Division of	of Health Service Regu	lation			FORM	APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL034093	B. WING	~~~~	07/2	26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA		1 0111	
			RKE MILL ROAI			
DANBY H	OUSE		N SALEM, NC 2			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
			TAG	DEFICIENCY)		DATE
	annual survey and co 07/24/19 through 07/2 10A NCAC 13F .0504 For LHPS Tasks 10A NCAC 13F .0504 Licensed Health Profe (a) An adult care hom	(a) Competency Validation Competency Validation For essional Support Task	D 000	Responses to sited deficiencies not constitute an admission or a by the facility of the truth of alley conclusions set fort in this state of deficiencies of Corrective Act Report; the plan is solely as a n compliance with state law. 10A NCAC 13F .0504 (LHPS Ta Executive Director (ED) and Bu	agreeme ged or ment tion natter of asks) siness	
	not practicing in their governed by their prac- licensing laws are con demonstration for any	licensed capacity as otice act and occupational npetency validated by return personal care task raph (a)(1) through (28) of ochapter prior to staff nd that their ongoing d through facility staff		Office Manager (BOM) will cond staff file audits to ensure LHPS competency and compliance.Ar identified areas will be addresse immediately. BOM will utilize a staff log to monitor staff require ED and/or BOM will notify RN w are in need of competency valid ED and BOM will perform mont of staff files to ensure complian	ny ed perpetua ments. vhen sta dation. hly audit	ff
	facility failed to assure A and Staff F) were co Registered Nurse (RN Professional Support transferring, nebulizer Thromboembolism-De	ws and interviews, the 2 of 4 sampled staff (Staff ompetency validated by a ) for Licensed Health (LHPS) tasks of ambulation,				
	The findings are:					
		Personal Care Aide (PCA)				
	Ith Service Regulation	UPPLIER REPRESENTATIVE'S SIGNATUR	C			<b></b>
			/	TITLE	- 1	(X6) DATE
STATE FORM	210	E	EXecuti		911	3/19
			0033	G56611	If continua	tion sheet 1 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		HAL034093	B. WING		07/26/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
		3150 BU	IRKE MILL ROAD			
DANBY H	OUSE	WINSTO	N SALEM, NC 271	03		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	THE APPROPRIATE	COMPLETE DATE
D 161	Continued From page	e 1	D 161	a da da constante da		
	personnel record rev	ealed:				
	-Staff A was hired on					
	-There was no docun					
	completed LHPS con					
	Interview with Staff A	on 07/26/19 at 2:00pm				
	revealed:	sere esta construction (non training) and a some final statistical statistic				
	-She started working	at the facility earlier this				
	year.					
		l, she started training with a				
	nurse, but the nurse					
		to complete the training, but				
		iled for LHPS training.				
		she assisted residents with s and putting on TED Hose.				
		and putting on TED hose.				
	Interview with the Ad	ministrator on 07/26/19 at				
	5:15pm revealed:					
		and was responsible for				
	assisting residents w	ith ambulation and transfers.				
		dents with dressing, which				
	included putting on s	tockings (including TED				
	hose).					
		Manager (BOM) was				
		e staff completed all training.				
	and the second se	BOM was on leave from				
	work and the previou					
	responsible for ensu	ring staff completed training.				
	1	DM on 07/26/19 at 6:06pm				
	revealed:					
		le LHPS training for Staff A				
	because she was on -The previous Admin					
	scheduled the staff f					
	2 Review of Staff F	s, Medication Aide (MA)				
	personnel record rev					
	-Staff F was hired or					
	-There was no docu					



D	ivis	ion	of	Health	Service	Reau	lation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL034093	B. WING	· · · · · · · · · · · · · · · · · · ·	07	07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
DANBY H	OUSE	3150 BU	RKE MILL ROAD				
	0035	WINSTO	N SALEM, NC 271	03			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 161	Continued From pag	e 2	D 161				
	completed a LHPS c	ompetency validation.					
	Review of the July 20 Administration Recorresidents' records with sugars and insulin inj documentation Staff checked fingerstick b 07/18/19, 07/19/10, 0 07/22/19.	019 electronic Medication rd (eMARs) of three diabetic th orders for fingerstick blood jections revealed F administered insulin and blood sugars on 07/14/19, 07/20/19, 07/21/19, and					
		Attempted interview with Staff F on 07/26/19 at 11:47am was unsuccessful.					
	Interview with the Administrator or 5:15pm revealed: -Staff F was a MA and was respon administering medications includir blood sugars, insulin injections, ne treatments, and ensuring oxygen a -She was unaware Staff F had not LHPS training. -The Business Office Manager (Bu responsible to ensure staff comple -Earlier this year the BOM was on work and the previous Administrat responsible for ensuring staff com -The BOM should have checked p records to ensure the required trait completed.	d was responsible for ations including fingerstick injections, nebulizer uring oxygen administration. taff F had not completed the Manager (BOM) was e staff completed all training. BOM was on leave from is Administrator was ring staff completed training. ve checked personnel		т.			
	revealed: -She had not schedu -She did not know the required LHPS trainin floor. -She was on leave fre was hired, therefore	OM on 07/26/19 at 6:06pm led Staff F for LHPS training, at Staff F did not have the ng prior to working on the om work shortly after Staff F the previous Administrator ed Staff F for the LHPS					

STATE FORM

6899

G56611

If continuation sheet 3 of 82

STATEMENT	of <u>Health Service Regu</u> r of DEFICIENCIES of CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- F2	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL034093	B. WING		07/2	6/2019
NAME OF P	ROVIDER OR SUPPLIER	3150 BU	DDRESS, CITY, STA RKE MILL ROAI N SALEM, NC 2	0		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 161	Continued From page training. -When she returned to check Staff F's record training had been cor	pack to work she did not I to ensure the LHPS	D 161			
D 164	Diabetic Residents An adult care home s the care of residents unlicensed staff prior insulin as follows: (1) Training shall be nurse, registered pha practitioner. (2) Training shall inc (a) basic facts about in the management of (b) insulin action; (c) insulin storage; (d) mixing, measurin for insulin storage; (d) mixing, measurin for insulin administrat (e) treatment and pro and hyperglycemia, i symptoms; (f) blood glucose mo precautions; (g) universal precaut (h) appropriate admit (i) sliding scale insul This Rule is not met Based on observatio interviews, the facility	5 Training On Care Of shall assure that training on with diabetes is provided to to the administration of provided by a registered armacist or prescribing lude at least the following: diabetes and care involved of diabetes; ag and injection techniques tion; evention of hypoglycemia ncluding signs and onitoring; universal tions; inistration times; and in administration.	D 164	10A NCAC 13F .0505 (Th Care of Diabetic Residen ED and BOM will conduc to ensure Diabetic Care T completed as required. A will be addressed immed utilize a perpetual staff lo staff training. All Medicati will complete required tra working as a MA and ann Registered Nurse (RN) w Diabetic Training for curr and BOM will perform mo audits to ensure compliant	it) It staff file audi Training is any identied an iately.BOM wi ig to monitor ion Aides (MA anining prior to nually thereafted vill conduct ent MAs. ED onthly staff file	eas I s) er.

6899

Division of Health Service Regulation

-	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
	HAL034093	B. WING	1NG		07/26/2019	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
DANBY HOUSE	3150 BU	RKE MILL ROAD				
	WINSTO	N SALEM, NC 271	03			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ( CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
residents completed tra diabetic resident prior to insulin. The findings are: 1. Review of Staff C's, I personnel record revea -Staff C was hired in Ja -There was no docume completed training on cor- resident. Review of residents' Ma Medication Administrati revealed there was door obtained finger stick blo administered insulin for Review of residents' Ju Medication Administrati revealed there was door obtained finger stick blo administered insulin thin Review of residents' Ju Medication Administrati revealed there was door obtained finger stick blo administered insulin thin Review of residents' Jul Medication Administrati revealed there was door obtained finger stick blo administered insulin two Interview with Staff C on revealed: -She had worked at the MA. -She had worked at the	ger stick blood sugars for ining on care of the o the administration of Medication Aide (MA) led: nuary 2008. ntation Staff C had are of the diabetic ay 2019 electronic on Records (eMARs) umentation Staff C bod sugars and ty-one times. ne 2019 electronic on Records (eMARs) umentation Staff C bod sugars and ty-eight times. by 2019 electronic on Records (eMARs) umentation Staff C bod sugars and ty-eight times. by 2019 electronic on Records (eMARs) umentation Staff C bod sugars and enty-eight times. h 07/26/19 at 9:58am facility since 2008 as a facility for over ten years bad diabetic care training.	D 164				

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 5 of 82

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING:		(X3) DATE S COMPL	
		HAL034093	B, WING		07/2	26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	03	و و و و و و و و و و و و و و و و و و و	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 164	Continued From page	5	D 164			
	<ul> <li>she had worked at the facility since 2008.</li> <li>-When she worked she checked fingerstick blood sugars, and administered insulin injections.</li> <li>Interview with the Administrator on 07/26/19 at 5:15pm revealed:</li> <li>-The Business Office Manager (BOM) was responsible to schedule training's for all staff and ensure training's were current.</li> <li>-The BOM should have checked Staff C's personnel record to ensure the training was completed.</li> <li>Interview with the BOM on 07/26/19 at 6:06pm revealed:</li> <li>-She was unaware Staff C did not have documentation of completing training on care of the diabetic resident.</li> <li>-The BOM and the Administrator were responsible for scheduling staff for training including training on care of the diabetic resident.</li> <li>2. Review of Staff D's, Medication Aide (MA) personnel record revealed:</li> <li>-Staff D was hired on 04/11/18 as a Personal Care Aide.</li> <li>-Staff D was moved into the MA position on 07/09/18.</li> <li>-There was no documentation Staff D had completed training on care of the diabetic resident.</li> </ul>					

Division of Health Service Regulation STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
-		HAL034093	B. WING		07/26/2019	
NAME OF P	PROVIDER OR SUPPLIER	3150 BU	DDRESS, CITY, STATE RKE MILL ROAD N SALEM, NC 271			
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 164	revealed there was de obtained finger stick & administered insulin t Review of residents'. Medication Administra revealed there was de obtained finger stick & administered insulin t Interview with Staff D revealed: -She had worked at th year. -She had not received diabetic residents. -She was worked as a medications such as: sugars, and administe Interview with the Adr 5:15pm revealed: -She did not know Sta required diabetic care -The Business Office have scheduled Staff diabetic resident. -The BOM should hav personnel record to e completed. Interview with the BO revealed: -She had not schedul care training. -The Administrator an for ensuring staff com	boumentation Staff D blood sugars and wenty-six times. July 2019 electronic ation Records (eMARs) bocumentation Staff D blood sugars and hirty-four times. on 07/26/19 at 11:55am he facility for a little over one d training on care of the a MA administering checked fingerstick blood ered insulin injections. ninistrator on 07/26/19 at aff D had not completed the e training. Manager (BOM) should D for training on care of the	D 164		Υ	

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 7 of 82

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING; B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 164 D 164 Continued From page 7 3. Review of Staff E's, Medication Aide (MA) personnel record revealed: -Staff D was hired on 03/22/11. -There was no documentation Staff E had training on care of the diabetic resident. Review of residents' May 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff E obtained finger stick blood sugars and administered insulin twenty-four times. Review of residents' June 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff E obtained finger stick blood sugars and administered insulin thirty times. Review of residents' July 2019 electronic Medication Administration Records (eMARs) revealed there was documentation Staff E obtained finger stick blood sugars and administered fourteen times. Attempted interview with Staff E on 07/26/19 at 11:48am was unsuccessful. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff E was a MA and was responsible for checking blood sugars and administering insulin. -She did not know Staff E had not completed the training on care of the diabetic resident. -The BOM should have scheduled Staff E for the diabetic care training. -The Business Office Manager (BOM) was responsible for ensuring staff had all the required training. -The BOM should have checked Staff E's personnel record to ensure the diabetic training

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 8 of 82

ND PLAN C	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL034093	B. WING			07/26/2019	
IAME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
ANBY HO	DUSE		URKE MILL ROAD ON SALEM, NC 271	102			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 164	Continued From page	8	D 164				
	was completed.						
	revealed: -She had not schedul care of the diabetic re -She did not know Sta diabetic training. -The BOM and the Ac responsible for sched including training on c	aff E had not completed Iministrator were uling staff for training, care of the diabetic resident. Medication Aide (MA) caled: 02/18/19. mentation Staff F had					
	Review of residents' Medication Administra revealed there was do obtained finger stick b administered insulin te	ation Records (eMARs) ocumentation Staff F blood sugars and					
	Review of residents' J Medication Administra revealed there was do obtained finger stick b administered insulin fi	ation Records (eMARs) ocumentation Staff F blood sugars and					
	Review of residents' J Medication Administra revealed there was do obtained finger stick b administered fourteen	ation Records (eMARs) ocumentation Staff F lood sugars and					
	Attempted interview w 11:47am was unsucce	rith Staff F on 07/26/19 at essful.					

G56611

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		IRKE MILL ROAD	0.2		
(XA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	N SALEM, NC 271	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 164	Continued From page	9 9	D 164			
	5:15pm revealed: -Staff F worked as a l checking finger stick administering insulin -She was unaware Si training on care of the -The Business Office responsible to ensure training. -The BOM should hav personnel record to e had been completed. Interview with the BO revealed: -She had not schedul care of the diabetic re- -She was unaware Si diabetic care training. -The BOM and the Ac responsible to ensure -She did not check st ensure all training have	Injections. aff F had not completed a diabetic resident. Manager (BOM) was a Staff F completed required we checked Staff F's nsure the required training M on 07/26/19 at 6:06pm ed Staff F for training on esident. aff F had not received				
D 338	all residents guarants Declaration of Reside and may be exercised	Resident Rights hall assure that the rights of ed under G.S. 131D-21, ents' Rights, are maintained d without hindrance.	D 338			
	This Rule is not met TYPE A1 VIOLATION Based on observation reviews, the facility fa	s, interviews and record				

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:		COMPL	ETED
No. of the second second second		HAL034093	B. WING		07/3	26/2019
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		012010
ANBY H			RKE MILL ROAL			
ANDIN	JU3E	WINSTO	N SALEM, NC 2	27103		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	COMPLET DATE
D 338	Continued From page	e 10	D 338	10A NCAC 13F .0909 (Re	esident RIghts	) 8/26/20
t a e s v v s i i r	sampled residents (F	Residents #8, #9 and #10) in		ED to conduct "Resident	Rights Trainin	L.,
	the Special Care Unit (SCU) were free of physical			to all staff. ED to educate		P
	abuse and neglect by	three staff (Staff A, Staff B,		the importance of reportir		hr
		ging the residents to fight		neglect to management in		Ψľ
	each other, resulting			Home Health Agency and		
	strangled with her fac	ce turning red (Resident #8)		Ombudsmen to complete		
		and shared the video through (Staff A) pushed a resident		"Resident Rights Training		
	into a room turned o	ff the light and yelled to the		resident rights framing	f to an stan.	
		p, and then closed the door		All staff received a copy of	of the "Declara	tion
		n the dark room (Resident		of Resident Rights." All st		
	#8); and a resident be	eing left on the floor while		acknowledging receipt an		and
	staff recorded a seco	nd video and shared the		a copy was placed in staf	f file All new	anu
	video through social i	media (Resident #10).		employees will complete		bto
				Training" upon hire and a	innually ROM	will
	The findings are:			utilize a perpetual staff lo	a to ensure	VVIII
				training is complete upon	hire and annu	ally
	A. Review of Video # revealed:	1 on 07/26/19 at 2:43pm				
		hree staff and two residents		ED will conduct training to	o current emp	loyees
	in the SCU.			regarding the company's		
	-The incident appeara	ed to have occurred in a		All new employees will be	e given a copy	of
	resident's room beca	use a bed and part of a		cell phone policy and a s	igned copy wil	
	bedside table were of	oserved in the video.		be placed in staff file. ED		
		two staff [Staff A (Personal		designee will monitor for	ongoing comp	liance
		Staff B (PCA)] observed in		through observations and	resident cou	hcil
		sidents were engaged in a		meetings.		
	physical altercation.			ED, DRC and/or RCC wi	ll conduct	
	All States and the second s	ff C (PCA)] voice could be		visits to the community o		1
	heard, but her face w	as not seen. Jents in the video, identified	1	minimum of three times		
	as Resident #8 and F			primary focus on second		
		revealed the residents were			and/or third s	int.
	involved in an alterca					
		standing in front of the side				
	of a bed.					
	-Resident #9 started I	hitting and kicking at				
	Resident #8 while the	ey were standing.				
	-Resident #9 put her	left arm around the back of				
1	Resident #8's neck ar	nd continued to hit Resident	1			

Division of Health Service Regulation STATE FORM

G56611

If continuation sheet 11 of 82

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WNG HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 D 338 Continued From page 11 #8. -Resident #8 had something in her right hand, and Resident #9 was yelling at Resident #8 saying "give it back." -Resident #8 yelled "let go, let go, let go ....." -Resident #8 fell on the bed and Resident #9 fell on bed beside her and continued to hit Resident #8. -Resident #8 was still yelling "let go, help me, help me, let go ....." -One staff told Resident #8 "stop screaming, [curse word]" -Staff continued to video record the incident and did not intervene, but allowed Resident #9 to continue hitting Resident #8. -One staff was heard saying "take it out of her hand." -Someone (unable to see staff face) took the item out of Resident #8's hand. -The staff continued to allow the residents to fight and did not intervene. -Resident #9 used her right hand and started to strangle Resident #8. -No staff intervened, but allowed Resident #9 to continue using her right hand to strangle Resident #8. -One of the staff was heard telling Resident #9 to "punch her in the face." -Another staff asked; "Are you recording?" "You gonna send it to send me?" -From the video all three staff could be heard talking, laughing and commenting as Resident #9 and Resident #8 were fighting. -Resident #8 was trying to push Resident #9 off of her. -This altercation continued with no staff intervention to stop the residents from fighting. -Resident #8 attempted to bite Resident #9's arm. -The voice of one staff was heard in the background commenting "you making her turn

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 12 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL034093	B. WING		07	/26/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		3150 BU	RKE MILL ROAD			
DANBY HO	JU3E	WINSTO	N SALEM, NC 271	103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	9 12	D 338	n and a second second	۲.	
	red."					
		intervene to stan the				
	-The staff still did not					
		out continued to allow the				
	residents to fight.					
	-One of the staff was					
-	•	ervisor (MA) to come to the				
	room.					
	-The staff allowed the residents to continue hitting each other.					
		t Resident #9 "why are you				
	doing this."	t Resident #8 "why are you				
1		d to get off the bed and				
	away from Resident #					
		-5. Resident #8 by her shirt				
1	and pulled her back d					
		neard again yelling for the				
	MA.	leard again yelling for the				
		/A "you moving too slow,				
	you moving too damn					
		off the bed with Resident				
	#9 still motioning with	both arms and hands to hit				
	Resident #8.	d to push Decident #0 put				
[		ed to push Resident #9 out attempted to close the				
	- 가장에는 이상에서 가장을 벗고 있는 것이 아니는 것이 아니는 것이 가장 같아.	yelling at Resident #8,"Don't				
	you push her".	yeiling at Resident #6, Dont				
		door smiling and did not				
		incident, but pointed her				
		saying, "Stop you better sit				
	down and stop, go to					
	-Resident #8 sat on th					
	-The video ended.	le bed,				
	-The video ended.					
	1. Review of Resident	t #8's current FL2 dated				
	05/29/19 revealed dia					
1		evel of care was Special				
	Care Unit (SCU).					
		stantly disoriented				
	-The resident was constantly disoriented. -The profile data for cognitive impairment					
	assessed the resident					1
	Ith Service Regulation	as being considinity			Charlenge	

STATE FORM

6899

G56611

If continuation sheet 13 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74401 2741	JI CONTRECTION		A, BUILDING:		
		HAL034093	B. WNG		07/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE	
DANDY	01165	3150 BURI	E MILL ROAD		
DANBY H	OUSE	WINSTON	SALEM, NC 27	/103	
(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 APPROP DEFICIENCY)	BE COMPLETE
D 338	Continued From page	ə 13	D 338		
D 338	disoriented. -The interventions that included supervision. Review of Resident # was no documentatio (fight) that occurred of Interview with Reside 7/26/19 at 6:05pm rev- -A Detective from the called and told the fail #8 was involved in a part another resident. -The Detective informative altercation was records staff at the facility, and through social media. -The Detective also in separate recordings to -The Detective told he staff shoving Resident the bed. -The second recording resident, while staff of intervene, but encour- -She was also contact "someone from the co- incident and was told doing an investigation	at were required by staff 8's record revealed there on related to the incident on 06/19/19. Int #8's family member on vealed: local police department mily member that Resident physical altercation with ned her that the physical ded on a cell phone by a d the video was shared Informed her there were two that involved Resident #8. er that the recording showed at #8 into her room and onto ang showed Resident #8 al altercation with another observed and did not raged the behavior. cted by the supervisor, orporate office", about the I that the facility would be n.	D 338		
	The ready set of the s	had contacted her since incident first occurred.			
	was not interviewable	ermined that Resident #8 ə.			
	Refer to interview the police department on	Detective from the local city			
Division of He	alth Service Regulation				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		HAL034093	B. WING		07/26/2019
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
ANBY H	OUSE		RKE MILL ROAD		
	1		N SALEM, NC 271	ndet an and	
(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 COMPLETE
D 338	Continued From page	9 14	D 338		
	Refer to interview with President of Operatio	n the Regional Vice ns on 07/25/19 at 3:38pm.			
		on 07/25/19 at 4:01pm.			
	Refer to interview with (PCA) in the Special ( 07/26/19 at 4:05pm.	n a Personal Care Aide Care Unit (SCU) on			
	Refer to interview with at 1:40pm.	n Staff C, PCA on 07/26/19			
	05/29/19 record revea dementia.				
	Care Unit (SCU).	evel of care was Special ermittently disoriented.			
	Review of Resident # assessment form date - The profile data for or assessed the resident disoriented. -The interventions that included supervision.	ed 06/26/19 revealed: cognitive impairment			
		9's record revealed no d to the incident (fight) that			
	07/26/19 at 5:50 pm r -She received a telep	nt # 9's family member on evealed: hone call from a police ed her about the incident			
	with Resident #9 and -The Detective made				

STATE FORM

6899

G56611

If continuation sheet 15 of 82

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  DANBY HOUSE  (X4) ID PREFIX (CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  STREET ADDRESS, CITY, STATE, ZIP  STREET ADDRESS, CITY, STATE, ZIP  STREET ADDRESS, CITY, STATE, Z	07/26/2019 (X5) COMPLETI DATE
A150 BURKE MILL ROAD WINSTON SALEM, NC 27103       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
DANBY HOUSE         WINSTON SALEM, NC         27103           (X4) ID PREFIX         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         ID PREFIX         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
DEFICIENCY)	
D 338       Continued From page 15       D 338         altercation.       -He also made her aware the incident was recorded on a cell phone, and that the recording was shared through social media.       -After the phone call from the detective she went to the facility to check on Resident #9, and she was fine.         -She had not seen the video, but was aware it was recorded and shared through social media.       -She had not seen the video, but was aware it was recorded and shared through social media.         -She had not seen the video, but was aware it was recorded and shared through social media.       -Someone from the facility's corporate office had also contacted her regarding the incident.         -After as she knew, there had been no other videos or incidents that occurred because another resident came into Resident #9 and staff video recording.       -She was told the incident cocurred because another resident #9 was telling the resident to get out.         -The other resident would not leave, so they started to fight.       -Resident #9 grabbed the other lady by the neck and put her down on the bad.         -She was told that the staff got out a cell phone and recorded the fight between them.       -She was told that the staff got out a cell phone and recorded the fight between them.         -She was told that the staff got out a cell phone and recorded the fight between them.       -She was told that the staff got out a cell phone and recorded the fight between them.         -She was told that the staff got out a cell phone and recorded the fight between them.       -She was told that the staff got out a cell phone and recorded the fight betweent them. <td></td>	

STATE FORM

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY
		HAL034093	B. WING		07	/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
	OURE	3150 BU	IRKE MILL ROAD			
DANBY H	OUSE	WINSTO	N SALEM, NC 271	103		
(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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 16	D 338		1 000000000000000000000000000000000000	
	President of Operatio	ons on 07/25/19 at 3:38pm.				
	Refer to interview wit Aide/Supervisor (MA)	h the Medication ) on 07/25/19 at 4:01pm.				
	Refer to interview with (PCA) in the Special 07/26/19 at 4:05pm.	h a Personal Care Aide Care Unit (SCU) on				
	Refer to interview with at 1:40pm.	h Staff C, PCA on 07/26/19				
	police department on revealed:	tective from the local city 07/26/19 at 2:30pm ice department received a				
	anonymous.	son desiring to remain e received two videos via				
	social media messen	ger that were disturbing. staff at an assisted living				
	-The caller stated she	a did not work at the assisted not know the staff at the				
	-The friend told her th employee that worked	iend sent her the video. hat she got the video from an d at the assisted living				
		incident happened three ng the police department.				
	investigate, but did no	cer went to the facility to ot get much information. rective went back to the				
	facility to observe if the involved in the physic					
	bruises. -The Detective did no bruises on the resider	nt observe any scars or nts.				
	-The Detective did ide	entify the staff and residents				

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 17 of 82

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE ID. (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREEIX PREEIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 338 Continued From page 17 D 338 in Video #1. -The two residents fighting in the video were identified as Residents #8 and #9. -The fight occurred in Resident #8's room, which was not Resident #9's room. -There were three staff present when the video was recorded. -One of the three staff (Staff C) recorded Video #1. -A second staff was heard asking, "Are you recording this, send me a copy?" -Staff A (Personal Care Aide/PCA) observed the fight. Staff B (PCA) also observed the fight and asked to be sent a copy of the video, and Staff C (PCA) recorded the video using her personal cell phone. -Staff C also encouraged Resident #9 to hit Resident #8 in the face. -Staff C told the Detective that Resident #8 often screamed at her roommate and other residents. -Staff C told the Detective on the date that she recorded the video Resident #8 was in a disturbance with her roommate and the roommate was on the floor. -When staff went to the room to see what was happening Resident #9 followed staff to the room. -When in the room Resident #8 started to yell and scream at Resident #9. -Resident #9 got upset and started hitting Resident #8. -She decided to record the video because Resident #8 was a "Pain in the butt." -Staff B told the officer that she sent the video to a friend that did not work at the facility. -Staff B told the Detective she sent the video because the friend wanted to work at the facility, and she wanted to warn the friend of the type of environment at the facility. -The Detective also found out who the staff and residents were in Video #2. Division of Health Service Regulation

Division of Health Service Regi STATE FORM

G56611

If continuation sheet 18 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 338 Continued From page 18 D 338 -In video #2, the resident on the floor in the hallway was identified as Resident #10. -In video #2, the resident that Staff A pushed in the room, turned the light off, told to go to sleep and closed the door was Resident #8. -Staff B (PCA) was the staff who recorded Video #2. Interview with the Regional Vice President of Operations on 07/25/19 at 3:38pm revealed: -She found out about one video via text message on 06/20/19 after 7pm. -In the text message a former employee informed her that she had received a video regarding residents in the SCU fighting. -On Friday, 06/21/19 during a staff meeting she asked all of the staff about a video. -No staff admitted to knowing about the video. -Later, Staff A called the regional office and said she wanted to talk about the video. -Staff A told her the name of the two residents that were fighting. -Staff A told her the video was recorded on 06/19/19. -Staff A admitted she was in the video, -Staff A stated that Resident #8 was having a bad night. -The resident had spit on her three times, and she walked away. -She called the Medication Aide/Supervisor (MA) to break-up the fight between the two residents. -Staff A informed her that Staff C had video recorded the incident, and Staff B asked to get a copy of the video. -The police came to the facility on 06/24/19, and informed her that there were two videos. -After watching both videos, Staff A, B, and C were put on probation pending termination. -She did an investigation and talked with the staff that were in the SCU on the date of the incident.

Division of Health Service Regulation

STATE FORM

**Division of Health Service Regulation** 

6899

G56611

If continuation sheet 19 of 82

Division of Health Service Regu	lation
---------------------------------	--------

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1,120,100,000,000,000,000,000	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL034093	B, WING		07/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	
DANDVU		3150 BURK	E MILL ROAD		
DANBY H	OUSE	WINSTON	SALEM, NC 27	103	
(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)	DBE COMPLETE
D 338	<ul> <li>The Medication Aide supervisor in charge a reported the incidents.</li> <li>They had informed s about a video circulat they knew.</li> <li>The MA denied knowing about Resident #8 and Resident #8 and Resident #8 and Resident #8 and Resident at the MA.</li> <li>Based on the MA's date altercation and the vide against the MA.</li> <li>All staff were trained confidentiality and report incidents of resident away.</li> <li>Staff should have report incidents to here posted for staff in the staff were staff were staff in the staff were staff were staff in the staff were staff</li></ul>	(MA) on duty was the and staff should have a to the MA. taff that if anyone knew ing they should tell what ving about a video and t a physical altercation with ident #9. enial of the physical deo no actions were taken on residents' rights, borting resident abuse and blicy that their staff were to sident abuse and neglect borted the incident to any of their telephone numbers to view. dication Aide/Supervisor 4:01pm revealed: broked in the SCU as the MA. sor and staff were to report the evening medication d heard Resident #8 and t each other. what moment the residents on, but the yelling could be yelling for her to come to room she noticed Resident	D 338	DEFICIENCY)	
	Resident #8. -She told the PCAs n	ot to "Entice" the residents			

Division of Health Service Regulation STATE FORM

.

6899

G56611

If continuation sheet 20 of 82

D	ivision	of Health	Service	Regul	lation
~	1101011	or round	001 1100	1 LOGUI	auor

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A, BUILDING:	CONSTRUCTION		E SURVEY PLETED
•		HAL034093	B. WING		07	7/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD			
			N SALEM, NC 27	103	ata	
(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 / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	20	D 338			
	to argue, but to calm or residents in their room -To her knowledge no fight between Resider -She did not know tha -She found out there or meeting on 06/21/19. -When she came to the staff using the phone. -It was the facility's po- with you or out when or -She did not assess Foon 06/19/19 because had been fighting. Interview with a Perso 07/26/19 at 4:05pm re -On 06/19/19, she wa second shift. -Close to 7:00pm she Resident #8 pushed h -The MA did an incide Resident #8's roomma -No one mentioned th were fighting. Interview with Staff C, 1:40pm revealed: -She had worked at the as a PCA. -When she was hired videos regarding reside confidentiality. -She knew that she way report any form of abu- -On 06/19/19, she wo second shift in the SC -Around 7:00pm she fill	everyone down and put the s. staff had encouraged a ht #8 and Resident #9. It staff recorded a video. was a video during a staff he room, she did not notice of the clock. tesident #8 or Resident #9 she did not know that they anal Care Aide (PCA) on evealed: s working as a PCA on the heard another staff say that ther roommate onto the floor. Int report regarding ate being on the floor. at Residents #8 and #9 PCA on 07/26/19 at he facility since May 2019, she was required to watch lents' rights, and as required to immediately use or neglect of a resident rked at the facility on the				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	1910 N. (2010) - California Control (1910) - California Control (1910)	3) DATE SURVEY COMPLETED
		HAL034093	B. WING		07/26/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
DANBY HO	311SE	3150 BUI	RKE MILL ROAD		
UANUTIN	5001	WINSTO	N SALEM, NC 271	03	
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
D 338	Continued From page	21	D 338		
D 338	-Staff went to Resident #9 followed staff, white Resident #9. -While staff was talkin #9 started to repeat w -Resident #8 started y loud voice. -Resident #8 started y loud voice. -Resident #9 got upse Resident #8. -The staff (Staff A and her cell phone to reco residents #8 and #9. -The staff asked her t because their cell pho -She recorded the fig Resident #9 and forw and Staff B. -She did not send the -The MA on duty was recording the video b room and could see f -Also, the MA was se the doorway of Resid where the incident to -She knew recording against the facility's r -She sent the video b asked her to record a -She knew that she w report the incident, bu -She had no reason of	nt #8's room and Resident ch was common for ag to Resident #8, Resident what staff was saying. yelling at Resident #9 in a et and started hitting at Staff B) asked her to use ord the fight between o use her cell phone ones were charging. It between Resident #8 and arded the video to Staff A evideo to anyone else. aware that she was ecause the MA came to the her phone recording. en in the video standing in ent #8's room, which was ok place. and sending the video was asidents' rights policy. ecause Staff A and Staff B nd to send them the video. vas required to immediately ut she did not. or excuse why she allowed	D 338		
	-It was the facility's pointervene and stop re -They (staff) allowed because Resident #8	the residents' to fight always caused problems. ed and yelled at other			
	·····································	voice. ent #8 was causing problems			

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 22 of 82

	Division	of Health	Service	Regulatio
--	----------	-----------	---------	-----------

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			E SURVEY PLETED
and the second		HAL034093	B. WING		07	/26/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD			
- CTLL			N SALEM, NC 271	03		
(X4) ID PREFIX TAG	(EACH DEFICIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	22	D 338			
	<ul> <li>Resident #8 pushed floor in the hallway.</li> <li>Resident #8 had also roommate and other in -They (Staff A, B and #8's behaviors.</li> <li>Staff A told Resident</li> <li>Staff A followed Resident</li> <li>Staff A followed Resident</li> <li>Staff A followed Resident</li> <li>She helped Resident</li> <li>She helped Resident</li> <li>She did not assess F informed the MA.</li> <li>She did not know if th #10 for bruises or injut</li> <li>Interview with the Adr 5:15pm revealed:</li> <li>All facility staff were the residents.</li> <li>The facility's confident recording of residents</li> <li>Staff should not be un they were on duty.</li> <li>She learned of the vither President of Operation someone that did not</li> <li>She did not know any the Detective from the came to the facility.</li> <li>The Detective also in two videos.</li> <li>Since she learned at videos Staff A, B, and facility.</li> </ul>	Resident #10 down on the o been into it with her residents in the SCU. C) had their fill of Resident #8 to go to her room, dent #8 to her room, turned he door. #10 off the hallway floor. Resident #10 for injuries, but the MA assessed Resident rise. Ininistrator on 07/26/19 at trained how to intervene with ors, especially SCU Intially policy did not allow the for social media. sing their cell phones when deo from the Regional Vice ns, who got the video from work at the facility. y details until 06/24/19 when e local police department formed her that there were yout and observed the C were terminated from the	D 338			
		hree staff (Staff A, Staff B orted to the health care 6/28/19.				
	Staff A and Staff B we					

STATE FORM

#### **Division of Health Service Regulation** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 338 D 338 Continued From page 23 interview. B. Review of Video #2 on 07/26/19 at 3:10pm revealed: -The video started with the view of the main hallway in the SCU. -The staff (Staff B) was recording the video as she walked down the hallway. -Staff B appeared to be following another staff person (Staff A/Personal Care Aide) down the hallway. -Staff A was walking hurriedly towards Resident #8's bedroom. -The video showed a resident (Resident #10) lying on the floor. -The staff that was walking down the hallway walked past the resident that was on the floor and left the resident on the floor. -The staff that was recording the video also walked past the resident that was lying on the floor and got a full body and face view of the resident. -There was a third staff (Staff C) in view of the resident lying on the floor in the hallway. -Out of the three staff no one stopped to assist the resident that was lying on the floor. -Resident #8 is seen standing in her bedroom doorway yelling. -In the video Staff A was seen verbally telling a resident (Resident #8), as Staff A was walking hurriedly toward Resident #8, she is seen making hand gestures and pointing at Resident #8, and is heard telling her sharply "Get in there, get in there." -In the doorway of the room was another staff (Staff C), who stood behind Resident #8. -Staff A approached Resident #8 abruptly, shoved her forcefully into the room, turned off the light, shut the bedroom door and yelled, "Go to sleep!". -Staff C moved from the doorway entrance a few

Division of Health Service Regulation STATE FORM

6699

G56611

If continuation sheet 24 of 82

Division	of Health	Service	Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	01 10000000000000000	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		E SURVEY PLETED
		HAL034093	B. WING		07	//26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
DANBY H	OUSE		IRKE MILL ROAD	102		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	E CORRECTION	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	24	D 338			
	inches further into the -The video ended.	hallway.				
	05/29/19 record revea	t #8's current FL2 dated aled diagnoses of dementia. evel of care was special astantly disoriented.				
	profile and assessment revealed: -The profile data for con- assessed the resident disoriented.					
	Based on record revie interviews, it was dete was not interviewable	ermined that Resident #8				
				×		
	There was no SCU pr in Resident #10's reco	ofile and assessment form ord.				
	Based on record revie interviews, it was dete was not interviewable	rmined that Resident #10				
	police department on revealed;	ce department received a				

Division of Health	Service	Requ	lation
--------------------	---------	------	--------

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CONRECTION	IDENTIFICATION NONBER.	A. BUILDING: _		CONTRECTED	
		HAL034093	B. WING		07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE		
DANDVU	01185	3150 BURK	E MILL ROAD			
DANBY H	UUSE	WINSTON	SALEM, NC 27	/103		
(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 COMPLE	
D 338	disturbing. -The videos involved facility and residents -The caller stated sha living facility and did in facility. -The caller stated a fr -The friend told her the employee that worker facility. -The caller stated the days prior to her callin -The Detective went to 06/22/19, and 06/24/ the staff and resident -The resident on the identified as Residen -The resident that state turned the light off, to the door was Residen -The staff that pusher turned off the light, to the door was Staff A -Staff B (PCA) was the Video #2. Interview with the Re Operations on 07/25/ -She found out about on 06/20/19 after 7:0 -In the text message she received a video unit residents fighting -On Friday, 06/21/19 asked all staff about	e received two videos messenger that were staff at an assisted living in the SCU. e did not work at the assisted not know the staff at the riend sent her the video. nat she got the video from an d at the assisted living e incident happened three ng the police department. to the facility on 06/21/19, 19, and was able to identify s in Video #2. floor in the hallway was t #10. aff pushed in the room, old to go to bed and closed nt #8. d Resident #8 into the room, old to go to bed and closed (PCA). the staff who recorded the gional Vice President of /19 at 3:38pm revealed: t one video via text message Opm. a former employee informed regarding to memory care g. during a staff meeting she	D 338			
	prior to the police she -The police detective	owing her the video. came to the facility on				

STATE FORM

STATEMENT	D Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURV COMPLETE	
		HAL034093	B. WING		07/26/201	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD			
	SI IMMARY ST	ATEMENT OF DEFICIENCIES	N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	DBE C	(X5) COMPLETE DATE
D 338	Continued From page	26	D 338			
		ed there were two videos.				
	-After watching the se	econd video, she informed				
	Staff A not to return ba- All staff were trained					
		porting resident abuse and				
	neglect.	the second se				
	-It was the facility's po	olicy that staff were to report				
	incidents right away.	10 10-010-000 Mr. 200-000 U.S. 67				
		ported the incident to any				
		of their telephone numbers			1	
	were posted for staff to view. -The facility had investigated the incident involving Resident #8 and Staff A. -During their investigation they talked with the MA					
	incident.	or on duty the date of the				
		ing Staff A had shoved				
	Resident #8 into her r					
	addressed.	eft on the floor was not				
	-No actions were take	en against the MA because				
	she denied having kn	owledge of the incident.				
		dication Aide/Supervisor				
	(MA) on 07/25/19 at 4					
	-One 06/19/19, she w MA.	rorked in the SCU as the				
		sor and staff were to report		5		
	all incidents to her.					
		the evening medication				
	pass after 7:00pm and	d heard two residents				
	yelling.	yelling for her to come to				
	Resident #8's room.	young for nor to come to				
		calm everyone down and				
	put the residents in th	eir room.				
		at staff recorded a video.				
		was a video during a staff				
	meeting on 06/21/19.	off no condina vide				
	-She had not seen sta alth Service Regulation	an recording videos.				

Division of Health Service Regulation STATE FORM

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		HAL034093	B. WING		07/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE	
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	03	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 338	<ul> <li>It was the facility's p their cell phones out - She did not know tha Resident #8 in her ro</li> <li>She did not know tha pushed to the floor of Interview with Staff C 1:40pm revealed:</li> <li>On 06/19/19, Reside with everyone.</li> <li>Resident #8 pushed floor in the hallway.</li> <li>Resident #8 was als roommate.</li> <li>They (Staff A, B and #8's behaviors.</li> <li>The MA had told stat calm and put the resi- Staff A told Resident</li> <li>Staff A followed Ress off the light and shut</li> <li>She helped Residert</li> <li>She did not assess informed the MA.</li> <li>She did not know if #10 for bruises or inj</li> <li>Staff A and Staff B w Interviews.</li> <li>The facility failed to p (Residents #8, #9, a neglect. Residents # residents of the facili Residents #8 and # residents # r</li></ul>	blicy for staff not to have when on the clock. at Staff A had pushed om. at Resident #10 had been thad fallen to the floor. c, PCA on 07/26/19 at ent #8 was causing problems Resident #10 down on the o causing problems with her C) had their fill of Resident ff to try to keep residents dents in their room. t #8 to go to her room. ident #8 to her room, turned the door. at #10 off the floor. Resident #10 for injuries, but the MA assessed Resident uries. off A's actions and Resident t. ere not available for	D 338		

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 28 of 82

Division o	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		HAL034093	B. WING		07	/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		IRKE MILL ROAD N SALEM, NC 271	03		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	#8 until Resident #8 # Staff C recorded the video through social in pushed Resident #10 followed Resident #8 yelling at Resident #8 #8 into her room, whi the floor unable to ge A's actions and Reside and later shared the The failure of the faci of all residents guara of Residents' Rights with the serious abuse an	ent #9 strangled Resident became red in the face while ncident and later shared the media. After Resident #8 down in the hall, Staff A down to the resident's room, and then shoved Resident le Resident #10 was lying on t up. Staff B recorded Staff tent #10 lying on the floor video through social media. lity to assure that the rights inteed under the Declaration were maintained resulted in	D 338		а 	
5	07/26/19 in accordan this violation. CORRECTION DATE	a Plan of Protection on ce with G.S. 131D-34 for EFOR THE TYPE A1 IOT EXCEED AUGUST 26,				
D 358	(a) An adult care hor preparation and admi	I(a) Medication I Medication Administration ne shall assure that the inistration of medications, prescription, and treatments	D 358	÷		

by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 29 of 82

#### Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: \_ B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 29 10A NCAC 13F .1004(a) Medication 9/9/2019 Administration Director of Resident Care (DRC) and Residen Care Coordinator (RCC) will conduct resident chart audits and cart audits. Any identified areas will be addressed immediately. ED, DRC and RCC will This Rule is not met as evidenced by: conduct training to MAs regarding medication TYPE B VIOLATION administration related to medications not in facility and administration of Based on observations, interviews and record meds. MAs will notify DRC and/or RCC reviews, the facility failed to administer when medications are not available for medications as ordered for 6 of 7 sampled residents (#1, #2, #4, #5, #6 and #7) including a administration. DRC and/or RCC will resident who did not receive a medication for fluid contact pharmacy immediately to have the build up, thyroid hormone deficiency, neuropathic medications delivered in a timely manner. pain, depression, and allergies (Resident #7), a DRC and RCC will conduct weekly resident who did not receive medications for high chart audits and cart audits to ensure blood pressure, neuropathic pain, overactive compliance. ED will monitor compliance bladder and pain (Resident #2), a resident who through random audits and observations. did not receive medications for chronic pain, fluid retention and anxiety (Resident #1), a resident who did not receive medications for depression and Alzheimer's disease(Resident #5) a resident who did not receive two medications for depression (Resident #6); and a resident with orders for Clonidine (used to treat high blood pressure) as needed for systolic blood pressures greater than 160 (Resident #4). The findings are: 1. Review of Resident #7's current FL2 dated 05/21/19 revealed the diagnosis of schizoaffective bipolar disorder. a. Review of Resident #7's current FL2 dated 05/21/19 revealed a physician's order for spiranolactone 50 mg (used to treat fluid build up) Division of Health Service Regulation

STATE FORM

6899

TATEMENT OF DEFICIENCIE ND PLAN OF CORRECTION		(X2) MULTIPLE CC A. BUILDING;		(X3) DATE COMF	SURVEY PLETED
	HAL034093	B, WING	80-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	07	/26/2019
AME OF PROVIDER OR SUP	PPLIER STRE	ET ADDRESS, CITY, STATE,	ZIP CODE		
ANBY HOUSE		BURKE MILL ROAD STON SALEM, NC 2710	)3		
PREFIX (EACH	JMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
D 358 Continued F	rom page 30	D 358		and the second	
twice daily.					
Medication A revealed: -An entry for -The entry in one tablet (5 -There was o	Resident #7's May 2019 electronic Administration Record (eMAR) spironolactone 50 mg, once daily. Included "special instructions" take 0 mg total) by mouth 2 times daily. documentation of administration of ne 50 mg once daily from 05/01/19 11/19.				
revealed: -An entry for -The entry for instructions" mouth 2 time -There was of spironolactor 06/02/19 and -There was of mg, once da	esident #7's June 2019 eMAR spironolactone 50 mg, once daily. or spironolactone included "special take one tablet (50 mg total) by es daily. documentation of administration of ne 50 mg once daily on 06/01/19, d from 06/21/19 through 06/30/19. documentation of spironolactone 50 ily "not administered: drug/item from 06/03/19 through 06/20/19.				
-An entry for -The entry for instructions" mouth 2 time -There was o	ocumentation of administration of ne 50 mg once daily from 07/01/19				
medication of spironolactor administration					
Interview wit	h a contracted pharmacy				

	PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
			B. WING		07	/26/2019
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	03		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	representative on 07/ -When refills were ne request refills for Res -The order on file at th spironolactone 50 mg times daily. -She did not know wh spironolactone 50 mg instructions" to take of daily, which was the s -The pharmacy sent 3 50 mg on 05/09/19, 0 07/23/19. Interview with a Medi 07/26/19 at 10:40 am -She did not know wh was unavailable for a #7 in June 2019. -She had never notice for the spironolactone -"I guess it should be Interview with Reside 07/26/19 at 12:20 pm -She expected medic ordered. -She had ordered the administered twice da -She was unaware th being administered o daily. -Resident #7 had no receiving the spirono twice daily. -Resident #7's edema	26/19 at 9:35 am revealed: eded, the facility staff had to ident #7. he pharmacy was one tablet by mouth 2 y the electronic entry for included "special ine tablet by mouth 2 times same as the order. 30 tablets of spironolactone 6/20/19, 07/05/19 and cation Aide (MA) on revealed: by the spironolactone 50 mg dministration for Resident ed the "special instructions" e entry on the eMARs. given twice every day". int #7's physician on revealed: ations to be administered as e spironolactone 50 mg to be aily. e spironolactone 50 mg was nce daily, instead of twice	D 358			

STATE FORM

#### STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From page 32 D 358 D 358 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the Resident Care Coordinator (RCC) on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. b. Review of Resident #7's current FL2 dated 05/21/19 revealed a a physician's order for levothyroxine 150 mcg (used to treat thyroid hormone deficiency) daily. Review of Resident #7's June 2019 eMAR revealed: -An entry for levothyroxine 150 mcg daily. -Levothyroxine was documented as administered for 27 of 30 opportunities from 06/01/19 through 06/30. -Levothyroxine 150 mcg was documented as "not administered: drug/item unavailable" for 3 of 30 opportunities during the month of June. Review of Resident #7's July 2019 eMAR revealed: -An entry for levothyroxine 150 mcg daily. -Levothyroxine 150 mcg was documented as administered for 13 of 24 opportunities from 07/01/19 through 07/24/19. -Levothyroxine 150 mcg was documented as"not administered: drug/item unavailable" for 11 of 24 opportunities during the month of July. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #7 revealed levothyroxine 150 mcg was available for administration, Interview with a contracted pharmacy

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

6699

#### **Division of Health Service Regulation** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 33 representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #7. -The pharmacy sent 30 tablets of levothyroxine 150 mcg on 04/23/19. -The pharmacy sent 30 tablets of levothyroxine 150 mcg on 05/06/19, and the facility staff returned it to the pharmacy. -She did not know why the facility staff returned the levothyroxine 150 mg to the pharmacy. -The pharmacy sent 14 tablets of levothyroxine 150 mcg on 07/14/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the levothyroxine 150 mcg was unavailable for administration for Resident #7 in June and July 2019. Interview with Resident #7's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of levothyroxine 150 mcg for Resident #7. -The missed doses of levothyroxine 150 mcg were "unacceptable". -She would order a thyroid stimulating hormone (TSH) lab to be drawn on Resident #7 as soon as possible. Interview with Resident #7 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. Division of Health Service Regulation

STATE FORM

6899

# Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034093	B. WNG		07/:	26/2019
	ROVIDER OR SUPPLIER					
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP GODE		
DANBY H	OUSE		RKE MILL ROAD			
		and the second	N SALEM, NC 27	103		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	Continued From page	34	D 358		ne patrica	
	05/21/19 revealed a p levothyroxine 50 mcg hormone deficiency) & Sunday, given with th Review of Resident # revealed: -An entry for levothyro Wednesday and Sund levothyroxine 150 mg -Levothyroxine 50 mc administered on Wedn of 9 opportunities from -Levothyroxine 50 mc administered: other, 3	, (used to treat thyroid every Wednesday and e levothyroxine 150 mcg. 7's May 2019 eMAR exine 50 mcg on day, along with the daily dose. g was documented as nesdays and Sundays for 8 n 05/01/19 to 05/31/19. g was documented as "not		8		
	of 9 opportunities from -Levothyroxine 50 mc administered: drug/ite 06/05/19 and Sunday opportunities from 06/ -Levothyroxine 50 mc administered: residen 06/19/19 and Wednes opportunities from 06/ Review of Resident # revealed:	oxine 50 mcg on lay, along with the daily dose. g was documented as nesdays and Sundays for 5 n 06/01/19 to 06/30/19. g was documented as "not m unavailable" on Sunday 06/26/19 for 2 of 9 01/19 to 06/30/19. g was documented as "not t refused" on Sunday sday 06/12/19 for 2 of 9 01/19 to 06/30/19.				
	-An entry for levothyro	oxine 50 mcg on				
Division of Hea	alth Service Regulation		1		and the second se	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A, BUILDING:		(X3) DATE COMF	LETED
		HAL034093	B. WING		07	/26/2019
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	0.2		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	ə 35	D 358			
	Wednesday and Sun	day, along with the				
	levothyroxine 150 mg					
		cg was documented as				
	administered on Wed					
		for 2 of 7 opportunities.				
		cg was documented as "not em unavailable" on Sunday				
		y 07/10/19 and Sunday				
	07/14/19 for 3 of 7 op					
		g was documented as "not				
	1	omment: duplicate" on				
		Wednesday 07/24/19 for 2				
	of 7 opportunities.					
	Observation on 07/25					
		or Resident #7 revealed				
	levothyroxine 50 mcg administration.	was available for				
	Interview with a contr					
		26/19 at 9:35 am revealed:				
		eded, the facility staff had to				
		9 tablets of levothyroxine 50				
	mcg on 04/23/19.					
	-The pharmacy sent mcg on 07/14/19.	5 tablets of levothyroxine 50				
	Interview with a MA c	on 07/26/19 at 10:40 am				
		gave the medicine" in				
		umentation of the missed				
		e on Sunday 05/05/19.				
		ny the levothyroxine 50 mcg				
	이 이 밖에서 안 없다고, 말한 다고 아파리고 아파 나라 나라 나라 가지 않는 것이 나라 있다. 이것	administration for Resident				
	#7 in June and July 2	2019.				
	Interview with Reside					
	07/26/19 at 12:20 pm	n revealed:				
	-Her expectation was	s medications would be				

STATE FORM

6699

G56611

If continuation sheet 36 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING			
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 07	/26/2019
ANBYH	OUSE		RKE MILL ROAD			
	OUSE	WINSTO	N SALEM, NC 271	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIE)	CTION SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 36	D 358	<u></u>		
	missed doses of levo Resident #7. -The missed doses of "unacceptable". -She would order a T Resident #7 as soon Interview with Reside pm revealed as far as administered her med Refer to interview with 11:35 am. Refer to interview with 07/26/19 at 2:15 pm. d. Review of Residen 05/21/19 revealed a p gabapentin 100 mg (u pain) two tablets even Review of Resident # revealed: -An entry for gabaper -Gabapentin 100 mg as administered for 2	not informed her of the thyroxine 50 mcg for f levothyroxine 50 mcg were SH lab to be drawn on as possible. ent #7 on 07/26/19 at 3:30 is she knew the facility dications as ordered. In the RCC on 07/26/19 at the the RCC on 07/26/19 at the the Administrator on it #7's current FL2 dated obysician's order for used to treat neuropathic ry evening. E7's June 2019 eMAR intin 100 mg two tablets daily, two tablets was documented 5 of 30 opportunities from				
	as "not administered:	two tablets was documented drug/item unavailable" for 5 uring the month of June.				
	-Gabapentin 100 mg	ntin 100 mg two tablets daily. two tablets was documented 8 of 23 opportunities from				

### Division of Health Service Regulation

STATEMEN	<u>of Health Service Regu</u> T of DEFICIENCIES OF CORRECTION	Iation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL034093	B. WNG		07/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E, ZIP CODE	
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	103	
(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 GORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	-Gabapentin 100 mg as "not administered: of 23 opportunities da Observation on 07/25 medication on hand f gabapentin 100 mg v administration. Interview with a contr representative on 07/ -When refills were ner request refills for Res -The pharmacy sent mg on 05/07/19 and on 07/24/19. Interview with a MA of revealed she did not 100 mg was unavailad days in June 2019 for Interview with Reside 07/26/19 at 12:20 pm -Her expectation was administered as order -The facility staff had missed doses of gab #7. -If the missed doses negative outcome, the be pain. -Resident #7 had not Interview with Reside pm revealed as far a administered her me	two tablets was documented drug/item unavailable" for 5 uring the month of July. 5/19 at 10:00 am of for Resident #7 revealed vas available for racted pharmacy (26/19 at 9:35 am revealed: weded, the facility staff had to sident #7. 60 tablets of gabapentin 100 30 tablets on 07/02/19 and on 07/26/19 at 10:40 am know why the gabapentin able for administration for 5 r Resident #7. ent #7's physician on n revealed: a medications would be ored. not informed her of the apentin 100 mg for Resident of gabapentin 100 mg had a ne negative outcome would	D 358		
Division of He	ealth Service Regulation				

Division of Health Service Regulation STATE FORM

6668

G56611

If continuation sheet 38 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING:	ONSTRUCTION		E SURVEY PLETED
	T.	HAL034093	B. WING		07	/26/2019
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ANBY H	OUSE		RKE MILL ROAD			
		WINSTO	N SALEM, NC 271	03	and the second s	
(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 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	38	D 358			
	Refer to interview with 07/26/19 at 2:15 pm.	n the Administrator on				
	e. Review of Residen 05/21/19 revealed a p bupropion HCL 150 m depression) daily.					
	administered for 12 of 05/01/19 to 05/31/19. -Bupropion HCL 150 r administered: on hold from 05/01/19 to 05/3 -Bupropion HCL 150 r	on HCL 150 mg daily. mg was documented as f 31 opportunities from mg was documented as "not " for 13 of 31 opportunities				
	administered for 10 o 06/01/19 to 06/30/19. -Bupropion HCL 150	on HCL 150 mg. mg was documented as f 30 opportunities from mg was documented as "not em unavailable" for 20 of 30			x a	
	administered for 16 o 07/01/19 to 07/24/19. -Bupropion HCL 150	on HCL 150 mg. mg was documented as f 24 opportunities from				

STATE FORM

6399

G56611

If continuation sheet 39 of 82

# Division of Health Service Regulation\_

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		DATE SURVEY COMPLETED
		HAL034093	B. WING		07/26/2019
NAME OF P	ROVIDER OR SUPPLIER	3150 BU	DDRESS, CITY, STATE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	WINSTO ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID ID PREFIX TAG	03 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	opportunities from 07 Review of Resident # revealed there was n HCL 150 mg. Observation on 07/25 medication on hand f buproplon HCL 150 m administration. Interview with a contr representative on 07/ -When refills were ne request refills for Res -The pharmacy sent 150 mg on 04/09/19, 15 tablets 07/04/19 a Interview with a MA of revealed she did not HCL 150 mg was una for Resident #7 on so July 2019. Interview with the phy pm revealed: -Her expectation was administered as ordet 150 mg was not on h -The facility staff had missed doses of bup Resident #7. -If the missed doses had a negative outco would be increased of -Resident #7 had not depression.	<ul> <li>/01/19 to 07/24/19.</li> <li>7's physician's orders order to holf bupropion</li> <li>6/19 at 10:00 am of or Resident #7 revealed ng was available for</li> <li>acted pharmacy</li> <li>'26/19 at 9:35 am revealed:</li> <li>eded, the facility staff had to ident #7.</li> <li>15 tablets of bupropion HCL 19 tablets on 05/20/19 and nd on 07/24/19.</li> <li>on 07/26/19 at 10:40 am know why the bupropion available for administration ome dates in May, June or</li> <li>ysician on 07/26/19 at 12:20</li> <li>a medications would be bred, and the bupropion HCL 10 mg for</li> <li>of bupropion HCL 150 mg for</li> <li>of bupropion HCL 150 mg me, the negative outcome</li> </ul>	D 358		

STATE FORM

6889

G56611

If continuation sheet 40 of 82

# (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: B. WING 07/26/2019

ANBY H	OUSE	RKE MILL ROAD	3	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION)	10.000 C 20.000 C 20.000	CROSS-REFERENCED TO THE APPROPRIATE	DATE
	-Loratadine 10 mg was documented as administered twice daily for 44 of 47 opportunities from 07/01/19 to 07/24/19. -Loratadine 10 mg was documented as "not			

STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

HAL034093

# Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			ESURVEY PLETED
	1	HAL034093	B. WING	07	07/26/2019	
NAME OF P DANBY H	PROVIDER OR SUPPLIER	3150 BU	NDDRESS, CITY, STATE IRKE MILL ROAD ON SALEM, NC 271	<ul> <li>The sum of provident to multi-</li> </ul>		
(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 AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	opportunities from 07. Observation on 07/25 medication on hand fe loratadine 10 mg was Interview with a contr representative on 07/ -When refills were ne request refills for Res -The pharmacy sent 6 mg on 05/01/19 and 06/20/1 and 07/17/19 and 06/20/1 and 07/17/19, and 30 Interview with a MA o revealed she did not 1 mg was unavailable f Resident #7 in May, Interview with Reside 07/26/19 at 12:20 pm -Her expectation was administered as orde -The facility staff had missed doses of lorat -If the missed doses negative outcome, th be increased allergy -Resident #7 had not symptoms. Interview with Reside pm revealed as far at administered her med Refer to interview with 11:35 am.	/01/19 to 07/24/19. //19 at 10:00 am of or Resident #7 revealed available for administration. acted pharmacy 26/19 at 9:35 am revealed: eded, the facility staff had to ident #7. 30 tablets of loratadine 10 05/23/19, 30 tablets on 9, 16 tablets on 07/05/19 tablets 07/26/19. or administration for June and July 2019. ant #7's physician on a revealed: medications would be red. not informed her of the tidine 10 mg for Resident #7. of loratidine 10 mg had a e negative outcome would symptoms. displayed increased allergy ent #7 on 07/26/19 at 3:30 is she knew the facility	D 358			

STATE FORM

G56611

If continuation sheet 42 of 82

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	ī.	
DANBY H	OUSE	3150 BL	IRKE MILL ROAD			
		WINSTO	N SALEM, NC 271	03		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	э 42	D 358			
	07/26/19 at 2:15 pm.					
	05/21/19 revealed dia	at #2's current FL2 dated agnoses included acute es mellitus, hematuria, se, and hypertension.				
	05/21/19 revealed a	sed to treat high blood				
	Medication Administra revealed: -An entry for amlodip -Amlodipine 10 mg w	ine 10 mg daily at 9:00 pm. as documented as				
	05/01/19 to 05/31/19. -Amlodipine 10 mg w	as documented as "not m not available" for 6 of 31				
	-Amlodipine 10 mg w administered daily for 06/01/19 to 06/30/19. -Amlodipine 10 mg w	ine 10 mg daily at 9:00 pm. as documented as r 28 of 30 opportunities from as documented as "not				
	opportunities from 06 Review of Resident #	em unavailable" for 2 of 30 /01/19 through 06/31/19. 2's July eMAR revealed: ine 10 mg daily at 9:00 pm.				
	-Amlodipine 10 mg w administered for 18 o 07/01/19 through 07/2 -Amlodipine 10 mg w	as documented as f 23 opportunities from				

STATE FORM

G56611

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 43 opportunities from 07/01/19 to 07/23/19, Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed amlodipine 10 mg was available for administration. Review of Resident #2's "Vitals Report" revealed: -Resident #2's blood pressure in May (no date was provided) was 122/72. -Resident #2's blood pressure on 07/26/19 was 130/78. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #2. -The pharmacy sent 30 tablets of amlodipine 10 mg on 04/17/19, 29 tablets on 05/10/19, 30 tablets 06/04/19 and 07/04/19. Interview with a Medication Aide (MA) on 07/26/19 at 10:40 am revealed she did not know why the amlodipine 10 mg was unavailable for administration for Resident #2 in May, June or July 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of amlodipine 10 mg for Resident #2, -If the missed doses of amlodipine 10 mg had a negative outcome, the negative outcome would be increased blood pressure. -Resident #7 had not displayed increased blood pressure.

Division of Health Service Regulation STATE FORM

G56611

If continuation sheet 44 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY	
		HAL034093	B. WING		07	07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
DANBY H	OUSE	3150 BU	RKE MILL ROAD				
		WINSTO	N SALEM, NC 271	)3			
(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 DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 44	D 358	1 March 199			
	- [사건: 19] 19] - 영상의 방향은 _ 양식의 방송가 없는 것 ~ 20~ 2007 (영향)	ent #2 on 07/26/19 at 2:52 not know what medications red to her.					
	Refer to the interview at 11:35 am.	with the RCC on 07/26/19					
	Refer to the interview 07/26/19 at 2:15 pm.	with the Administrator on					
	05/21/19 revealed a p	It #2's current FL2 dated ohysician's order for lisinopril high blood pressure) every					
	05/01/19 to 05/31/19. -LisInopril 10 mg was administered: drug/ite opportunities from 05 -Lisinopril 10 mg was	10 mg daily. documented as f 31 opportunities from documented as "not em unavailable" for 12 of 31 /01/19 to 05/31/19. documented as "not " for 5 of 31 opportunities					
		2's physician's orders o order to hold lisinopril 10		5			
		5/19 at 10:00 am of or Resident #2 revealed available for administration.					
	-Resident #2's blood was provided) was 12	2's "Vitals Report" revealed: pressure in May (no date 22/72. pressure on 07/26/19 was					

STATE FORM

G56611

If continuation sheet 45 of 82

#### Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 45 130/78. Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility had to request refills for Resident #2. -The pharmacy sent 14 tablets of lisinopril 10 mg on 05/25/19, 30 tablets on 06/05/19 and 07/04/19. Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the lisinopril 10 mg was unavailable for administration for Resident #2 in May 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered, and the lisinopril 10 mg was not on hold. -The facility staff had not informed her of the missed doses of lisinopril 10 mg for Resident #2. -If the missed doses of lisinopril 10 mg had a negative outcome, the negative outcome would be increased blood pressure. -Resident #7 had not displayed increased blood pressure. Interview with Resident #2 on 07/26/19 at 2:52 pm revealed she did not know what medications the facility administered to her. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. c. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for gabapentin 300 mg (used to treat neuropathic Division of Health Service Regulation

STATE FORM

6899

G56611

If continuation sheet 46 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
a),		HAL034093	B. WING	B. WING		07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
DANBY H	OUSE		RKE MILL ROAD				
0/10.10	CLIMMADV CT	ATEMENT OF DEFICIENCIES	N SALEM, NC 271				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 46	D 358				
	pain) three times daily	٧.					
	daily. -Gabapentin 300 mg administrated three til opportunities from 05 -Gabapentin 300 mg	ntin 300 mg three times was documented as mes daily for 77 of 93 /01/19 to 05/31/19. was documented as "not " for 16 of 93 opportunities					
	Review of Resident # revealed there was no 300 mg.	2's physician's orders o order to hold gabapentin					
	Observation on 07/25 medication on hand fo gabapentin 300 mg w administration.	or Resident #2 revealed					
	-When refills were new request refills for Res -The pharmacy sent 9 mg on 04/30/19, 48 ta tablets on 06/04/19, a	26/19 at 9:35 am revealed: eded, the facility staff had to ident #2. 90 tablets of gabapentin 300 ablets on 05/23/19, 90 ind 90 tablets on 07/05/19.					
	revealed she did not l	n 07/26/19 at 10:40 am know why the gabapentin ble for administration for 019.					

STATE FORM

6899

G56611

#### Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 Continued From page 47 D 358 -The facility staff had not informed her of the missed doses of gabapentin 300 mg for Resident #2. -If the missed doses of gabapentin 300 mg had a negative outcome, the negative outcome would be increased pain. -Resident #7 had not complained of pain. Interview with Resident #2 on 07/26/19 at 2:52 pm revealed: -She did not know what medications the facility administered to her. -She denied having increased pain. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. d. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for myrbetrig 50 mg (used to treat overactive bladder) daily. Review of Resident #2's May 2019 eMAR revealed: -An entry for myrbetriq 50 mg daily. -Myrbetrig 50 mg daily was documented as administrated for 28 of 31 opportunities from 05/01/19 to 05/31/19. -Myrbetrig 50 mg was documented as "not administered: drug/item unavailable" for 3 of 31 opportunities from 05/01/19 to 05/31/19. Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed myrbetrig 50 mg was available for administration. Interview with a contracted pharmacy Division of Health Service Regulation

STATE FORM

G56611

If continuation sheet 48 of 82

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 48 D 358 representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #2. -The pharmacy sent 30 tablets of myrbetriq 50 mg on 04/17/19, 29 tablets on 05/10/19, 30 tablets on 06/04/19 and 07/04/19, Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the myrbetrig 50 mg was unavailable for administration for Resident #2 in May 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of myrbetrig 50 mg for Resident #2. -If the missed doses of myrbetrig 50 mg had a negative outcome, the negative outcome would be increased frequency of urination. -Resident #7 had not displayed or complained of increased frequency of urination. Interview with Resident #2 on 07/26/19 at 3:30 pm revealed as far as she knew the facility administered her medications as ordered. Refer to the interview with the RCC on 07/26/19 at 11:35 am. Refer to the interview with the Administrator on 07/26/19 at 2:15 pm. e. Review of Resident #2's current FL2 dated 05/21/19 revealed a physician's order for tramadol 50 mg (used to treat pain) two tablets three times daily. Division of Health Service Regulation

**Division of Health Service Regulation** 

G56611

07/26/2019

(X5) COMPLETE

DATE

(X3) DATE SURVEY

COMPLETED

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: B. WING HAL034093 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 49 Review of Resident #2's May 2019 eMAR revealed:

1	and a second	· · · · · ·		4
	-An entry for tramadol 50 mg, two tablets, three			
	times daily.			
	-Tramadol 50 mg, two tablets, three times daily			
	was documented as administered for 59 of 93			
	opportunities from 05/01/19 to 05/31/19.			
	-Tramadol 50 mg, two tablets, three times daily			
	was documented as "not administered: drug/item			
	unavailable" for 34 of 93 opportunities from			
	05/01/19 to 05/31/19.			
	Review of Resident #2's June 2019 eMAR			
	revealed:			
	-An entry for tramadol 50 mg, two tablets, three			
	times daily.			
	-Tramadol 50 mg, two tablets, three times daily			1
	was documented as administered for 34 of 90			l
	opportunities from 06/01/19 to 06/30/19.			
	-Tramadol 50 mg, two tablets, three times daily			
	was documented as "not administered: drug/item			
	unavailable" for 51 of 90 opportunities from			
	06/01/19 to 06/30/19.			
	-Tramadol 50 mg, two tablets, three times daily			
	was documented as "not administered: other,			
	waiting on pharmacy" for 3 of 90 opportunities			
	from 06/01/19 to 06/30/19.			ŀ
	-Tramadol 50 mg, two tablets, three times daily			
	was documented as "not administered; on hold"			
	for 2 of 90 opportunities from 06/01/19 to			L
	06/30/19.			L
	Review of Resident #2's physician's orders			
	revealed there was no order to hold tramadol 50			
	mg.			

Observation on 07/25/19 at 10:00 am of medication on hand for Resident #2 revealed tramadol 50 mg was available for administration.

6899

G56611

Division of Health Service Regulation STATE FORM

#### Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A, BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 50 D 358 Interview with a contracted pharmacy representative on 07/26/19 at 9:35 am revealed: -When refills were needed, the facility had to request refills for Resident #2. -The pharmacy sent 180 tablets of tramadol 50 mg on 04/19/19, 06/19/19 and 07/16/19, Interview with a MA on 07/26/19 at 10:40 am revealed she did not know why the tramadol 50 mg was unavailable for administration for Resident #2 in May and June 2019. Interview with Resident #2's physician on 07/26/19 at 12:20 pm revealed: -Her expectation was medications would be administered as ordered. -The facility staff had not informed her of the missed doses of tramadol 50 mg for Resident #2. -If the missed doses of tramadol 50 mg had a negative outcome, the negative outcome would be increased pain. -Resident #2 had not complained of increased pain. -She planned to complete an assessment on Resident #2 on the next office visit day at the facility. Interview on with Resident #2 on 07/26/19 at 2:52 pm revealed: -She did not know what medications the facility administered to her. -She denied having increased pain. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 07/26/19 at 2:15 pm. 3. Review of Resident #1's current FL-2 dated Division of Health Service Regulation

STATE FORM

6609

G56611

If continuation sheet 51 of 82

# Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			ESURVEY PLETED
	*	HAL034093	B, WING		07	/26/2019
VAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD	03		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	obstructive pulmonar, and epilepsy. a. Review of Residen 05/21/19 revealed a p hydrocodone acetam tablet (used to treat of daily. Review of Resident # Medication Administra- revealed: -An entry for hydroco 7.5-325 mg three time -Hydrocodone acetar times daily was docu administered: drug/ite opportunities from 05 -Hydrocodone acetar times daily was docu administered: on hold from 05/01/19 to 05/3 Review of Resident # revealed: -An entry for hydroco 7.5-325 mg three time -Hydrocodone acetar times daily was docu administered: on hold from 05/01/19 to 05/3 Review of Resident # revealed: -An entry for hydroco 7.5-325 mg three time -Hydrocodone acetar times daily was docu 55 of 90 opportunities -Hydrocodone acetar times daily was docu administered: drug/ite opportunities from 06	agnoses included chronic y disease, Type II diabetes t #1's current FL-2 dated obysician's order for inophen 7.5-325 mg one hronic pain) three times ation Record (eMAR) done acetaminophen es daily. ninophen 7.5-325 three mented as administered for s from 05/01/19 to 05/31/19. ninophen 7.5-325 mg three mented as "not em unavailable" for 6 of 93 /01/19 to 05/31/19. ninophen 7.5-325 three mented as "not em unavailable" for 6 of 93 /01/19 to 05/31/19. ninophen 7.5-325 three mented as "not ation 16 of 93 opportunities 31. ati's June 2019 eMAR done acetaminophen es daily. ninophen 7.5-325 three mented as administered for s from 06/01/19 to 06/15/19. ninophen 7.5-325 mg three mented as "not em unavailable" for 31 of 90	D 358			

Division of Health Service Regulation STATE FORM

6699

G56611

If continuation sheet 52 of 82

#### Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY D 358 Continued From page 52 D 358 administered: on hold" for 2 of 90 opportunities from 06/01/19 to 06/30/19. Review of Residents #1's July eMAR revealed: -An entry for hydrocodone acetaminophen 7.5-325 mg three times daily. -Hydrocodone acetaminophen 7.5-325 three times daily was documented as administered for 46 of 71 opportunities from 07/01/19 to 07/24/19. -Hydrocodone acetaminophen 7.5-325 mg three times daily was documented as not administered: drug/item unavailable" for 23 of 71 opportunities from 07/01/19 to 07/24/19. Review of Resident #1's physician's orders revealed there was no order to hold hydrocodone acetaminophen 7.5-325 mg Observation on 7/25/19 at 10:15 am of medication on hand for Resident #1 revealed hydrocodone acetaminophen 7.5-325 mg was available for administration. Interview with the Medication Aide (MA) on 07/26/19 at 10:40 am revealed: -She did not know why the hydrocodone acetaminophen 7.5-325 mg was not ordered. -When the medication was out or was getting low, the MA should fax the request to the pharmacy. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -When refills were needed, the facility staff had to request refills for Resident #1, -The pharmacy sent 45 tablets of hydrocodone acetaminophen 7.5-325 on 5/15/19, 45 tablets on 5/31/19, 45 tablets on 6/28/19 and 45 tablets 7/23/19. Interview with the primary care physician on Division of Health Service Regulation

STATE FORM

G56611

If continuation sheet 53 of 82

# Division of Health Service Regulation

HAL034093	B. WNG	07/26/2019
IAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
DANBY HOUSE	3150 BURKE MILL ROAD	
AND THOUSE	WINSTON SALEM, NC 27103	and the second
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION	. PREFIX (EAC	ROVIDER'S PLAN OF CORRECTION (X5) CH CORRECTIVE ACTION SHOULD BE COMPLETE S-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
<ul> <li>D 358 Continued From page 53</li> <li>07/26/19 at 12:20 pm revealed: <ul> <li>The hydrocodone acetaminophen 7.5-325 mg was used to treat chronic pain and had not beer ordered as "hold".</li> <li>She did not know the medication was not beir given as prescribed.</li> <li>The outcome of Resident #1 not receiving the hydrocodone acetaminophen 7.5-325 mg wou be increased pain.</li> </ul> </li> <li>Interview with Resident #1 on 07/26/19 at 2:57 pm revealed: <ul> <li>She received a lot of medication.</li> <li>"I'm assuming they are giving me what I need</li> </ul> </li> <li>Refer to interview with the RCC on 07/26/19 at 11:35 am.</li> <li>Refer to the interview with the Administrator on 07/26/19 at 2:15 pm.</li> <li>b. Review of Resident #1's current FL-2 dated 05/21/19 revealed a physician's order for torsemide 10 mg one tablet every other day (used to treat fluid retention).</li> <li>Review of Resident #1's May 2019 eMAR revealed: <ul> <li>An entry for torsemide 10 mg every other day was documented as administered for 7 of 15 opportunities from 05/01/19 to 05/31/19.</li> <li>Torsemide 10 mg every other day was documented as "not administered: drug/item unavailable" for 3 of 15 opportunities from 05/01/19 to 05/31/19.</li> <li>Torsemide 10 mg every other day was documented as "not administered: drug on ho for 3 of 15 opportunities from 05/01/19 to 05/31/19.</li> </ul> </li> </ul>	en ing indicated in a second s	

STATE FORM

6899

.

G56611

If continuation sheet 54 of 82

# Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
<b>L</b> -1		HAL034093	B. WING		07/26/201	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	03		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	1 of 15 opportunities 1 -Torsemide 10 mg evidocumented at all for 05/01/19 to 05/31/19. Review of Resident # revealed: -An entry for torsemidi- -Torsemide 10 mg evidocumented as admir opportunities from 06. -Torsemide 10 mg evidocumented as "not a unavailable" for 3 of 1 06/01/19 to 06/30/19. -Torsemide 10 mg evidocumented as "not a for 11 of 15 opportunition 06/30/19. Review of Resident # revealed: -An entry for torsemidi- -Torsemide 10 mg evidocumented as admir opportunities from 7/0 -Torsemide 10 mg evidocumented as admir opportunities from 7/0 -Torsemide 10 mg evidocumented as "not a for 8 of 12 opportunition 07/24/19. Review of Resident # revealed the was no comg. Observation on 7/25/7 medication on hand for	administered: not given " for from 05/01/19 to 05/31/19, ery other day was not 1 of 15 opportunities from 1's June 2019 eMAR le 10 mg every other day, ery other day was nistered for 1 of 15 /01/19 to 06/30/19, ery other day was idministered: drug/item 6 opportunities from ery other day was idministered: drug on hold" ties from 06/01/19 to 1's July 2019 eMAR e 10 mg every other day, ery other day was nistered for 4 of 12 1/19 through 7/24/19, ery other day was sidministered: drug on hold" es from 07/01/19 to	D 358			

# Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	eu	HAL034093	B. WING		07	26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE	, ZIP CODE		
DANBY H	01185	3150 BUR	KE MILL ROAD			
DANDIA	0032	WINSTON	SALEM, NC 271	03		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page Interview with the MA revealed: -The facility has not b torsemide 10 mg for I -She did not know wh unavailable, but the m a month. -When the medication the MA on duty shoul pharmacy. Interview with the cor representative on 7/2 -When refills were ne request refills for Res -The pharmacy dispe 10 mg on 5/19/19 and -The medication was medical supplier and fill the prescription un Interview with the prin 7/26/19 at 12:20 pm -Torsemide 10 mg wa of the lower extremiti -Resident #1 would s the side effects. -She was unaware of given as prescribed. -She was concerned receiving medications -She did not place ar 10 mg.	e 55 a on 7/26/19 at 10:40 am even able to get the Resident #1. by the medication was hedication had been out over in was out or was getting low, d fax the request to htracted pharmacy 6/19 at 9:35 am revealed: eded, the facility staff had to ident #1. Insed 8 tablets of torsemide d 8 tablets 7/16/19. on back order from the the pharmacy was unable to til the middle of July. mary care physician on revealed: as prescribed to treat edema es. ometimes refuse because of f the medication not being Resident #1 was not	D 358			
Division of the	back order from the p Interview with Reside	oharmacy. ent #1 on 07/26/19 at 2:57 < so many medications and				

STATE FORM

G56611

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	an a	HAL034093	B. WING		07	//26/2019
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 2710	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	• 56	D 358			
	Refer to interview with 11:35 am.	n the RCC on 07/26/19 at				
	Refer to interview with 7/26/19 at 2:15 pm.	n the Administrator on				
	05/21/19 revealed a p	t #1's current FL-2 dated ohysician's order for tablet at bedtime (used to				
	Medication Administra revealed: -An entry for lorazepa -Lorazepam 1 mg dai documented as admir opportunities from 06/ -Lorazepam 1 mg dai	am 1 mg daily at bedtime. ly at bedtime was nistered for 21 of 30 /01/19 to 06/30/19. ly at bedtime was administered: drug/item 60 opportunities from				
	-Lorazepam 1 mg dail documented as admir opportunities from 07/ -Lorazepam 1 mg dail	am 1 mg daily at bedtime. ly at bedtime was histered for 14 of 22 /01/19 to 07/22/19. ly at bedtime was administered: drug/item 2 opportunities from				
		19 at 10:15 am of or Resident #1 revealed available for administration.				
	Interview with the MA revealed:	on 7/26/19 at 10:40 am				

STATE FORM

G56611

If continuation sheet 57 of 82

STATEMENT	f Health Service Regu of Deficiencies F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP GODE		
DANBY HO	DUSE		RKE MILL ROAD	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	ə 57	D 358			
	not ordered. -When the medication the MA should fax the	ny the lorazepam 1 mg was n was out or was getting low, e request to pharmacy.				
	-When refills were ne request refills for Res -The pharmacy sent	6/19 at 9:35 am revealed: eded, the facility staff had to				
	-The medication was	ent #1's primary care at 12:20 pm revealed: prescribed to treat anxiety. f the medication not being				
	pm revealed: -She received a lot o -She had so many m of what she took.	ent #1 on 07/26/19 at 2:57 f medication. edications and was unsure / are giving me what I need".				
	Refer to interview wit 11:35 am.	th the RCC on 07/26/19 at				
	Refer to interview wit 7/26/19 at 2:15 pm.	th the Administrator on				
	05/23/19 revealed di with behaviors, cons hypertension, anemi	nt #5's current FL2 dated agnoses included dementia tipation, hyperlipedemia, a, Vitamin D deficiency, ncy and Type II Diabetes			đđ.	
	a. Review of Resider alth Service Regulation	nt #5's current FL-2 dated				

G56611

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		HAL034093	B. WING		07	//26/2019
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
ANBYH	OUSE		JRKE MILL ROAD			
		WINSTO	ON SALEM, NC 271	03		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 358	Continued From page	ə 58	D 358			
	05/23/19 revealed a physician's order for trazadone 100 mg one tablet at bedtime (used to treat depression).					
	Medication Administra revealed: -An entry for trazador -Trazadone 100 mg o documented as admin opportunities from 05, -Trazadone 100 mg o documented as "not a unavailable" for 7 of 3 05/01/19 to 05/31/19, -Trazadone 50 mg on documented as "not a of 31 opportunities for -Trazadone 50 mg on	the 100 mg one time daily, one time daily was nistered for 17 of 31 /01/19 to 05/31/19. In time daily was administered: drug/item 81 opportunities from the time daily was administered: on order" for 5 r 05/01/19 to 05/31/19. The time daily was not be documentation spaces opportunities from				
	-Trazadone 100 mg o documented as admin opportunities from 06 -Trazadone 100 mg o documented as "not a unavailable" for 1 of 3 06/01/19 to 06/30/19. -Trazadone 100 mg o documented as "not a of 30 opportunities fro	ne 100 mg one time daily. Ine time daily was histered for 23 of 30 /01/19 to 06/30/19. Ine time daily was administered: drug/item 80 opportunities from Ine time daily was administered: on order" for 6 for 06/01/19 to 06/30/19.		·		

STATE FORM

G56611

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A, BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 59 administration. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -Refills for trazadone 100 mg for Resident #5 were automatic. -The pharmacy sent 30 tablets of trazadone 100 mg on 4/9/19, 6/4/19, and 7/4/19. Interview with the Medication Aide (MA) on 7/26/19 at 10:40 am revealed: -She did not know why the medication was not available. -When the medication was out or was getting low, the MA should fax the request to pharmacy. Interview with Resident #5's primary care physician on 7/26/19 at 12:20 pm revealed: -She was unaware of the medication not being given as prescribed. -She was concerned Resident #5 was not receiving medications as ordered. Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with the Administrator on 7/26/19 at 2:15 pm. b. Review of Resident #5's current FL-2 dated 05/23/19 revealed a physician's order for donepezil 5 mg two tablets daily (used to treat Alzheimer's dementia). Review of Resident #5's record revealed a physician's order dated 06/17/19 for donepezil 10 Division of Health Service Regulation

STATE FORM

6899

G56611

If continuation sheet 60 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE	3150 BU	RKE MILL ROAD			
	0001	WINSTO	N SALEM, NC 271	03		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	9 60	D 358	(*		
	mg daily.					
	-Donepezil 5 mg two documented as admin opportunities from 05 -Donepezil 5 mg two documented as "not a unavailable" for 2 of 3 05/01/19 to 05/31/19, -Donepezil 5 mg two documented as "not a of 31 opportunities from documented as "not a of 31 opportunities from documented as admin opportunities from 06, -Donepezil 5 mg two documented as admin opportunities from 06, -Donepezil 5 mg two documented as "not a 16 of 17 opportunities -There was no entry f -Donepezil 10 mg dai administered for 13 of 06/18/19 to 06/30/19. Review of Resident # revealed: -An entry for donepezil -Donepezil 10 mg was administrated for 12 of	til 5 mg two tablets daily. tablets daily was histered for 22 of 31 /01/19 to 05/31/19. tablets daily was administered: drug/item 11 opportunities from tablets daily was administered: on order" for 7 om 05/01/19 to 05/31/19. 5's June 2019 eMAR til 5 mg two tablets daily. tablets daily was histered for 1 of 17 /01/19 to 06/30/19. tablets every day was administered: on order" for 6 from 06/01/19 to 06/17/19. or donepezil 10 mg daily. ly was not documented as f 13 opportunities from 5's July 2019 eMAR				Υ
	07/01/19 to 07/24/19. -Donepezil 10 mg dai	ly was documented as "not m unavailable/on order" for				

G56611

#### Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL034093	B. WING	B. WING		//26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		3150 BI	JRKE MILL ROAD			
DANBY H	JUSE	WINSTO	ON SALEM, NC 271	03		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 61	D 358			
	Observation on 7/25/ medication on hand f donepezil 10 mg was administration.	or Resident #5 revealed				
	-Refills for donepezil Resident #5 was on a	6/19 at 9:35 am revealed: 5 mg and 10 mg for	5			
fo -T ta	for the month of May. -The order changed to tablets daily to doner					
	until 6/17/19. -The pharmacy sent 21 tablets of mg on 6/17/19.	21 tablets of donepezil 10				
	revealed: -She did not know wi	on 7/26/19 at 10:40 am ny the donepezil had not				
		n was out or was getting low, e request to pharmacy.				
	-She was unaware o given as prescribed.	at 12:20 pm revealed: f the medication not being				
	receiving medication	donepezil 5 mg was not				
		ns, interviews and record nined Resident #5 was not				
	Refer to interview wi 11:35 am. alth Service Regulation	th the RCC on 07/26/19 at				

Division of Health Service Regulation STATE FORM

6889

G56611

If continuation sheet 62 of 82

# Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A, BUILDING:			E SURVEY PLETED
		HAL034093	B. WING	94-849-844	07/26/201	
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
DANBY H	OUSE		JRKE MILL ROAD			
		TIONOVICE ADDR.	ON SALEM, NC 271	03		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	62	D 358			
	Refer to interview with 7/26/19 at 2:15 pm.	n the Administrator on				
	05/29/19 revealed dia disorder, schizophren	t#6's current FL-2 dated gnoses included bipolar ia, hypertension, post der, and anxiety disorder.				
	a. Review of Resident #6's current Fl 05/29/19 revealed a physician's orde mirtazapine 15 mg one tablet at bedt treat depression).	hysician's order for				
	Medication Administra revealed;	5's May 2019 electronic ttion Record (eMAR) ine 15 mg one time daily at				
		histered for 19 of 31 01/19 to 05/31/19. as documented as "not m unavailable" for 12 of 31				
	Review of Resident #6 revealed:	S's June 2019 eMAR				
	bedtime. -Mirtazapine 15 mg or					
		01/19 to 06/30/19. ne time daily was dministered: drug/item				
	through 6/30/19.	portunities from 6/1/19				
	Observation on 7/25/1 medication on hand fo					

STATE FORM

6899

G56611

If continuation sheet 63 of 82

# Division of Health Service Regulation

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
AME OF PR	OVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
ANBY HO	OUSE		RKE MILL ROAD N SALEM, NC 271	03		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
	-The mirtazapine 15 r automatic refills. -The pharmacy sent ' -No refills remained for Resident #6 after 6/21 Interview with the Me 7/26/19 at 10:40 am r -She did not know wh had not been filled. -When the medication MA should fax the red Interview with the prin 7/26/19 at 12:20 pm r -She was unaware of given as prescribed. -She was concerned receiving medications Interview with Reside pm revealed: -She did not know all medications. -She did get medicati know the times, usua Refer to interview witt 11:35 am. Refer to interview witt 07/26/19 at 2:15 pm.	as available for tracted pharmacy 6/19 at 9:35 am revealed: ng for Resident #6 was on 18 tablets on 6/20/19. or the mirtazapine 15 mg for D/19. dication Aide (MA) on revealed: ny the mirtazapine 15 mg in is out or getting low, the quest to pharmacy. mary care physician on revealed: i the medication not being that Resident #6 was not a as ordered. of her prescribed tons every day, but did not Ily morning and bedtime. In the RCC on 07/26/19 at the the Administrator on at #6's current FL-2 dated	D 358			

STATE FORM

6899

G56611

If continuation sheet 64 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL034093	B. WING		07	07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
DANBY H	OUSE		IRKE MILL ROAD				
		This is a second s	N SALEM, NC 271		17 D D To D to D to D		
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	64	D 358				
	sertraline 50 mg one t depression).	tablet daily (used to treat					
	-Sertraline 50 mg one as administered for 11 05/01/19 to 05/31/19. -Sertraline 50 mg one as "not administered: 31 opportunities from -Sertraline 50 mg one as "not administered: opportunities from 05/ Review of Resident #6 revealed: -An entry for sertraline -Sertraline 50 mg one as "not administered:	e 50 mg one time daily. time daily was documented 1 of 31 opportunities from time daily was documented drug/item unavailable" 5 of 05/01/19 to 05/31/19, time daily was documented on hold for 15 of 31 01/19 to 05/31/19.					
	-Sertraline 50 mg one as "not administered: o of 24 opportunities fro -Sertraline 50 mg one as "not administered: o opportunities from 07/ Review of Resident #6	50 mg one time daily. time daily was documented drug/item unavailable for 5 m 07/01/19 to 07/24/19. time daily was documented on hold" for 19 of 24 01/19 to 07/24/19. S's physician's orders rder to hold sertraline 50					
		r Resident #6 revealed					

STATE FORM

G56611

#### **Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 65 administration. Interview with the MA on 7/26/19 at 10:40 am revealed: -She did not know why the sertraline 50 mg had not been filled. -When the medication was out or getting low, the MA should fax the request to pharmacy. Interview with the contracted pharmacy representative on 7/26/19 at 9:35 am revealed: -A renewal request was sent to the provider in May. -The pharmacy sent 30 tablets of sertraline 50 mg on 04/09/19. Interview with the primary care physician on 7/26/19 at 12:20 pm revealed: Sertraline 50 mg was not on hold. -She was unaware of the medication not being given as prescribed. -She was concerned that Resident #6 was not receiving medications as ordered. Interview with Resident #6 on 07/26/19 at 2:52 pm revealed: -She did not know all of her prescribed medications. -She depended on the facility staff to administer her medications as prescribed. Refer to interview with the RCC on 07/26/19 at 11:35 am. Refer to interview with Administrator on 7/26/19 at 2:15 pm. 6. Review of Resident #4's previous FL2 dated 01/17/19 revealed: -Diagnoses included dementia, hypertension, Division of Health Service Regulation

STATE FORM

6899

G56611

If continualion sheet 66 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL034093	B. WING	B. WING		07/26/2019	
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE	and the second sec		
			IRKE MILL ROAD				
ANBY H	OUSE		N SALEM, NC 271	03			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE	
D 358	Continued From page	9 66	D 358				
D 358	stage IV chronic kidne -A physician's order for needed for systolic bl -A physician's order to pressure (BP) daily and Review of signed phy #4 revealed: -A signed physician's with orders to administ needed for systolic bl 160, and an order to of pressure daily and reo- -A signed physician's check Resident #4's k and record. Review of Resident # Medication Administrat revealed: -There was an entry for tablet every day as ne	II diabetes mellitus, bathy, hypoglycemia, and ey disease. or Clonidine 0.3mg daily as ood pressure greater 160, o check the resident's blood and record. sician's orders for Resident order sheet dated 05/14/19, ster Clonidine 0.3mg daily as ood pressures greater than check Resident #4's blood cord. order dated 06/18/19 to blood pressure twice daily 4's May 2019 electronic ation Record (eMARs) or Clonidine HCI 0.3mg one beded for systolic blood	D 358				
	administered for syste than 160.	entation Clonidine was blic blood pressures greater					
	between 7:00am - 3:0 documented). -There were four BPs	or blood pressures daily Opm (no specific time was documented on the May					
		umented BPs had systolic than 160 and in range to					
	-On 05/29 the systolic -On 05/30 the systolic -On 05/31 the systolic	BP was 186. BP was 178.					

6899

G56611

#### Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 358 D 358 Continued From page 67 Review of Resident #4's June 2019 eMARs revealed: -There was an entry for Clonidine HCI 0.3mg one tablet every day as needed for systolic blood pressure greater than 160. -There was no documentation Clonidine was administered for systolic blood pressures greater than 160. -There was an entry for blood pressures daily between 7:00am - 3:00pm (no specific time was documented) from 06/01/19 through 06/19/19. -There was a second entry for blood pressures twice daily at 8:00am and 8:00pm. -There were thirty-eight BPs documented on the June 2019 eMAR. -Twenty-three of thirty-eight blood pressures had systolic blood pressures that were greater than 160 and within range to administer Clonidine as follows: -On 06/01 the systolic BP was 190. -On 06/02 the systolic BP was 184. -On 06/03 the systolic BP was 175. -On 06/04 the systolic BP was 182. -On 06/05 the systolic BP was 168. -On 06/06 the systolic BP was 174. -On 06/07 the systolic BP was 164. -On 06/09 the systolic BP was 166. -On 06/10 the systolic BP was 180. -On 06/11 the systolic BP was 186. -On 06/15 the systolic BP was 182. -On 06/16 the systolic BP was 174. -On 06/17 the systolic BP was 166. -On 06/21 at 8:00am the systolic BP was 182. -On 06/24 at 8:00am the systolic BP was 192. -On 06/24 at 8:00pm the systolic BP was 178. -On 06/25 at 8:00am the systolic BP was 182. -On 06/26 at 8:00am the systolic BP was 186. -On 06/26 at 8:00pm the systolic BP was 178. -On 06/27 at 8:00am the systolic BP was 182. -On 06/28 at 8:00am the systolic BP was 194.

Division of Health Service Regulation STATE FORM

6899

G56611

If continuation sheet 68 of 82

Division	of Health	Service	Regu	lation
----------	-----------	---------	------	--------

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	5 The second	(X3) DATE SURVEY COMPLETED	
			-		
	78-10-10-10-10-10-10-10-10-10-10-10-10-10-	HAL034093	B. WING		07/26/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
DANBY H	DUSE	3150 BUR	KE MILL ROAD		
		WINSTON	SALEM, NC 271	103	
(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)	D BE COMPLETE
D 358	Continued From page	68	D 358		
		the systolic BP was 184. the systolic BP was 190.			
	Review of Resident #- revealed: -There was an entry fi	4's July 2019 eMARs or Clonidine HCI 0.3mg one		5 N	
	tablet every day as ne pressure greater than	eeded for systolic blood			
		lic blood pressures greater			
	daily at 8:00am and 8				
		en BPs documented on the			
		07/01/19 through 07/24/19. seven blood pressures had			
		es that were greater than			
		to administer Clonidine as			
		the systolic BP was 162.			
		the systolic BP was 173.			
		the systolic BP was 188.			
1		the systolic BP was 172.			
		the systolic BP was 166.			
		the systolic BP was 162.			
		the systolic BP was 184.			
		the systolic BP was 161.			
		the systolic BP was 182.			
		the systolic BP was 173.			
		the systolic BP was 174. the systolic BP was 162.			
		the systolic BP was 162.			
		the systolic BP was 102.			
		the systolic BP was 167.			
		the systolic BP was 184.			
		the systolic BP was 167.			
		the systolic BP was 170.			
		the systolic BP was 168.			
	Interview with Resider	nt #4's Primary Care			
l Division of Hea	Ith Service Regulation				

#### Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 07/26/2019 HAL034093 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 69 Provider (PCP) on 07/26/19 at 12:28pm revealed: -Resident #4 sometimes had high blood pressures. -She wanted the resident's blood pressure monitored and Clonidine administered because the resident had a history of strokes. -She wanted Clonidine administered when the resident's systolic blood pressures was greater than 160. -She had last seen Resident #4 in July 2019, for another issue, but did not know Clonidine was not administered as ordered. Interview with the first shift Medication Aide (MA) on 07/26/19 at 11:58am revealed: -She administered medications to Resident #4. -The resident's BP was checked daily on her shift. -She did not know there was an order for as needed Clonidine. -She did medication cart audits weekly and checked the eMARs with the medications on the cart -She did not check the as needed medications. -Clonidine was an as needed medication, and reminders did not pop-up on the eMAR as the scheduled medications. -Because the system did not remind her to administer the as needed Clonidine it was not administered. -The Resident Care Coordinator (RCC) checked behind the MAs, but the facility had been without an RCC since May 2019. Interview with a second shift MA on 07/26/19 at 6:45pm revealed: -She checked Resident #4's BP on her shift. -She did not know the resident had an as needed order for Clonidine when her BPs were greater than 160. -She had worked at the facility since March 2019, Division of Health Service Regulation

STATE FORM

6699

G56611

If continuation sheet 70 of 82

	ivis	ion	of	Health	Service	Requi	lation
-		1011	01	( localut	0011100	rugu	lagori

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ANBY H		3150 BU	RKE MILL ROAD			
	OUSE	WINSTO	N SALEM, NC 271	03		
(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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 70	D 358			
		tered Clonidine to Resident blood pressure was greater				
	Based on record revi interviews, it was det was not interviewable	termined that Resident #4				
	Refer to interview wi 11:35 am.	th the RCC on 07/26/19 at				
	Refer to interview wil 2:15 pm.	th Administrator on 7/26/19 at				
	revealed: -MAs were responsible when needed. -MAs can order medi- reorder sticker from the and faxing the order calling the pharmacy -Medication refills shi- days prior to the medi- basis to determine if ordered, and then orrigharmacy then if nee- -Sometimes a reside- didn't cover the spec- that can cause a delay	cation carts on a weekly medications need to be der medications from the eded. nt's insurance company ific medication ordered and			1	
	2:15 pm revealed: -MAs were responsit when needed.	ministrator on 07/26/19 at ble for ordering medications refills when 3 to 5 doses of be ordered from the				

STATE FORM

6899

G56611

If continuation sheet 71 of 82

	of Health Service Regu of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SU COMPLE	
2		HAL034093	B. WING		07/26	/2019
IAME OF P	ROVIDER OR SUPPLIER	3150 BU	DDRESS, CITY, ST. RKE MILL ROAI	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES WINST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
D 358	pharmacy before the medication. The facility failed to a ordered for 6 of 7 sail #5, #6 and #7) include Resident #7, who had bipolar disorder; block Resident #2, who had and kidney failure; a to Resident #1, who medication for deme needed blood pressue #4, who had a history hypertension. This failure placed the medication mismana to the health, safety and constitutes a Type The facility provided accordance with G.S this violation. CORRECTION DATI VIOLATION SHALL 19, 2019. 10A NCAC 13F.1300 Profile & Care Plan 10A NCAC 13F.1300 Profile & Care Plan In addition to the recommendation to the recommendation of	resident ran out of the administer medications as mpled residents (#1, #2, #4, ling an antidepressant to d a history of schizoaffective od pressure medications to d a history of hypertension medication for fluid retention had a history of COPD; a ntia to Resident #5; and as ure medication to Resident y of multiple strokes and he residents at risk due to gement and was detrimental and welfare of the residents be B violation. - a plan of protection in 5. 131D-34 on 07/26/19 for E FOR THE TYPE B NOT EXCEED SEPTEMBER 7 Special Care Unit Res. 7 Special Care Unit Res. 7 Special Care Unit Resident puirements in Rules 13F 2 of this Subchapter, the	D 358	10A NCAC 13F .1307 (Special Resident Profile and Care Plar DRC and RCC will audit reside Any identified issues will be ad immediately.Upon admission to all required documentation will completed and placed in reside Quarterly Reviews will be com by DRC within thirty days of ac and quarterly thereafter. DRC will utilize resident tickler to en Reviews are completed in a tir	n) ent charts. Idressed o SCU, be ent chart. pleted dmission and RCC sure Quar	terly

STATE FORM

6899

G56611

If continuation sheet 72 of 82

#### (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION D (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 464 Continued From page 72 D 464 assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities, This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to complete guarterly Resident Profiles for 1 of 6 residents sampled (Residents #10) in the Special Care Unit (SCU). The Findings are: Review of Resident #10's current FL2 dated 05/29/19 revealed diagnoses included dementia and hypertension. -The resident was constantly disoriented. -The recommended level of care was Special Care Unit (SCU). Review of Resident #10's Resident Register revealed the resident was admitted to the facility on 10/13/16. Review of Resident #10's record for SCU required documents and assessment revealed: -There was no SCU profile and assessment form. -The most current quarterly review was dated 03/31/17. -There were no more guarterly reviews in

Division of Health Service Regulation

Division of Health Service Regulation

STATE FORM

6689 G56611

If continuation sheet 73 of 82

#### Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B, WING HAL034093 07/26/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3150 BURKE MILL ROAD DANBY HOUSE WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 464 D 464 Continued From page 73 Resident #10's record. Interview with the Administrator on 07/26/19 at 5:35pm revealed: -Resident #10 had dementia and resided in the SCU. -She searched their records and was unable to find a profile and screening assessment form for Resident #10. -She was unable to find quarterly reviews more current than 03/31/17. The document should have been completed every ninety days. -She did not know why there were no current quarterly assessments for Resident #10. -The profile and assessment form should have been completed upon the resident's admission to the SCU. -The nurse was responsible for completing the SCU profile and assessment form and the quarterly reviews. -The nurse that is at the facility now is not the same nurse that was at the facility 2016. -She could not say why the profile was not completed. D912 D912 G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Division of Health Service Regulation

G56611

If continuation sheet 74 of 82

Division of Health Service Re	gulation
-------------------------------	----------

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 10 10 10 10 10 10 10 10 10 10 10 10 1		(X3) DATE S COMPL		
		HAL034093	B. WING		07/2	07/26/2019	
AME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, ST.	ATE, ZIP CODE			
			RKE MILL ROA				
ANBY H	DUSE		N SALEM, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
D912	Continued From page	e 74	D912				
D914	reviews, the facility fa had the right to receive are adequate, approprelevent state laws ar medication administration The findings are: Based on observation reviews, the facility fa medications as ordered residents (#1, #2, #4 resident who did not not build up, thyroid horm pain, depression, and resident who did not not blood pressure, neuro bladder and pain (Reading did not receive medic retention and anxiety who did not receive medic retention and anxiety who did not receive for depression (Resident orders for Clonidine (for pressure) as needed greater than 160 (Res 0358 10A NCAC 13F Administration (Type G.S. 131D-21(4) Dect	has, interviews and record iiled to assure every resident ve care and services which oriate and in compliance with ad rules related to ation. hs, interviews and record iled to administer ed for 6 of 7 sampled , #5, #6 and #7) including a receive a medication for fluid one deficiency, neuropathic allergies (Resident #7), a receive medications for high opathic pain, overactive sident #2), a resident who ations for chronic pain, fluid (Resident #1), a resident nedications for depression ase(Resident #5) a resident vo medications for #6); and a resident with used to treat high blood for systolic blood pressures sident #4). [Refer to Tag .1004(a). Medication B Violation]].	D914	GS 131D-21(2) Resident F Residents will have the rigit care and services which ar appropriate and in complia relevant federal & state law regulations. ED to complet Rights Training" to all staff and services. All staff rece of the "Declaration of Resid All staff signed acknowledg agreement and a copy was file. All new employees wil "Resident Rights Training" annually.BOM will utilize a log to ensure "Resident Rig completed upon hire and a Home Health Agency and Ombudsmen to complete ' Training" to staff. ED and/o monitor for ongoing compli observations and resident meetings.	ht to receive re adequate, nce with vs and rules & e "Resident regarding ca ived a copy dent Rights". ging receipt a s placed in sta complete upon hire an perpetual sta ghts Training innually. County 'Resident Rig or designee wi iance through	re nd aff ff '' is hts ill	
	<ul> <li>G.S. 131D-21 Declaration of Residents' Rights</li> <li>Every resident shall have the following rights:</li> <li>To be free of mental and physical abuse, neglect, and exploitation.</li> </ul>						

## Division of Health Service Regulation

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second second		(X3) DATE SI COMPLE	
		HAL034093	B, WING		07/2	6/2019
AME OF PR	ROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, ST	ATE, ZIP CODE		
ANBY H	DUSE		RKE MILL ROA			
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D914 Continued From page 75 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all residents were free from physical abuse and neglect . The findings are:		D914	GS1314 D21(4) Resident Rig Residents will have the right from physical abuse and neg complete "Resident Rights T all staff. Home Health Agenc County Ombudsmen to comp regarding "Resident Rights." received a copy of the "Decla	to be free lect. ED to raining" to y and olete trainin All staff	9/9/2019 g	
	The findings are: Based on observations, interviews and record reviews, the facility failed to assure 3 of 6 sampled residents (Residents #8, #9 and #10) in the Special Care Unit (SCU) were free of physical abuse and neglect by three staff (Staff A, Staff B, and Staff C) encouraging the residents to fight each other, resulting in one resident being strangled with her face turning red (Resident #8) while staff recorded and shared the video through social media; a staff (Staff A) pushed a resident into a room, turned off the light and yelled to the resident to go to sleep, and then closed the door leaving the resident in the dark room (Resident #8); and a resident being left on the floor while staff recorded a second video and shared the video through social media (Resident #10). [Refer to Tag 338, 10A NCAC 13F .0909 of Residents' Rights (Type A1 Violation).			Resident Rights." All staff sig acknowledging receipt and a a copy was placed in staff file employees will complete "Re Training" upon hire and annu will utilize a perpetual staff lo training is completed upon hi ED and/or designee will mon ongoing compliance through and resident council meeting	ned greement a e. All new sident Righ ally. BOM g to ensure re and ann itor for observation	ts ually.
D934	<ul> <li>G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements</li> <li>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</li> <li>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe</li> </ul>		D934	1		

STATE FORM

6899

G56611

If continuation sheet 76 of 82

# Division of Health Service Regulation

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	12 13 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		HAL034093	B. WING		07/26/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TE, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD			
		10-700 CD %	N SALEM, NC 2	7103		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE CC	(X5) DMPLETE DATE
D934	Continued From page 76 practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5		D934	GS 131 D-4.5B (a) Infe All current staff will hav Infection Control Trainin by a Registered Nurse. will complete infection of prior to working in their departments which will a Registered Nurse. A will be completed annu Trainings will be review and periodically spot ch	re completed ng taught All new staff control training perspective be reviewed with Il ongoing training ally thereafter. ved by the BOM	
	facility failed to assure C, D and E) had comp infection control trainin The findings are: 1. Review of Staff C's personnel record reve -Staff C was hired in J -Staff C had complete control training on 03/2 -There was no docume	ws and interviews, the 2 of 4 staff sampled (Staff bleted the mandatory annual ng. Medication Aide (MA) aled: anuary 2008 as a MA. d the annual infection 25/18. entation Staff C had				
ision of Hea	completed infection control training in 2019. Interview with Staff C on 07/26/19 at 9:58am revealed: -She worked at the facility since 2008 as a MA. -She administered medications, checked fingerstick blood sugars, gave insulin injections, and administered eye drops. -She had the infection control training last year,					

STATE FORM

G56611

If continuation sheet 77 of 82

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ANBY H	OUSE		IRKE MILL ROAD ON SALEM, NC 271	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D934	5:15pm revealed: -The Business Office responsible to schedu ensure training were -The BOM should har personnel record to e completed. Interview with the BO revealed: -She had not schedul infection control train -She had not schedul because she did not -The Administrator ar scheduling staff for tr 2. Review of Staff D's personnel record reve- -Staff D was hired on Care Aide. -Staff D was moved i 07/09/18. -There was no docur completed infection of Interview with Staff D revealed: -She had not completed and -She was worked as	raining this year. ministrator on 07/26/19 at Manager (BOM) was ule training for all staff and current. ve checked Staff C's msure the training was M on 07/26/19 at 6:06pm led Staff C for the annual ing. led Staff C for the training know it was due. ad her were responsibility for aining. s Medication Aide (MA) ealed: 04/11/18 as a Personal into the MA position on mentation Staff D had control training. 0 on 07/26/19 at 11:55am the facility for a little over one itted infection control training.	D934			
		injections, and eye drops. ministrator on 07/26/19 at				

Division of Health Service Regulation

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING		07/26/2019	
NAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DANBY HO	DUSE		RKE MILL ROAD	03		
(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'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	the required infection -Staff D should have I annual infection contr -The Business Office responsible for ensuri current. -The BOM should hav personnel record to en completed. Interview with the BOI revealed: -She had not schedule control training. -She did not have a re scheduled Staff D for 3. Review of Staff E's personnel record reve -Staff D was hired on -There was document the annual infection co 06/11/15. Attempt interview with 11:48am was unsucce Interview with the Adm 5:15pm revealed: -She did not know Sta required infection control -The BOM should hav annual infection control	At Staff D had not completed control training. Deen scheduled for the ol training. Manager (BOM) was ng all staff training's were we checked Staff D's nsure the training was M on 07/26/19 at 6:06pm ed Staff D for the infection wason why she had not the training. Medication Aide (MA) aled: 03/22/11. ation Staff E had completed pontrol training on 06/11/15. entation Staff E had control training since Staff E on 07/26/19 at essful. binistrator on 07/26/19 at ff E had not completed the trol training. e scheduled Staff E for the ol training. Manager (BOM) was ng all staff training were	D934	DEFICIENC		

STATE FORM

6839

G566**1**1

If continuation sheet 79 of 82

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING.	AND		
		HAL034093	B. WING		07/2	6/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
			KE MILL ROAD			
DANBY H	OUSE	WINSTON	SALEM, NC 2	7103		
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
D934	Continued From page	9 79	D934			
	personnel record to e completed,	nsure the training was				
	revealed: -She had not schedul control training. -She did not have a r	M on 07/26/19 at 6:06pm ed Staff E for the infection eason why she had not the infection control training.		GS 131D-4.5B(b)		
D935	D935 G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.		D935	All Medication Aide files will be immediatly for verification of 5/ or verification letter. All new M Aides will have a 5/10, 15 hour verification letter present prior independantly as a Medication	10,15 hou edication or to working	
	home is prohibited fro any unsupervised me that individual has pro- medication aide durir an adult care home of of the following: (1) A five-hour trainin Department that inclu- in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monit bleeding occurs or the exists. (2) A clinical skills ev NCAC 13F .0503 and (3) Within 60 days fro	ng the previous 24 months in or successfully completed all g program developed by the ides training and instruction of medication rs for Disease Control and s on infection control and, if				

STATE FORM

6899

G56611

If continuation sheet 80 of 82

# Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	-		IPLETED
		HAL 024002	B. WING			
		HAL034093			0	7/26/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
DANDY	01105	3150 BI	JRKE MILL ROA	D		
DANBY H	OUSE	WINSTO	ON SALEM, NC	27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN	OF CORRECTION	()(5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A	CTION SHOULD BE	(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIE		DATE
					101)	
D935	Continued From page	80	D935			
	a. An additional 10-ho	our training program				
		partment that includes				
		n in all of the following:				
	1. The key principles					
	administration.					
	and the second	s of Disease Control and				
	a second s	on infection control and, if				
	applicable, safe inject					
		pring or testing in which				
		e potential for bleeding				
	exists.	perentian fer broeding				
	Second Seco	veloped and administered	1			
		alth Service Regulation in				
		ection (c) of this section.				
	This Rule is not met	as evidenced by:				
		and record reviews, the				
		e 1 of 4 sampled medication	1			
		eted the 5, 10 or 15 hour				
	state approved medic					
	103	.5				
	The findings are:					
						1
	Review of Staff F's Me	edication Aide (MA)				
	personnel record reve					
	-Staff F was hired on	02/18/19.				
	-There was document	ation Staff F completed the				
	clinical skills checklist					
	-There was document	ation Staff F had passed				
	the written medication	examination on 03/20/19.				
	-There was no docum	entation Staff F had				
	completed the 5, 10, o	or 15 hour MA training.				
	वडता है है					
	Observation on 07/24	/19 at various times from				
Division of Hea	alth Service Regulation		1			
STATE FORM			6899	G56611	If contin	uation sheet 81 of 82

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	HAL034093				07	07/26/2019
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
ANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	03		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETE D THE APPROPRIATE DATE	
D935	Continued From page 81 3:30 pm through 5:00pm revealed: -Staff F worked independently on the medication cart. -Staff F administered medications to residents. Attempted interview with Staff F on 07/26/19 at 11:47 am was unsuccessful. Interview with the Administrator on 07/26/19 at 5:15pm revealed: -Staff F worked as a medication aide, and was responsible for administering medications to residents. -She was unaware Staff F had not completed the required 5, 10, or 15 hour MA training. -The BOM should have checked Staff F's personnel record to ensure the required training had been completed. Interview with the BOM on 07/26/19 at 6:06pm		D935			
	revealed: -She did not know St the medication aide t -The Administrator ar to ensure staff compl -She had not checke	aff F was not scheduled for				