STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 10/18/2019

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SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 000	Initial Comments The Adult Care Licensure Section and the Forsyth County Department of Social Services coducted a follow-up survey and complaint investigation on 10/16/19 through 10/18/19. The complaint investigation was initiated by the Adult Care Licensure Section on 10/16/19.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 7 sampled residents (#1) with a diagnosis of dementia with behavior disturbance and a history of aggression and falls. The findings are: Review of Resident #1's current FL-2 dated 04/24/19 revealed: -Diagnoses included dementia with behavior disturbance, hypertension, diabetes mellitus type 2, stage 2 chronic kidney disease, hyperlipidemia,	D 270		

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gastroesophageal reflux disease, acute renal failure, and falls.
-Resident #1 required personal care assistance with bathing and dressing.
-Resident #1 was ambulatory.
-There was no documentation regarding Resident #1's orientation.

Review of Resident #1's care plan dated 04/19/19 revealed:
-Resident #1 was documented as combative.
-Resident #1 required limited assistance with all activities of daily living except for ambulation.
-Resident #1 was ambulatory with aide or devices.
-Resident #1 was documented as forgetful and needed reminders.

Review of the facility's Fall Policy and Procedure revealed:
-Staff will respond to a resident's fall utilizing the Resident Fall Response Guidelines.
-Residents with a fall that included the possibility of head trauma will be sent to the Emergency Department of a local hospital for evaluation and treatment.
-Family, guardians, responsible parties, and physicians will be notified of resident falls.
-Upon discovery of a fall, staff will evaluate the situation using the #1 and #2 of the Resident Fall Response Guidelines.
-The Medication Aide (MA) Supervisor and/or facility nurse will be called to assess the resident and will make arrangements for any physician notification, and/or treatment.
-A Resident Incident/Accident Report will be filled out and family, guardian, responsible parties will be notified.
-The staff will follow instructions noted in the Fall Packet to ensure complete reporting.

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D 270	Continued From page 2 -Follow up will be done utilizing the 24 Hour Post Fall Checklist. Review of the Hospice patient Incident Management Policy and Procedure revealed: -If a hospice patient experiences an incident, the hospice nurse will be called. -If the physician needs to be called, the hospice nurse will place that call and report any medical orders to the facility representative. -The MA Supervisor/MA will follow the procedure from the Fall Prevention Program with the only change being that the call to the physician will be changed to a call to the hospice nurse. -Physician notification will be handled by the hospice nurse and any changes in orders or recommendations will be called back to the facility by the hospice nurse. Review of Resident #1's Incident and Accident Report dated 05/26/19 at 11:00am revealed: -Resident #1 got up to walk and fell in the living room. -There was no documentation of whether the fall was witnessed or unwitnessed. -Resident #1 seemed to be more disoriented than usual. -Resident #1's primary care provider (PCP) and family member was notified. -Range of motion (ROM) was performed and blood pressure was taken and noted to be extremely low. -No injuries were noted on the report. Review of Resident #1's record revealed there was no Post Fall Checklist or 24 Hour Post Fall Checklist completed after Resident #1's fall on 05/26/19. Review of the facility's care notes dated 05/26/19	D 270		

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revealed:
-Resident #1 fell on her left side on the morning of 05/26/19.
-ROM was performed and was effective.
-Vitals were taken and Resident #1's blood pressure was documented as 81.
-The PCP was contacted and instructed facility to hold Resident #3's blood pressure medication due to her blood pressure being low.

Review of the PCP Facility Communication Log revealed:
-There was an entry dated 05/26/19 which documented a nurse came to the facility to assess Resident #1 on this date.
-Per staff, Resident #1 slid to the floor, scraping her left knee.
-There was no redness or swelling of Resident #1's left knee, but there was a slight scrape noted.
-Resident #1's blood pressure was 80/40.
-Resident #1 was on 4 blood pressure medications and all were discontinued by the PCP.

Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls following the incident on 05/26/19.

Review of Resident #1's Incident and Accident Report dated 07/24/19 at 3:15pm revealed:
-Resident #1 had an unwitnessed fall in her room.
-No injuries were documented.
-Resident #1's PCP and family member were notified.
-Emergency Medical Services (EMS) was contacted and Resident #1 was taken to the hospital.

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D 270	Continued From page 4 Review of the Post Fall Checklist dated 07/24/19 revealed: -The checklist was to be completed when a resident fell and included the following instructions: Seek medical attention when the resident had any unusual pain bleeding, head injury or body distortion after a fall; Notify the family or responsible party; Notify the physician of the fall; check on the resident frequently after a fall and document these checks in the care notes; Fill out an accident report; The supervisor will complete the 24-Hour Post Fall Checklist and file the report in the 24 hour report book until complete. -There was no documentation Resident #1 had a scrape, skin tear, or any bleeding. -There was documentation the physician and the resident's family were notified. -There was documentation an Incident and Accident report was completed and the accident was noted in the Resident Care Notes. -There was documentation a 24 hour Post Fall Checklist was placed in the 24 hour report book for completion for Resident #1. -EMS was contacted and Resident #1 was transported by ambulance to the hospital. Review of the 24 hour Post Fall Checklist dated 07/24/19 revealed: -The instructions included: Always keep the 24 Hour Post Fall Checklist in the 24 hour report book until completed; the supervisor must make entries in the resident care notes a minimum of every 8 hours post fall for 24 hours; Answer the questions asked on the checklist and follow directions according to the answer given. -There was no documentation Resident #1 complained of any pain or discomfort, any changes in her walking ability, any outward	D 270		

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rotation of the legs or arms, any increased drowsiness, or any difficulty getting out of bed.
-There was documentation of the Post Fall check-up with the date and time should have been documented in Resident #1's care notes.

Review of Resident #1's care notes dated 07/24/19 revealed there was no documentation regarding Resident #1 falling.

Review of the PCP Facility Communication Log revealed there was no entry dated 07/24/19.

Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls after the incident on 07/24/19.

Review of Resident #1's Incident and Accident Report dated 07/25/19 at 1:30am revealed:
-Resident #1 was found laying face down in her room bleeding from her head.
-The action taken in response to the fall was staff contacted management, Resident #1's family member, and EMS.
-Resident #1 was taken to the hospital.

Attempted telephone interview with the MA who completed the Incident and Accident Report on 10/28/19 at 3:50pm was unsuccessful.

Review of the Post Fall Checklist dated 07/25/19 revealed:
-There was documentation Resident #1 had a scrape or skin tear and was bleeding.
-There was documentation the physician and the resident's family were notified.
-There was documentation an Incident and Accident report was completed and the accident

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was noted in the Resident Care Notes.
-There was documentation a 24 Hour Post Fall Checklist was placed in the 24 hour report book for completion for Resident #1.

Review of the 24 Hour Post Fall Checklist dated 07/25/19 revealed the form was missing information regarding reported complaints of pain and discomfort, changes in walking ability, outward rotation of the legs or arms, increased drowsiness, and difficulty with getting out of bed.

Review of Resident #1's care notes dated 07/25/19.
-There was no documentation regarding Resident #1 falling.
-There was documentation Resident #1 returned to the facility from the hospital the morning of 07/25/19 and had an x-ray on her shoulder.

Review of Resident #1's local hospital discharge summary dated 07/25/19 revealed:
-Resident #1 had a history of Lewy body dementia with a history of agitation and violent behavior.
-Resident #1 was transported to the hospital for evaluation status post unwitnessed fall with questionable altered mental status.
-Resident #1 had a 1 centimeter laceration to the left temple with surrounding contusion, oozing dark red blood.
-Steri-strips were placed on the laceration.
-There was a contusion to Resident #1's left shoulder.
-An x-ray of Resident #1's left shoulder was suggestive of a rotator cuff injury, though there was no deficit in her motor function.
-Resident #1 was discharged back to the facility on 07/25/19.

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Review of the PCP Facility Communication Log revealed:
-There was an entry dated 07/25/19 which documented a nurse came to the facility to assess Resident #1 on this date for a "routine" visit.
-Resident #1 had a fall "on last night."
-There was no documentation Resident #1's PCP was notified of the fall.
-There was documentation of a laceration over Resident #1's left eye with steri-strips in place and left shoulder dislocation possible.
-There was documentation of bruising to Resident #1's face, shoulder, and left knee.
-There was documentation a second x-ray was to be completed on 07/25/19.

Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls.

Review of Resident #1's Incident and Accident Report dated 08/24/19 (no time indicated) revealed:
-Resident #1 had an unwitnessed "incident" in the hallway.
-Resident #1 was bleeding under her left eye.
-The PCP was contacted and would come and assess Resident #1.
-No vital signs were taken.
-EMS was contacted and Resident #1 was transported to the hospital.

Attempted interview on 10/18/19 at 4:20pm with the MA who completed the Incident Accident Report dated 08/24/19 was unsuccessful.

Review of the Post Fall Checklist dated 08/24/19 revealed:

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D 270	Continued From page 8 -There was documentation the resident was bleeding. -There was documentation the physician and the resident's family were notified. -There was documentation an Incident and Accident report was completed and the accident was noted in the Resident Care Notes. -There was documentation a 24 Hour Post Fall Checklist was placed in the 24 hour report book for completion for Resident #1. Review of Resident #1's record revealed there was no Post Fall Checklist or 24 Hour Post Fall Checklist completed after Resident #1's fall on 08/24/19. Review of Resident #1's care notes dated 08/24/19 revealed: -There was documentation Resident #1 had an unwitnessed fall. -There was documentation the MA contacted the PCP who came out to assess Resident #1. -There was documentation Resident #1 had a gash over her left eye and the PCP and Resident #1's daughter made the decision to send Resident #1 to the hospital. -There was documentation the MA completed an Incident and Accident Report. Review of the PCP Facility Communication Log revealed: -There was an entry dated 08/24/19, written by the PCP's nurse, which documented the nurse came to the facility to assess Resident #1 on this date after fall. -Resident #1 fell and had a bruise and open area under her left eye approximately the size of a pencil eraser. -There was no documentation PCP was notified of the fall.	D 270		

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-The nurse contacted the family member regarding sending Resident #1 to the emergency room.

Review of Resident #1's local hospital discharge summary dated 08/24/19 revealed:
-Resident #1 had a fall in unknown circumstances and landed on a hard floor.
-The point of impact was the head.
-Resident #1 had a laceration on her left cheek which measured 2 centimeters.
-The laceration was cleaned and repaired with tissue adhesive.
-Some swelling of the left hand was noted.
-Imaging studies were ordered to evaluate for any acute injuries from the fall, but Resident #1's family declined the imaging stating Resident #1 was on hospice and they would not do any interventions even if abnormalities were found.
-Resident #1's family just wanted the laceration repaired and for Resident #1 to be sent back to hospice care.
-Resident #1 was discharged back to the facility on 08/24/19.

Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls after the incident on 08/24/19.

Review of Resident #1's Incident and Accident Report dated 09/06/19 at 12:00pm revealed:
-Resident #1 bit her lip.
-Resident #1's vital signs were taken and range of motion was performed.
-The PCP and Resident #1's family member were notified.
-There was a staff statement attached to the incident report which revealed the staff was

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outside with other residents and saw Resident #1 lay on the floor in the facility. The staff came in and helped Resident #1 up off the floor and noticed she had bitten her lip.

Interview with the MA who completed the Incident and Accident Report dated 09/06/19 on 10/17/19 at 10:16am revealed:
-Resident #1 was a fall risk and has had multiple falls.
-Resident #1 also had a lot of behavioral issues such as kicking, hitting, headbutting, spitting, and attempting to bite.
-She did not see Resident #1 on the floor on 09/06/19.
-A personal care aide (PCA) told her Resident #1 was on the floor in front of the air conditioner.
-The PCA told her she saw Resident #1 lay down on the floor.
-Since Resident #1 did not fall, she did not complete a Post Fall Checklist.
-She contacted Resident #1's PCP and they came out to assess Resident #1 on 09/06/19.
-EMS was not contacted.
-Usually when a Resident had a fall, she would assess the resident, perform range of motion, and determine if the resident hit his or her head.
-If a resident hit their head, they would be sent out to the hospital.
-A resident would not be automatically sent out to the hospital if they were bleeding, only if they needed stitches or if a band aid would not be sufficient treatment for the resident.
-After a fall, the MA should complete an Incident and Accident Report and a Post Fall Checklist, a 24 Hour Post Fall Checklist was to be completed if the resident was not sent to the emergency room, and contact the resident's physician and responsible party.
-After a witnessed or unwitnessed fall, staff

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should check on the resident every 30 minutes for 24 hours.
-After a resident returned from the hospital after having a fall, the resident would be placed on 30 minute checks and the checks would be documented in the resident's care notes.
-Sometimes 30 minute checks on a resident were extended beyond 24 hours.
-There was a 30 minute check form which should be completed for residents after a fall.
-The 30 minute check forms were usually kept in a designated notebook, but she did not see any 30 minute check forms for Resident #1.
-Facility staff communicated with Resident #1's PCP (hospice agency) very closely, administered scheduled and as needed medication, and Resident #1's PCP made several changes in her medication in attempt to address anxiety and behavioral issues.
-She did not know of any specific intervention put in place for Resident #1 after her fall on 09/06/19.

Review of Resident #1's record revealed there was no Post Fall Checklist or 24 Hour Post Fall Checklist completed after Resident #1's fall on 09/06/19.

Review of Resident #1's care notes dated 09/06/19 revealed:
-Resident #1 was lying down on the floor.
-A PCA helper Resident #1 to her room.
-Resident #1 had bit her lip.
-Resident #1's vitals were taken, the PCP was called and Resident #1's family member was notified.
-The PCP was in route to examine Resident #1.

Review of PCP's Facility Communication Log revealed:
-There was no entry on 09/06/19 documenting

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Resident #1 was assessed.
-There was documentation Resident #1 was seen for a routine visit on 09/09/19, 09/12/19, 09/16/19, and 09/19/19.
-There was documentation PCP made a referral for a psychiatric evaluation on 09/19/19.

Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls after the incident on 09/06/19.

Review of Resident #1's Incident and Accident Report dated 09/25/19 at 1:30am revealed:
-Resident #1 had unwitnessed scratches and bruises.
-Resident #1 was in another resident's room hitting the resident and the other resident hit and scratched Resident #1.
-The incident happened in the other Resident's room.
-Resident #1 was cleaned up and antibiotic ointment was applied.
-Resident #1's PCP and family member were notified.
-EMS was not contacted.

Review of a second Incident and Accident Report dated 09/25/19 at 1:30am for Resident #1 revealed:
-Resident #1 came up the hallway bleeding and stated another resident had hit her.
-The incident was unwitnessed.
-Resident #1 was cleaned up and antibiotic ointment was applied to Resident #1's scratches.
-It was unknown where the incident happened.
-Resident #1's PCP and family member were notified.
-EMS was not contacted.

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D 270	Continued From page 13 Attempted telephone interview on 09/18/19 at 4:15pm with the MA who completed both Incident and Accident Reports dated 09/25/19 was unsuccessful. Review of Resident #1's care notes dated 09/25/19 revealed: -There was no entry documenting any incident occurred on 09/25/19. -There was an entry entered by a MA who documented she was notified Resident #1 had a busted lip and her eyes were swollen, but there was no documentation who notified her. -The MA documented she was told Resident #1 had been in an altercation with another resident on the night before. Interview with the MA who wrote the care note dated 09/25/19 on 10/17/19 at 10:16am revealed: -The third shift MA should have documented the incident that occurred on 09/25/19 in the care notes as well as completed an Incident and Accident Report and contact the resident's PCP and family. -When she came in to work, the third shift MA reported to her Resident #1 had a "busted lip" and swollen eyes due to being in an altercation with another resident. Interview with the other resident on 10/17/19 at 10:06am revealed: -Resident #1 came into her room and got into her bed. -"I told her to get out, but she said it was her bed." -"I was trying to get her out and she kicked me on the leg. I told her to stop and she kept kicking me." -The resident sat in her chair beside the bed and Resident #1 punched her in the face with her fist.	D 270		

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D 270	Continued From page 14 -She punched Resident #1 back in the face, but she did not remember which side of the face she hit her on. -There was no staff present when Resident #1 was in her bed or when Resident #1 punched her. Review of the PCP's Facility Communication Log revealed: -There was documentation of a nurse visit dated 09/26/19. -The nurse documented Resident #1's eyes were swollen, she had scratches on both her right and left neck, and she had a "fat" lip on the right side with a bruise and a scratch. -She was on-call last night and was not notified of the incident. Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls. Review of Resident #1's Incident and Accident Reports revealed there was no report dated 09/27/19 and no Post Fall Checklist or 24 Hour Post Fall Checklist for Resident #1. Review of Resident #1's care notes dated 09/27/19 at 11:20pm revealed: -Resident #1 was found laying on the floor by a PCA. -Resident #1 had scratches on her face and her finger was bleeding. -The MA who wrote the care note documented she contacted Resident #1's PCP and a nurse would contact Resident #1's family member. Attempted telephone interview on 10/18/19 at 4:20pm with the MA who wrote the care note dated 09/27/19 was unsuccessful.	D 270		

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D 270	Continued From page 15 Review of the PCP's Facility Communication Log dated 09/27/19 revealed: -There was documentation on 09/27/19 a nurse visited Resident #1 and observed Resident#1's face bruised, left hand scraped, and a skin tear on her middle finger. -The visiting nurse on 09/27/19 documented staff informed her Resident #1 had an unwitnessed fall and she reviewed with staff the availability of 24 hour nursing services and encouraged staff to call for Resident #1's needs. Review of Resident #1's record revealed there was no documentation of interventions put in place by the facility nor any increase in supervision for Resident #1 to prevent falls after the incident on 09/27/19. Review of Resident #1's Incident and Accident Report dated 09/29/19 at 6:00am revealed: -During morning rounds, Resident #1 was found in her room with blood on her foot. -Staff did not notice any cuts on Resident #1's foot where the blood was found. -Later during morning rounds, staff noticed blood coming from Resident #1's hair and assessed Resident #1 for the blood site. -Staff noticed a small knot forming on Resident #1's right temple and called her PCP and family member. -Resident #1 was cleaned up by staff. -It was documented staff was unable to obtain vital signs. -There was no documentation EMS was called. -There was a Post Fall Checklist attached to the incident report. Interview with the MA who completed the incident report dated 09/29/19 on 10/17/19 at 4:53pm	D 270		

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revealed:
-She usually worked on second and third shifts.
-Resident #1 was a fall risk, but she had not witnessed any of Resident #1's falls.
-She thought Resident #1's unsteady gait, dementia, and anxiety may have contributed to her falls.
-She had worked second and third shifts on 09/28/19.
-She had checked on Resident #1 around 4:00am and Resident #1 was agitated.
-A PCA reported to her Resident #1 fell on 09/29/19.
-She and the Resident Care Coordinator (RCC) noticed Resident #1 had blood on her feet and did not notice until later Resident #1 had blood in her hair.
-Resident #1 was cleaned up and her PCP and family member were contacted.
-When a resident had a fall, staff should be checking on that resident every 15 minutes for 24 to 48 hours. If the resident hit their head then there should be 15 minute checks for 48 to 72 hours.
-Some staff were documenting the increased checks after a fall and some staff were not documenting the increased checks on residents after a fall.
-There were 15 minute check sheets and 30 minute check sheets that were to be completed to document increased checks on residents after a fall.
-Resident #1 was admitted to the hospital after her fall on 09/29/19 and did not return to the facility.

Review of Resident #1's care notes dated 09/29/19 at 4:23am revealed:
-There was documentation Resident #1 was found the morning of 09/29/19 with blood on her

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foot.
-The RCC and the MA writing the care note cleaned Resident #1's foot and could not find the source of blood.
-After staff completed morning rounds on 09/29/19, staff noticed Resident #1 was bleeding from the left side of her hair line.
-Resident #1 was assessed again the morning of 09/29/19 and staff found a small knot on the left side of her head with a small cut that was bleeding.
-The MA contacted Resident #1's PCP and family member who instructed the MA to not send Resident #1 to the hospital until she and the PCP arrived at the facility.

Review of a second care note for Resident #1 dated 09/29/19 at 2:49pm revealed:
-When the MA started her shift the morning of 09/29/19, she was told Resident #1 had fallen throughout the night.
-Resident #1 had a "huge" contusion on her left temple which was "extremely swollen and black and blue in color."
-She had been told by the third shift MA the PCP had been contacted but had still not arrived at the facility.
-She made a second call to the PCP who arrived at the facility around 9:00am.
-The PCP assessed Resident #1 and recommended she be sent to the emergency room.
-Resident #1's daughter transported Resident #1 to the emergency room rather than waiting on EMS.

Review of Resident #1's local hospital discharge summary dated 09/29/19 revealed:
-The chief complaint of the visit was a fall.
-Resident #1's physical exam at the hospital

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noted Resident #1 had bruises in various stages of healing around her face.
-The area of concern on 09/29/19 was the left temporal area where there was a hematoma with an abrasion.
-There was no active bleeding noted.
-There was an abrasion noted to the left fourth finger.
-Resident #1 was admitted to the hospital secondary to multiple falls leading to a left-sided eighth and ninth acute rib fracture and a punctured lung.
-The hospital physician discussed treatment options with Resident #1's family member who did not want to pursue any further work-up and/or interventions and wanted comfort care for Resident #1.
-Resident #1 was discharged to a hospice facility on 10/03/19.

Review of the PCP's Facility Communication Log revealed there was no documentation for 09/29/19.

Interview with Resident #1's family member on 10/16/19 at 4:49pm revealed:
-Resident #1 was a hospice patient and had been a resident at the facility since April 2019.
-Resident #1 had aggressive behaviors and was would not take her medication at times.
-Resident #1 had an unwitnessed fall in May 2019 during the night and the facility did not contact her to inform her of the fall.
-On 07/24/19 at 9:00am she received a call from an emergency room physician at a local hospital stating Resident #1 was admitted to the hospital around 1:00am and was discharged back to the facility around 7:00am on the same date.
-Resident #1 had a hospital visit on 07/25/19 due to a fall and steri-strips were placed on her eye in

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the emergency room.
-On 07/30/19, the family member observed Resident #1 with a left black eye and bruise on her cheek and there was no emergency room visit on this date.
-She had not received a call from the facility regarding Resident #1 falling on 07/24/19 and there was no documentation at the facility Resident #1 went to the hospital on 07/24/19.
-On 08/24/19, she received a call from staff stating Resident #1 had an unwitnessed fall.
-The hospice nurse was at the facility on 08/24/19 and had Resident #1 sent to the emergency room for stitches.
-The family member observed Resident #1 on 08/24/19 with a black eye, a bruise on her cheek, and the cut on her eye had been glued by emergency room staff.
-On 09/25/19, she visited Resident #1 in the facility and found Resident #1 with her right eye swollen, a bruise on her lip, and 2 finger prints on her neck where it appeared nails had dug into her skin. There was dried blood on Resident #1's neck.
-Resident #1 had a history of wandering and slept all day and was up all night.
-Staff told her on 09/25/19 Resident #1 went into another resident's room and the other resident asked Resident #1 to leave and they started fighting.
-The Administrator had discussed with her having someone sit outside Resident #1's door all night, for an extra $250 fee per month, to make sure she did not come out and that no one went in her room.
-She agreed to have someone sit outside Resident #1's door at night.
-She received a call from the hospice nurse on 09/27/19 who told her Resident #1 had a fall.
-On 09/28/19, she observed Resident #1's right

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eye was black.
-On 09/29/19, she received a call from a MA Supervisor at 6:50am informing her Resident #1 had an unwitnessed fall during the night and Resident #1 had a contusion with bruising on the right side of her forehead.
-When she arrived at the facility, there were drops of blood falling from Resident #1's head onto the table and staff asked her if she wanted gloves to clean Resident #1 up.
-She and a MA took Resident #1 to the Assisted Living (AL) side of the facility to talk to a MA supervisor on the AL side.
-The family member wanted to wait on the hospice nurse to arrive at the facility to assess Resident #1 before sending Resident #1 out to the hospital.
-It was decided Resident #1 needed to be evaluated at the hospital and Resident #1's family member decided to transport Resident #1 in her own vehicle instead of waiting on EMS.
-She did not know of any interventions or increased supervision that was put in place after each fall.
-Once Resident #1 was examined at the hospital on 09/29/19, she was found to have broken ribs, broken facial bones, punctured lung, cuts, and scrapes.
-Resident #1 was discharged from the hospital to a hospice facility.

Interview with the AL MA Supervisor on 10/17/19 at 11:10am revealed:
-When a resident fell, staff were to contact the resident's physician and family.
-If a resident hit their head, they were automatically sent out unless the resident was a hospice patient.
-If a resident received hospice services, the staff would contact hospice prior to sending the

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resident out of the facility to the emergency room for evaluation.
-She was working in the facility on 09/29/19 when Resident #1's family member brought Resident #1 to the AL side.
-She observed Resident #1 had a bruise on the left side of her head and an old scratch on the left side of her nose and face.
-She did not know if Resident #1 fell or what happened.
-Resident #1's family member did not want Resident #1 to be sent out to the hospital until the hospice nurse arrived at the facility and requested the EMS call be canceled because she (the family member) would transport Resident #1 to the hospital.

Interview with the Special Care Unit (SCU) Resident Care Coordinator (RCC) on 10/17/19 at 11:17am revealed:
-When a resident had a fall, staff was to contact the resident's family and the resident's physician.
-If the resident was not sent out to the hospital, the MA on duty was to sign off on a Post Fall Checklist on each shift.
-All residents in the special care unit were checked on at least every 30 minutes and some were checked on every 15 minutes.
-If a resident was sent out to the hospital then they were placed on 15 minute checks when they returned.
-There were 30 minute and 15 minute check sheets that were supposed to be initialed by staff and placed in a designated notebook.
-She would check to see if she could find the 30 minute and 15 minute check sheets for Resident #1.
-The implementation of the 30 minute checks and 15 minute checks should have been documented in Resident #1's care notes.

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-There was an extra staff person put in place on third shift beginning on 09/25/19.
-The extra staff person was supposed to sit in the hallway where Resident #1 resided and monitor that hall.
-She did not know of any specific interventions put in place for Resident #1 after previous falls.
-She kept Resident #1 with her most of the time during her shift.

Interview with a hospice nursing director at the PCP's office on 10/17/19 at 3:34pm revealed:
-Resident #1's nursing visit frequency fluctuated according to her needs, but she was seen by a hospice nurse at least once a week.
-Resident #1 always had a nursing visit after each reported fall.
-The hospice nurse provided education on falls, redirection, and not waiting until Resident #1's anxiety or behaviors escalated before administering as needed medications for anxiety.

Interview with the Administrator on 10/17/19 at 6:07pm revealed:
-When a resident had an unwitnessed fall, the protocol was to send the resident out to the emergency room, take the resident's vital signs, contact the responsible part, notify the PCP, and follow the instructions of the PCP.
-When a resident had a witnessed fall, but did not hit their head, the resident was placed on 15 minute or 30 minute checks for at least 72 hours.
-The 15 minute and 30 minute checks were kept in a designated notebook.
-She would expect for staff to document the implementation of the 15 minute or 30 minutes checks in the resident's care notes.
-All falls should be documented and reported at morning staff meeting and with shift change.
-Most of the time after a fall, the resident would

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be evaluated for physical therapy.
-Resident #1 was a fall risk.
-Resident #1 started falling a lot after some of her medications were discontinued by her previous PCP.
-When Resident #1 fell, staff were instructed to contact her PCP who made the decision of whether to send Resident #1 out to the hospital or not.
-She knew about of all of Resident #1's falls.
-Resident #1's PCP and family were contacted after each fall, but she did not know if any interventions or increased supervision was put in place for Resident #1 after each fall to prevent further falls.
-All interventions would have come from Resident #1's PCP and the PCP would have instructed the facility if they wanted Resident #1 to be placed on 30 minute checks or 15 minute checks.
-Any interventions and need for increased supervision would have been discussed between the MA, the RCC and Resident #1's PCP.
-The staff kept Resident #1 safe by keeping her with the SCU RCC in her office.
-There was also an extra staff person placed in the hallway during third shift beginning on 09/25/19.
-There was a chair set up for the extra staff in the hallway where Resident #1 resided. If the staff sat in the chair in the hallway, the staff could see Resident #1's door, but could not see into Resident #1's room.
-She did not know about Resident #1's injuries after her last fall on 09/29/19 and she did not understand how Resident #1 could have sustained the injuries when she walked out of the facilty.

Interview with a hospice nurse clinical coordinator at the PCP's office on 10/18/19 at 3:13pm

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D 270	Continued From page 24 -Resident #1 was admitted to hospice services on 05/03/19 and was discharged from services on 09/29/19 after she was admitted to the hospital. -A hospice nurse visited Resident #1 on 39 different days between 05/03/19 and 09/29/19 for routine and as needed visits. -There were several recommendations to the facility and interventions initiated by the PCP including multiple medication changes, multiple visits, and a referral to psychiatric services documented in the PCP's Facility Communication Log on 09/19/19. -The recommendations to the facility staff included contacting the PCP for any issues, rounding on Resident #1 frequently, and putting a 1 on 1 sitter in place for Resident #1. A second interview with the Administrator on 10/18/19 at 9:10am revealed: -She had the Resident Fall Policy and Procedure and the Hospice Patient Incident Management Policy and Procedure. -She obtained a Fall Intervention Protocol from a sister facility, but the Fall Intervention Protocol had not been implemented with the staff in the facility yet. The facility failed to supervise Resident #1 who had a diagnosis of dementia with behavior disturbance; the resident had multiple falls resulting in a contusion, multiple bruises, cuts, left-sided eighth and ninth acute rib fracture and a punctured lung. The facility's failure resulted in serious injury of the resident and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/17/19. CORRECTION DATE FOR THE TYPE A2	D 270		

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D 270	Continued From page 25 VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 1 of 7 sampled residents (Resident #2) related to documenting the administration of Humalog sliding scale based on fingerstick blood sugar (FSBS) parameters. The findings are: Review of Resident #2's current FL2 dated 05/01/19 revealed diagnoses included vascular dementia and diabetes mellitus. Review of Resident #2's physician's orders dated 04/29/19 revealed a clarification order for Humalog sliding scale insulin (SSI) subcutaneously before meals and at bedtime with parameters: For fingerstick blood sugars (FSBS) less than 70 notify the provider. For FSBS 151-200 give 2 units, for FSBS 201-250 give 4	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	R 10/18/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26	D 358		

units, for FSBS 251-300 give 6 units, for FSBS 301-350 give 8 units, for FSBS 351-400 give 10 units, for FSBS greater than 401 notify the provider. There were also orders for FSBS before meals and at bedtime.

Review of Resident #2's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Humalog insulin 100unit/mL, check FSBS and inject per sliding scale at 6:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry at 6:30am, 11:30am, 4:30pm and 8:00pm for the initials of the medication aide that administered the medication.
-There was an entry for FSBS results 6:30am, 11:30am, 4:30pm and 8:00pm.
-There was documentation the resident's FSBS were within range for the Humalog sliding scale 109 times from 08/01/19 through 08/31/19.
-There was no space on the eMAR to document the amount of SSI administered.
-There was no documentation Humalog sliding scale was administered 80 of 109 opportunities when FSBS were within parameters for insulin.

Review of Resident #2's September 2019 eMAR revealed:
-There was an entry for Humalog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale for 6:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry at 6:30am, 11:30am, 4:30pm and 8:00pm for the initials of the medication aide that administered the medication.
-There was an entry for FSBS results 6:30am, 11:30am, 4:30pm and 8:00pm.
-There was no space on the eMAR to document the amount of SSI administered.
-There was documentation the resident's FSBS

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D 358	Continued From page 27	D 358		

were within range for the Humalog sliding scale 83 times from 09/01/19 through 09/30/19.
-There was no documentation Humalog sliding scale was administered 67 of 83 opportunities when FSBS were within parameters for insulin.

Review of Resident #2's October 2019 eMAR revealed:
-There was an entry for Humalog insulin 100unit/mL, check fingerstick blood sugar (FSBS) and inject per sliding scale for 6:30am, 11:30am, 4:30pm and 8:00pm.
-There was an entry at 6:30am, 11:30am, 4:30pm and 8:00pm for the initials of the medication aide that administered the medication.
-There was an entry for FSBS results 6:30am, 11:30am, 4:30pm and 8:00pm.
-There was no space on the eMAR to document the amount of SSI administered.
-There was documentation the resident's FSBS were within range for the Humalog sliding scale 49 times from 10/01/19 through 10/16/19.
-There was no documentation Humalog sliding scale was administered 38 of 49 opportunities when FSBS were within parameters for insulin.

Interview with the Memory Care Unit Coordinator (MCUC) on 10/17/19 at 12:01pm revealed:
-The medication aides (MAs) were to administer Humalog SSI to Resident #2 according to the parameters that was ordered by the Primary Care Provider (PCP).
-The pharmacy set the eMARs up in the system and did not include an area to document the units of insulin administered.
-She had instructed the MAs to document the units of insulin administered in the notes section of the eMARs.
-She performed weekly audits of the medication cart and the eMARs.

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	HAL034098	A. BUILDING: _____ B. WING _____	R 10/18/2019

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D 358	Continued From page 28 -When she checked the eMARs she specifically checked the FSBS to ensure they were being done. -She did not look to see if the MAs documented the units of insulin administered. -She believed the MAs had administered Resident #2's SSI as ordered but without documentation she could validate the medication had been administered. Interview with a medication aide supervisor (MA) on 10/17/19 at 11:41am revealed: -She checked Resident #2's FSBS at least twice on her shift. -Resident #2 had orders to administer Humalog insulin based on sliding scale parameters. -The eMARs did not have a designated section to document the units of insulin administered. -When she administered Humalog SSI, she was to document the units of insulin administered in the notes section of the eMARs. -She had to wait and document the insulin administered in the notes after she administered the medications to the resident. -She sometimes forgot to document the units of insulin administered. -She was aware that no documentation of the units SSI administered means it could not be validated the medication was administered. -She also was responsible for completing cart and eMAR audits at least twice weekly. -She had observed that some MAs documented units of Humalog administered. -She did not thoroughly check the eMARs to ensure the MAs documented each administration of Humalog to Resident #2.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 29 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 7 sampled residents (#1) with a diagnosis of dementia with behavior disturbance and a history of aggression and falls. [Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D912		