8's physician orders led an order for nystatin ed to treat antifungal cally to penis two times a day				
	03/05/19 revealed: -At 8:50am Resident:	00am medication pass on #8 was administered four ne medication aide (MA). as not administered.				

Division of Health Service Regulation

Review of Resident #8's March 2019 electronic

STATE FORM 6899 1HE211 If continuation sheet 87 of 109

Division of	of Health Service Regu	ulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	₹
		HAL034098	B. WING		03/0	08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	ATE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	N SALEM, NC 2	7127		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 87	D 358			
	medication administra					
	revealed:	AUDIT IECOTA (EINIMIN)				
		100,000 ointment apply				
		time a day until healed and				
		stration at 8:00am and				
	8:00pmThe medication was	not documented as				
	administered on 03/0					
		ent #8's medication on hand				
	for administration on (	03/05/19 at 1:11pm				
	revealed: -Two tubes of nystatir	n was available for				
	administration.	I was available to				
	-Both nystatin tubes v	were half full.				
		dia-tia- aida (MA)				
	Interview with the me	nt #8's medications on				
	03/05/19 at 1:58pm re					
		administer medications for				
	Resident #8.					
		the morning med pass and				
	administered the nyst	tatin ointment. It was not kept on the				
	,	is kept on the treatment cart.				
	, , , , , ,					
		ent #8 on 03/05/19 at 2:12				
	pm revealed:					
	-He denied receiving 03/05/19.	nystatin ointment on				
		was ordered the nystatin				
	ointment or what it wa					
	-He denied ever recei	iving the nystatin ointment.				

as ordered.

Interview with Resident #8's primary care provider

-She expected the resident to receive the nystatin

-Not receiving the nystatin ointment as ordered

(PCP) on 03/08/19 at 1:03 pm revealed:

could cause delayed healing.

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Division o	of Health Service Regu	liation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			B. WING		R	
		HAL034098	B. WING		03/0	8/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE		SALEM, NC 2			
		WINSTON	JALEWI, NC 2	1121		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		DATE
1,10		,	17.0	DEFICIENCY)		
D 358	Continued From page	e 88	D 358			
	The facility had not n	notified her the nystatin was				
	not administered as o					
		aff to notify her of the missed				
	nystatin.					
	Interview with a repre	scentative from the facility				
		esentative from the facility				
		on 03/05/19 at 4:20pm				
	revealed:					
	-She provided educat					
		the eMAR system for staff.				
	•	t to always compare the				
	eMAR to the medicati					
		nt was dispensed on 01//4/19				
	for 30 grams and 02/	11/19 for 30 grams.				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 03/08/19 at	t 9:20am revealed she				
	expected the MA to c	ompare the eMAR to				
	Resident #8's medica	ation labels and administer				
	the medications due f	for their shift.				
	Interview with the Adr	ministrator on 03/08/19 at				
	2:50pm revealed:					
	-The MAs were exped	cted to administer the				
	medications due on the					
	-MAs should compare					
		he bubble pack or the bottle				
	and follow directions	•				
	administration.	ioi modication				
	aariii ilottatiori.					
	3 Review of Residen	it #9's current FL2 dated				
	04/04/18 revealed:	it no o carrent i LL dated				
	-The diagnoses include	ded hypertension				
		hage, epilepsy, general				
	muscle weakness, an					
		for alphagan 0.2% (used to				
	-	l one drop into the right eye				
	three times a day.					

Division of Health Service Regulation

Observation of the 8:00am medication pass on

STATE FORM 6899 1HE211 If continuation sheet 89 of 109

DIVISION	n nealth Service Regu	iialion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	:IED
			B. WING		R	
		HAL034098	B. WING		03/0	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OI F	SALISBURY R	OAD		
SALEM TE	ERRACE		SALEM, NC 2			
		WINSTON	SALEIVI, NC 2	1121	Т	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG	NEODEMONT ON	EGG IDEITH THICK IN GIAW, MIGHY	TAG	DEFICIENCY)		
			+			
D 358	Continued From page	e 89	D 358			
	03/05/19 revealed:					
		#0 a desiriata and faces				
		#8 was administered four				
	<del>_</del>	he medication aide (MA).				
	-Alphagan was not ac	dministered or offered.				
	D : (D :: , "	101 14 1 0040 1 4				
		9's March 2019 electronic				
	medication administra	ation record (eMAR)				
	revealed:					
		n 0.2% instill one drop in				
		a day and scheduled for				
	administration at 8:00	am and 8:00pm.				
	-The medication was	not documented as				
	administered on 03/0	5/19.				
		ent #9's medication on hand				
	for administration on	03/05/19 at 1:11pm revealed				
	alphagan 0.2% was a	available for administration				
	Interview with the me	dication aide (MA)				
	administering Reside	nt #9's medications on				
	03/05/19 at 1:58pm re	evealed:				
		administer Resident #9's				
	medications.					
		ly the medications due on				
	her shift.					
		MAR to the medications				
	available on the cart.					
		refused alphagan eye drops.				
	1 tooldont #o diways i	. c.acca aipriagari cyc arops.				
	Interview with Reside	ent #9 on 03/05/19 at 2:07				
	pm revealed:	on oo, oo, 13 at 2.01				
		ered eye drops during the				
	8:00 am medication p	· · · · · · · · · · · · · · · · · · ·				
		e drops during the morning				
	medication pass on 0					
	-He never refused his	s eye drops.				
		esentative from the facility				
	contracted pharmacy	on 03/05/19 at 4:20pm				

Division of Health Service Regulation

revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. DOILDING		R
		HAL034098	B. WING		03/08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
SALEM TE	ERRACE	2609 OLD	SALISBURY RO	DAD	
OALLIN II		WINSTOI	N SALEM, NC 27	127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	90	D 358		
	staffThe staff were taugh the medication labels -Alphagan was last dimilliliter bottle.  Interview with the Res (RCC) on 03/08/19 at -She expected all MA the medication labels medications due for the MAs should read assure the medication -Resident #9 often resident #9 often resident #9 refuse medication pass; the medication was not as	the eMAR system for the  t to compare the eMAR to spensed 02/08/19 for 10  sident Care Coordinator 9:20am revealed: s to compare the eMAR to and administer the heir shift. d the directions carefully to n was given correctly. fuse medications. A to attempt to administer  ad the alphagan during the MA should document the dministered on the eMAR			
	and provide a reason administered.	the medication was not			
	2:50pm revealed: -The MAs were expect medications due on the -MAs should compare medication label on the and follow directions that administrationThe MA should have medications due for Felf Resident #9 refuse medication pass; the	neir shift.  The the eMAR to the set the eMAR to the bubble pack or the bottle for medication  attempted to administer all Resident #9.  The difference of the eligible of the			

Division of Health Service Regulation

-The MA was also expected to document a reason the medication was not administered.

STATE FORM 6899 1HE211 If continuation sheet 91 of 109

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL034098	B. WING		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	
TO WILL OF T	NOVIDEN ON OUT FIELD		SALISBURY R	,	
SALEM T	ERRACE		SALISBURT R		
	OUR MAR DV OT		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	91	D 358		
	Interview with Reside (PCP) on 03/06/19 at -Resident #9 was pre to glaucomaHe expected staff to orderedHe was not notified F the alphagan 0.2% ey medication pass on 0 -He was at the facility -He was not concerne administered alphaga morning medication p  4. Review of Residen 06/27/18 revealed: -Diagnoses included type two diabetes, ne	nt #9's primary care provider 2:00pm revealed: scribed alphagan 0.2% due administer medications as Resident #9 did not receive ye drops during the morning 3/05/19. y once a week. ed Resident #9 was not an 0.2% eye drops during the pass.  t #7's current FL2 dated end stage renal disease,			
	(fast-acting insulin to sliding scale insulin surprise Fingerstick Blood Sug 201-250 give 1 unit, 2 301-350 give 3 units, greater than 400 call four times daily.  Review of Resident # subsequent physician on 12/04/18 sliding insulin subcuta between 201-250 give units, 301-350 give 3	ohysician's order for Novolog help control diabetes) ubcutaneously when gar (FSBS) ranged between 251-300 give 2 units, 351-400 give 4 units, the physician, and FSBS			

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R
		HAL034098	5		03/08/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM TE	RRACE		SALEM, NC 2		
			· ·		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
5.050			D 050		
D 358	Continued From page	92	D 358		
	Review of Resident #	7's December 2018.			
		d March 2019 electronic			
	Medication Record Ad				
	revealed:	(0.111.11)			
		entry for Novolog sliding			
		nree times daily at 7:30am,			
	11:30am, and 4:30pm				
		entry for FSBS four times			
		0am, 4:30pm, and 8:00pm.			
	-There was documen				
		of insulin was documented			
	as administered:	or meanir was assumented			
		am, FSBS was 438, required			
	4 units.	,			
		am, FSBS was 579, required			
	4 units.	,			
		am FSBS was 487, required			
	4 units.	020 mao 101, 104amoa			
		am FSBS was 487, required			
	4 units.	020 mao 101, 104amoa			
	Observation of Residen	ent #7's medications on			
	hand at the facility on				
	revealed Novolog was				
	administration.				
	Interview with Reside	nt #7 on 03/07/19 at 8:34am			
	revealed:				
	-She was a severe dia	abetic and was ordered			
	Novolog sliding scale	insulin to reduce her high			
	blood sugars.	3			
		s (MAs) checked her FSBS			
		uding the times she was at			
	dialysis.	3 and amice one mad at			
		ed Novolog sliding scale			
	when her blood sugar				
	~	nber the exact numbers the			
		nd she did not ask staff how			
	much insulin they adr				
	aon mounir tricy aut		1	İ	1

STATE FORM 6899 1HE211 If continuation sheet 93 of 109

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	)
		HAL034098	B. WING		R	040
		HALU34096			03/08/2	019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OLI	SALISBURY R	OAD		
SALEM TE	RRACE	WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE C	OMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IGIENCI )		
D 358	Continued From page	93	D 358			
	. •					
		hift MA on 03/07/19 at				
	3:05pm revealed:	INC. I. P.P.				
		ered Novolog sliding scale				
	three times daily base					
	<ul> <li>The units of Novolog documented on the el</li> </ul>					
		y there were FSBS results				
		inistration Novolog and				
	none was given.	inistration (vovolog and				
	-There was an audit of	of the eMARs and				
		art two to three days per				
	week.	ar two to times days per				
		ecked for holes, but no one				
	looked at the units of					
	documented.	3 1 1 3				
	Interview with Reside	nt #7's Endocrinologist				
	03/07/19 at 11:14am	revealed:				
	-Resident #7 was a se					
		lered routine Novolog and				
	Novolog sliding scale					
	-When a blood sugar					
	administer the sliding	_				
		administered in conjunction				
		to control blood sugars.				
	•	od sugar, greater than 400				
	was serious and could resident harm or deat	· ·				
	resident nann di deat	11.				
	Interview with the Rea	sident Care Coordinator				
	(RCC) on 03/08/19 at					
		at Resident #7 had FSBS				
		Novolog and the medication				
	was not administered	•				
		ication cart and the eMARs				
		not noticed there were some				
	-	ented units of Novolog				

administered.

Interview the Administrator on 03/08/19 12:48pm

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R	
		HAL034098	B. WING		03/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE	2609 OLD 9	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	94	D 358			
	all medications.  -The MAs and RCC of cart and medications -The MAs and RCC of Resident #7's Novolo administered as orde  5. Review of Resident 06/26/18 revealed: -Diagnoses included hypoxic respiratory far pulmonary disease, a dementia, hypertension macular degeneration -There was an order for the resident and resi	should check to ensure g sliding scheduled was red.  In #4's current FL2 dated diabetes mellitus, chronic illure, chronic obstructive inxiety and depression, on, hyperlipidemia, and				
	the physician on 12/0 lbuprofen every six he per day and an order times daily as needed. There was an order of 12/13/18 which reques order for lbuprofen 60 needed for pain (take 3200 mg per day. The physician gave of clarification sheet dat 600mg three times dated to the control of the cont	an's order sheet signed by 5/18 with an order for ours not to exceed 3200 mg for Ibuprofen 600 mg three of for pain. Clarification sheet dated ested clarification on the 00 mg three times a day as with food) not to exceed clarification on the order ed 12/13/18 for Ibuprofen				

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 95 of 109

Division of	of Health Service Regu	lation			1 Oran	IAITROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPL	
					F	۱
		HAL034098	B. WING			8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
041 514 71	-DDAGE	2609 OL	D SALISBURY RO	OAD		
SALEM TI	ERRACE	WINSTO	N SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	Continued From page	95	D 358			
	-There was an entry f mg tablet, take tablet not to exceed 3200 m 6:00am, 12:00pm, an -There was document was administered at 1 and at 6:00pm from 1 12/7/18 through 12/18, 1 and on 12/31/18.  -There was document 600 mg was not administered and twenty-following dates: 12/06 6:00pm; 12/11/18 at 12:00am and 6:00am; 12/15/18 and 6:00am; 12/15/18 and 6:00am; 12/20/18 at 612:00am and 6:00am; 12/20/18 at at 12:00am; 12/28/18 at at 12:00am; 12/28/18 at at 12:00am; 12/29/18 at at 12:00pm.  -There was document was not administered "physically unable to 10 documentation for the There was an entry for take one tablet by moneeded for pain and to 12/19/18.  -There was an entry for take one tablet by moneeded with meals.	or scheduled Ibuprofen 600 by mouth every six hours, 19 per day at 12:00am, 12:00pm, 2:00am, 6:00am, 12:00pm, 2:01/18 through 12/5/18, 12/16/18 through 12/22/18, 12/18 through 12/22/18, 13:00am, 12:00am; 12/10/18 at 12:00am; 12/10/18 at 12:00am; 12/11/18 at 12:00am; 12/14/18 at 12:00am; 12/14/18 at 12:00am; 12/14/18 at 12:00am; 12/14/18 at 12:00am; 12/24/18 at 12:00am; 12/24/18 at 12:00am and 12:00am and 6:00am; 12/00am and 6:00am; 12/00am; 12/00am and 6:00am; 12/00am; 12/00a				

three times daily as needed was administered once from 12/01/18 through 12/31/18.

Review of the eMAR for January 2019 revealed:

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Division o	FORM APPROVED Division of Health Service Regulation						
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
-	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			7 501251110.		_		
			B. WING		F		
		HAL034098	B. WING		03/0	8/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
SALEM T	EDDACE	2609 OL	D SALISBURY R	OAD			
SALEWI II	ERRACE	WINSTO	N SALEM, NC 2	7127			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE	
	,			DEFICIENCY)			
D 358	Continued From page	96	D 358				
	-There was not an en	try for Ibuprofen 600 mg					
		e times daily with meals.					
		for scheduled Ibuprofen 600					
		et by mouth every six hours,					
	not to exceed 3200 mg per day at 12:00am,						
	6:00am, 12:00pm, an	- · · · · · · · · · · · · · · · · · · ·					
		tation scheduled Ibuprofen					
		12:00 am, 6:00 am, 12:00					
		on 01/05/19, 01/09/19,					
		1/19/19, 01/22/19, and					
	01/28/19 through 01/3	30/19.					
		tation scheduled Ibuprofen					
		inistered thirty two of one					
		our opportunities on the					
	1	1/19 at 6:00am; 01/02/19 at					
	_	; 01/03/19 at 12:00am and					
		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					
		12:00am; 01/21/19 at					
		12:00am and 6:00am;					
	01/24/19 at 6:00am; (						
	,	and 6:00am; 01/27/19at					
	12:00pm; and 01/31/						

medication.

needed with meals.

from 01/01/19 through 01/31/19.

-There was documentation scheduled Ibuprofen was not administered due to "resident refused" or there was no documentation for the missed

-There was an entry for Ibuprofen 600 mg tablet, take one tablet by mouth three times daily as

-There was no documentation Ibuprofen 600 mg three times daily as needed was administered

Review of the eMAR for February 2019 revealed:

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Division (	of Health Service Regu	ulation			FORM	1 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	
		HAL034098	B. WING		03/0	R 08/2019
NAME OF P	PROVIDER OR SUPPLIER	STREET A'	DDRESS, CITY, STAT	TE, ZIP CODE		
041 514 5		2609 OL!	D SALISBURY RO	DAD		
SALEM T	ERRACE	WINSTO	N SALEM, NC 27	<sup>7</sup> 127		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 97	D 358			
	tablet, one tablet thre -There was an entry f mg tablet, take 1 table not to exceed 3200 m 6:00am, 12:00pm, an -There was documen was administered at 2 pm, and 6:00 pm fron 02/12/19, 02/14/19, 00 through 02/23/19, and -There was documen 600 mg was not admi and twelve opportunit 02/13/19 at 12:00am; 6:00am; 02/16/19 at 6:00am; 02/24/19 at 12:00pm; 02/27/19 at 6:00amThere was documen was not administered "out of facilty," or ther the missed medicatio	for scheduled Ibuprofen 600 let by mouth every six hours, and per day at 12:00am, and 6:00pm. atation scheduled Ibuprofen 12:00 am, 6:00 pm, 12:00 and 02/01/19 through 02/17/19, 02/19/19, 02/21/19 d 02/25/19. atation scheduled Ibuprofen atinistered ten of one hundred ties on the following dates: (c) 02/15/19 at 12:00am and 6:00pm; 02/18/19 at t 12:00am and 6:00pm; (c) 02/26/19 at 6:00am; and atation scheduled Ibuprofen d due to "resident refused," re was no documentation for				

-There was not an entry for Ibuprofen 600 mg tablet, one tablet three times daily.

Review of the eMAR for March 2019 revealed:

take one tablet by mouth three times daily as

-There was no documentation Ibuprofen 600 mg 3 times daily as needed was administered from

needed with meals.

02/02/19 through 02/28/19.

-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

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLET	
			A. BUILDING:		_	
		HAL034098	B. WING		03/0	≀ 08/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	FRRACE	2609 OLD	SALISBURY R	OAD		
OALLIN II	WINSTO			7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 98	D 358			
	03/05/19.					
		tation Ibuprofen 600 mg was				
		of twenty two opportunities				
		: 03/03/19 at 12:00am.				
		tation Ibuprofen was not				
	administered due to "					
		nentation Ibuprofen 600 mg needed was administered				
	from 03/01/19 through					
	3					
		ent #4's medications on				
	hand at the facility on	03/07/19 at 9:58am				
	revealed:	nours was available on the				
		dministration with a dispense				
	date of 03/05/19.	arminotication with a disperior				
	-The Ibuprofen medic	cal label had directions for				
		ours, do not exceed 3200				
	mg per day.	f 000 th ti d-ih.				
		ofen 600 mg three times daily on the medication care.				
	as needed available of	on the medication care.				
	Interview with Reside	ent #4 on 03/07/18 at				
	10:55am revealed:	ed medication at 8:00am,				
		nd 8:00 pm but did not know				
	which ones.					
	-She could not remer	nber the last time she				
	requested an as need	ded pain medication.				
	Interview with a Medi	cation Aide (MA) on				
	03/07/19 at 9:41am re	evealed:				
		nsible for reviewing new			I	
	orders and faxing the					
	-She did not know the	ere was an order for nistered three times daily				
	with meals.	instered timee times daily				
		edication according to what				
	the eMAR indicated.					

Division of Health Service Regulation

-lbuprofen, one tablet every six hours scheduled

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL034098	B. WING		03/08/2019
NAME OF D		0.10551.400	DEGG OITY OTA	TE 710 000E	,
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA		
SALEM TERRACE			SALISBURY R		
WINSTON			SALEM, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	99	D 358		
	was on the elviar.				
	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				
	on the eMAR.	- C- L- LL L L			
	on the eMAR by the F could be administered	<del></del>			
	•	nsible for making sure atch 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 dailyHad the pharmacy received the order dated 12/13/18 for Ibuprofen three times daily, the pharmacist would have clarified because the order was unclear.				
	-lbuprofen three times eMAR.	s daily was not added to the			

Division of Health Service Regulation

STATE FORM 6899 1HE211 If continuation sheet 100 of 109

	of Health Service Regu				_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		03/08/2019	
					1 00:00:20:0	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	DDACE	2609 OLD	SALISBURY R	DAD		
SALEIVI IE	RRACE	WINSTON	N SALEM, NC 27	7127		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	E
			+			
D 358	Continued From page	e 100	D 358			
	Attampted intensions	with Posidont #4's Primary				
	•	with Resident #4's Primary 8/08/19 at 2:32pm was				
	unsuccessful.	706/19 at 2.32pm was				
	unsuccessiui.					
	Interview with the Adı	ministrator on 03/08/19 at				
	2:48pm revealed:	ministrator on co/co/15 at				
	-	narmacy were responsible for				
reviewing new orders when they came into the facility.						
	•	to the pharmacy and the				
		o the orders to the eMAR.				
		ere was an order dated				
		n for Resident #4 to be				
	administered 3 times					
		ation to be administered as				
	ordered by the physic					
	<b>, ,</b>					
D 367	10A NCAC 13F .1004	1(i) Medication	D 367			
2 00.	Administration	T() Wedication	5 00.			
	Administration					
	10A NCAC 13F .1004	Medication Administration				
		dication administration				
		e accurate and include the				
	following:					
	(1) resident's name;					
		cation or treatment order;				
		age or quantity of medication				
	administered;					
	(4) instructions for administering the medication or treatment;					
	•	tion for the administration of				
	· ·	nents as needed (PRN) and				
		ulting effect on the resident;				
	(6) date and time of a	_				
	(7) documentation of					

Division of Health Service Regulation

medications or treatments and the reason for the

(8) name or initials of the person administering the medication or treatment. If initials are used, a

omission, including refusals; and,

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILDING			R	
		HAL034098	B. WING		03	/08/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
SALEM TI	ERRACE		D SALISBURY ROA				
	T		N SALEM, NC 271				
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 367	Continued From page	e 101	D 367				
		o those initials is to be ntained with the medication (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:						
	hypoxic respiratory far pulmonary disease, and dementia, hypertension macular degeneration -There was an order of blood sugars (FSBS) -There was an order of insulin to help control insulin (SSI): FSBS 1 201-250 = 4 units; FS	diabetes mellitus, chronic ilure, chronic obstructive nxiety and depression, on, hyperlipidemia, and il. for to check finger stick before meals. for novolog (fast-acting diabetes) sliding scale 50-200 = 2 units; FSBS ilbs 251-300 = 6 units; FSBS ilbs 351-400 = 10 units;					
	Administration Record 2018 revealed:	4's electronic Medication d (eMAR) for December or FSBS check before					

Division of Health Service Regulation

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Division o	of Health Service Regu	ulation			FORM	IAPPROVED
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R <b>03/08/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
CALEMA	SALEM TERRACE 2609 OLD			OAD		
SALEMIN	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 102	D 367			
	150-200 = 2 units; FS 251-300 = 6 units; FS 351-400 = 10 units at 4:30 pm.  -There was an entry I the injection under no an entry line to docur given.  -Resident #4's blood 269.  Review of Resident # revealed:  -There was an entry I meals at 7:30am, 11:  -There was an entry I 150-200 = 2 units; FS 251-300 = 6 units; FS 351-400 = 10 units at 4:30pm.  -There was an entry I the injection under no an entry line to docur given.	for novolog SSI: FSBS SBS 201-250 = 4units; FSBS SBS 301-350 = 8 units; FSBS t 7:30 am, 11:30 am and line to document the site of ovolog SSI, but there was not ment the number of units sugars ranged from 76 to 44's eMAR for January 2019 for FSBS check before				

the injection under novolog SSI, but there was not Division of Health Service Regulation

4:30pm.

revealed:

Review of Resident #4's eMAR for February 2019

-There was an entry line to document the site of

-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

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Division of Health Service Regulation							
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING	B. WING		8/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
I SALEM TERRACE		SALISBURY RO N SALEM, NC 27					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 367	Continued From page	e 103	D 367				
	-	nent the number of units					
	givenResident #4's blood = 244.	sugars ranged from 78 to					
	revealed: -There was an entry f meals at 7:30am, 11: -There was an entry f 150-200 = 2 units; FS 251-300 = 6 units; FS 351-400 = 10 units at 4:30 amFrom 03/01/19 throu there was an entry lin the injection under no an entry line to docum givenThe novolog SSI ord the eMAR and a new entered on the eMAR to document the amo according to the slidir	for novolog SSI: FSBS SBS 201-250 = 4units; FSBS SBS 301-350 = 8 units; FSBS T:30 am, 11:30 am and gh 03/05/19 at 11:30am, le to document the site of ovolog SSI, but there was not ment the number of units ler had been discontinued on novolog SSI order was which included an entry line unt of insulin given leg scale. Sugars ranged from 103 to cation aide (MA) on evealed:					

-Insulin was administered to Resident #4 according to the sliding scale and should be

-She documented SSI on the eMAR and completed a SSI sheet which was given to the

-She did not realize Resident #4 did not a place to

December, January, February, and part of March

Resident Care Coordinator (RCC).

document SSI amount on her eMAR in

documented on the eMAR.

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
					R	
		HAL034098	B. WING		1	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
WANTE OF T	KOVIDER OR OUT FEEL		SALISBURY R	,		
SALEM TI	ERRACE		SALISBURT R			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	) BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				,		
D 367	Continued From page	e 104	D 367			
	-She thought the RC0	C completed eMAR audits				
	twice a week.	·				
	Interview with Reside	nt #4 on 03/07/19 at				
	10:55am revealed:	d had FSBS three times				
	daily.	d flad i OBO tillee tilles				
	,	ed SSI insulin three times				
	daily, but did not know	w her blood sugar ranges or				
	how much insulin was	s administered.				
	latamiaith tha DO	C == 02/08/40 =± 0:48===				
	revealed:	C on 03/08/19 at 9:18am				
	-She was responsible	for checking the				
		he eMARS one or two times				
	a month.					
	•	onsible for completing eMAR				
		ondays, Wednesdays, and				
	Fridays.	oMARs sho shocked the				
	medication, dosage, a	eMARs she checked the				
		ly calculated in the eMAR				
		ave been documented on				
	the eMAR when giver					
	-She did not know the	e SSI units given were not				
		MAR in December, January,				
	February and part of					
	information on the eM	esponsible for entering				
	illioilliation on the elv	IAN.				
	Interview with a MA o	n 03/08/19 at 11:51am				
	revealed:					
		nsible for completing MAR				
	audits, but she did no					
		I for Resident #4 on the				
	eMAR.	SSI units diven were not				

2019.

Division of Health Service Regulation

showing as documented on the eMAR in December, January, February, and part of March

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	,
		HAL034098	B. WING		1	8/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE	2609 OLD	SALISBURY R	OAD		
OALLIII IL		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 105	D 367			
	revealed: -The pharmacy was reorders on the eMARThe SSI order was us include an entry to do given.  Attempted interview where Primary Care Physicials 2:32pm was unsuccess.  Interview with the Adr 2:48pm revealed: -The RCC and the phemar auditsShe expected for eM once a week to check	esponsible for entering pdated on 03/05/19 to cument amount of insulin  with Resident #4's the an (PCP) on 03/08/19 at ssful.  ministrator on 03/08/19  armacy were responsible for				
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	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:				

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Based on observations, interviews, and record

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		0.3	R / <b>08/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	•	DDRESS, CITY, STATE	, ZIP CODE	1 33	
SALEM TI	ERRACE		D SALISBURY ROANN SALEM, NC 271			
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D912	received care and se appropriate, and in confederal and state law related to health care.  The findings are:  Based on observation reviews, the facility fanotification for 4 of 7 (Residents #2, #4, #6 contacting the physic sugar was greater the out of the facility and when residents refus Tylenol, Auryxia, gab tears, and midodrine (renvela) (#6), anti-in inhaled Fluticasone Freferral and contacting	ailed to assure residents revices that were adequate, ompliance with relevant is and rules and regulations and rules and regulations and rules and record ailed to assure physician sampled residents and an an an appropriate (#7), Sevelamer Carbonate (flammatory cream and an appropriate (#2), a podiatrist ing the physician regarding #4). [Refer to Tag 273,	D912			
D992	G.S. § 131D-45. Exa the presence of control for applicants for emphomes.  (a) An offer of employlicensed under this A conditioned on the apexamination and screen substances. The example be conducted in according to the present the conducted in according to the present t	mination and screening mination and screening for rolled substances required ployment in adult care  yment by an adult care home rticle to an applicant is oplicant's consent to an eening for controlled mination and screening shall ordance with Article 20 of eneral Statutes. A screening	D992			

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Division of	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					R		
		HAL034098	B. WING		03/08/2019		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,			
SALEM TE	ERRACE		SALISBURY R				
		WINSTON	SALEM, NC 2	7127			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX (EACH DEFICIENCY TAG REGULATORY OR L		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE			
				DEFICIENCY)			
D992	Continued From none	. 407	D992				
D992	Continued From page	9 107	D992				
		examination and screening					
		y be administered on-site. If					
		licant's examination and					
		e presence of a controlled					
		care home shall not employ					
		he applicant first provides to vritten verification from the					
		g physician that every					
	controlled substance						
		ening is prescribed by that					
		applicant's medical or					
		on. The verification from the					
	physician shall include	e the name of the controlled					
		ribed dosage and frequency,					
		which the substance is					
	prescribed. If the resu						
		ion and screening indicates					
	•	ntrolled substance, the adult					
		re a second examination fy the results of the prior					
	examination and scre	•					
	examination and sore	ering.					
	This Rule is not met	as evidenced by:					
	Based on observation	n, record reviews, and					
	interviews, the facility						
		ening for the presence of					
		s for 1 of 6 sampled staff (B)					
	who were hired after	10/01/13.					
	The findings are:						
	1 Review of Staff R's	s personnel record revealed:					
	-She was hired on 02						
	Administrator.						
		nentation of examination and					
	screening for the pres						

substances.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 20.22		R
		HAL034098	B. WING		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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)					
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D992	Continued From page	e 108	D992		
	5:01pm revealed: -She was pulled from as part-time interim A February 2018She had a drug screethe corporate office, but she started working ir -She did not know if the documentation of her  A second interview with 03/08/19 at 5:03pm results -Drug screenings show orientation of new em	here was any having had a drug screen.  th the Administrator on evealed: uld be completed prior to			

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