Division	of Health	Service	Regulation
DIVISION	Unitealth	DEIVICE	regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE	ETED
		HAL034093	B. WING		04/1	6/2020
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
ANBY HO	DUSE		DRKE MILL ROAD			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
	Desk Review follow-u 4/13/20 to 4/16/20.	sure Section conducted a up survey 4/09/20 and I(b) Personal Care and	{D 000} {D 270}	Responses to the cited defic constitute an admission or a facility of the truth of the fac conclusions set forth in this deficiencies or corrective ac of Correction is prepared so compliance with state law.	agreement by the ts alleged or statement of tionreport; the Plan	
	 3 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. 			10A NCAC 13F. 0901 (b) Per Supervision	rsonal Care and	
	failed to provide super residents (Residents frequent falls resultin a fractured pelvis (Re falling out of a wheeled The findings are:	PE A1 VIOLATION n was abated. tinues. s and interviews the facility ervision for 2 of 4 sampled #1 and #2) experiencing g in one resident sustaining esident #2) and one resident chair (Resident #1).		All residents put on a 1hour a accountability checklist. Resident Care Coordinator v daily for completion. Staff education will occur for and accountability checklist a by 4/24/2020 and ongoing. For any resident incident, the supervision and accountabili increased to evry 30 minutes notified. We will re evaluate improvement/discontinuation monitoring. For any second supervision and accountabili increased to every 15 minute reviewed for improvement/di For any falls, a Fall risk asse completed. If 2 falls in a 4 week period of referral will be requested unit warranted.	vill review checklist Staff supervision and Incident reporting e Increased ity checklist will be s and the MD will be in 1 week for n of increased incidents, Increased ity checklist will be es for 1 week then iscontinuation. essment tool wil be occur, a therapy	
ision of Hoo	revealed: -When a staff finds a	s Accident/Falls policy resident that had an to send or call for help.				
			. Ex	ecutive Director	(10m) (0)	(X6) DATE

Reviewed and accepted 05/15/20 KHH

Division of	of Health Service Regu	lation			FORM APPROVE
STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL034093	B. WING		R 04/16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
		3150 BU	RKE MILL ROAD		
DANBY H	OUSE	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
{D 270}	Continued From page	e 1	{D 270}		
	-Staff were to evaluat assess the resident. -If injury or accident v staff are to complete Report form within 48 -Call/notify the reside responsible party. 1. Review of Residen 04/03/20 revealed: -Diagnoses included hyperlipidemia, degen	e the situation, call 911, and vas greater than first aid an Accident and Incident hours. nt's physician and t #2's current FL2 dated lewy body dementia, nerative joint disease. ermittently disoriented and			
	toileting, ambulation, grooming. -Resident #2 required eating and transferrin	netimes disoriented, reminders. I extensive assistance with bathing, dressing and I limited assistance with g.			
	01/31/20 revealed Re	2's Progress Note dated esident #2 was found by a PCA) sitting on the floor. The the hospital.			
	dated 01/31/20 at 2:2	2's Accident/Incident report 3am revealed a PCA found n the floor beside her bed. er leg injury.			
	Review of the 01/31/2 summary report revea that resulted in a pelv	aled Resident #2 had a fall			
	Telephone interview	with the PCA on 04/16/20 at			
sion of He	alth Service Regulation				

Division (of Health Service Regu	ation			FOR	M APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	PLETED
		HAL034093	B. WING		04	R / 16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	OURE	3150 BU	RKE MILL ROAD			
DANBY H	OUSE	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 270}	Continued From page	2	{D 270}			
	8:43am revealed: -She worked the third doing her rounds, she floor. -She was not sure how the floor. -Just before Christma #2 had started to decl -The resident was no for herself. -She had to help Resident bed into her wheelcha -Resident #2 no longer transfer the resident. -She checked on Resident thirty-minutes. -This was the first time shift. -She was not aware of -If she was walking the Resident #2 more free -The end of last year Coordinator (MCUC) Resident #2 every this resident's health had -Before Christmas 20 stand and assist staff her. -Now staff had to do e -Resident #2 was tota everything for her. -Resident #2 had to b her wheelchair. -The resident was als wheelchair to the toile -She was aware Resident	shift on 01/31/20, and when found Resident #2 on the w Resident #2 ended-up on s she noticed that Resident ine. longer able to do anything dent #2 get in and out of air. er walked so she had to ident #2 every e Resident #2 fell on her of other falls. e hall, she checked on quently than thirty-minutes. the Memory Care Unit instructed staff to check ty-minutes because the started to decline. 19, Resident #2 was able to with dressing and toileting everything for Resident #2. If care because staff did e assisted from the bed to o assisted from the		χ		
Division of Lin	Telephone interview of the MCUC revealed: alth Service Regulation	on 04/15/20 at 4:23pm with				

6899

L3W712

If continuation sheet 3 of 19

(X3) DATE SURVEY

	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
					R
		HAL034093	B. WING		04/16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E, ZIP CODE	
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 27'	103	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
{D 270}	Continued From page	3	{D 270}		
	-A few days after the was put on thirty-minute sup staff to check on Resi thirty-minutes. -When staff checked to ask her if she needed -The facility's policy for hours. -The thirty-minute sup for staff to lay eyes or -Resident #2 was also February 2020 (unable). It was the facility's policy for staff to lay eyes or -Resident #2 was also February 2020 (unable). It was the facility's policy for staff to lay eyes or -Resident #2 was also february 2020 (unable). Review of the facility's fail administration record documentation the resident of the facility's fail Review of the January was no documentation were checked for 72 here the floor. The resident #2,02/04/20 revealed Reo on the floor. The reside to go to the floor. The reside to go to the floor the facility's fail add 02/04/20 at 7:44 was observed sitting of Review of the facility's Accountability monitor was documentation Revery thirty-minutes from 02/29/20.	01/31/20 fall Resident #2 ute supervision checks. pervision checks required ident #2 every the resident, they were to anything. or toileting was every two pervision checks were just in the resident. or ordered physical therapy in le to recall the exact date). olicy after a fall to monitor a for 72 hours. 1/20 the electronic medical (eMAR) should have sident vital were checked as Il protocol. y 2020 eMAR revealed there in Resident #2's vital signs hours after the fall. 2's Progress Note dated esident #2 was found sitting dent complained of toe pain he hospital. 2's Accident/Incident report 0am revealed Resident #2 on the floor on her bottom. s Increased Supervision and ring sheets revealed there tesident #2 was checked			
Division of Hea	alth Service Regulation		1		

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

L3W712

If continuation sheet 4 of 19

	OF DEFICIENCIES	ation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMF	SURVEY PLETED
		HAL034093	B. WING		04	/16/2020
IAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	03		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
{D 270}	Continued From page	A	{D 270}	DEFICIEN		
(2 2/0)		ed vital sign checks from				
	the MCUC revealed: -On 02/04/20 the median to come to Resident # -She witnessed Resid -The resident complain (unable to recall what -Resident #2 refused -A couple days after the in place thirty-minute -No changes were man 02/04/20. -Staff continued thirty -Physical therapy star recall the exact date). -She was not sure if the	lent #2 sitting on the floor. ned of pain in her toe toe). to go out to the hospital. he fall on 01/31/20 she put checks. ade after the fall on -minute supervision checks. ted in February (unable to he resident was still getting nuse all outside visitors had				
		2's Progress Note dated sident #2 was found on the the hospital.				
	dated 03/09/20 at 8:5	2's Accident/Incident report 3pm revealed the MA found her buttocks on the floor				
	Review of the 03/09/2 summary report revea with no injuries noted.	aled Resident #2 had a fall				
	Supervision and Acco					

Division o	of Health Service Regu	lation			FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL034093	B. WING		R 04/16/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
DANBY H		3150 BU	RKE MILL ROAD		
DANGTH	OUSE	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 OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{D 270}	Continued From page	9.5	{D 270}		
	revealed there was no #2's vital signs were of the fall on 03/09/20. Telephone interview v 4:45pm revealed: -On 03/09/20, she wo -It was 9:00pm or 10: down the hall of the s she observed Residen the floor. -Resident #2 was una on the floor. -She took the residen the resident for injurie -She called emergend they helped Resident -Resident #2 was ser returned the same nig -The hospital did not -Resident #2 was alre supervision checks ev -The thirty-minute sup	cy medical responders and #2 off the floor. It out to the hospital and ght before midnight. note any injuries. eady on monitoring and			
	-The MAs sometimes	did the thirty-minute mostly completed by the			
	04010-0495300000000	gned the thirty-minute			
	increase or decrease	only person that could the thirty-minute checks.			
	 Resident #2 had not than every thirty-minu 	been placed on checks less			
	-In March (unable to				
	• • • • • • • • • • • • • • • • • • •	red to a room that was			
	closer to the nurse's	station.			
Division of Ho	alth Service Regulation				

STATE DENNING FOR CERCIPATION OF CONTRUCTION A BUILDANCY CON DEPUNCE A BUILDANCY CON DEPUNCE A BUILDANCY CON DEPUNCE A BUILDANCY CONDUCTION A	Division of	of Health Service Regu	lation			FOR	MAPPROVED
HAL03403 B.WMC							
DARRY HOLE RADE WINSTON SALEM, NO 27103 CAPUID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCING REACH DEFICIENCY MUST BE PRECEDED BY YULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION) (EACH CORRECTION (EACH CORRECTION) (EACH CORRECTION (EACH CORRECTION) (EACH C			HAL034093	B. WING			
DANEY HOUSE WINSTON SALEM, NC 27103 (PA)/D TRA SUMMARY STATEMENT OF DEFICIENCES (EAC) ESPREIDENTIATION STATEMENT OF DEFICIENCES (EAC) ESPREIDENTIATION AND LE DESTRIPTING MEMORATION) D PRECENT TRAC D PROVIDER'S FLAN OF CONRECTION (EAC) ESPREIDENTIATION AND LE DESTRIPTING MEMORATION) D PRECENT TRAC D PROVIDER'S FLAN OF CONRECTION (EAC) ESPREIDENCY, TRAC Continued From page 6 (D 270) Continued From page 6 (D 270) (D 270) D EFRICIENCY, TRAC D PROVIDER'S FLAN OF CONRECTION (EAC) ESPREIDENCY, TRAC D PROVIDENCE (EAC) ESPREIDENCY, TRAC D PROVIDENCE (EAC) ESPREIDENCY, TRAC D PROVIDENCE (EAC) ESPREIDENCY, TRAC D PROVIDENCENT, TRAC D PROVIDENCENT	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
Winstow SALEM, Ko 27103 Preprint Tag Submany statement of percensues (EACH OBRIGENCY MUST BE PRECEDED BY PULL RESULTORY OR LISC DETITIVEN INFORMATION) PREPRINT Tag PROVIDERS PLAN OF CORRECTION (EACH OORSENEREENDED To THE APROPRIATE DEFICIENCY) DR COMPLETE (CORSENEREENDED TO THE APROPRIATE DEFICIENCY) DR COMPLETE (CORSENERED TO THE APROPRIATE DEFICIENCY) DR COMPLETE (CORSENERED TO THE APROPRIATE DEFICIENCY) DR COMPLETE (CORSENERED TO THE AP		OUSE	3150 BU	IRKE MILL ROAD			
Preprint TAG IEAD IDENCISION WILT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFINIG INFORMATION) PREFIX TAG Calculation of the construction of the conston and accountability monitoring sheets revealed there war		OUSE	WINSTO	ON SALEM, NC 271	03		
Telephone interview with the MCUC on 04/15/20 at 4:23pm revealed: -In March 2020 (unable to recall exact date), but thought it was after the second fall in March 2020 Resident #2 was moved closer to the nurse's station. -It was the facility's protocol after a fall to monitor the resident's vital signs for 72 hours. -This should have been noted on the electronic medical administration record (eMAR). Review of Resident #2's Progress Note dated 03/23/20 at 11:04am revealed: -Resident #2 was observed lying on the floor by her bed. -The resident was holding her head. -The resident was bolding her head. -A bump was observed on the resident's head. -Resident #2's Accident/Incident report dated 03/23/20 at 71:15am revealed a PCA found Resident #2's Accident/Incident report dated 03/23/20 at 7:15am revealed a PCA found Resident #2's component was a fall. There were no injuries noted. Review of the 03/23/20 hospital discharge summary report revealed Resident #2's initial encounter was a fall. There were no injuries noted. Review of the facility's March 2020 Increased Supervision and Accountability monitoring sheets revealed there was documentation the resident was checked on every thity-minutes from 03/01/20. Review of Resident #2's March 2020 eMAR revealed there was documentation Resident #2's barch 2020 at AR	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
at 4:23pm revealed: -In March 2020 (unable to recall exact date), but thought it was after the second fall in March 2020 Resident #2 was moved closer to the nurse's station. -It was the facility's protocol after a fall to monitor the resident's vital signs for 72 hours. -This should have been noted on the electronic medical administration record (eMAR). Review of Resident #2's Progress Note dated 03/23/20 at 11:04am revealed: -Recident #2 was observed lying on the floor by her bed. -The resident was holding her head. -The resident was holding her head. -Recident #2 was sent to the hospital for an evaluation. Review of Resident #2's Accident/Incident report date 03/23/20 at 7:15am revealed a PCA found Resident #2 lying on the floor holding the front of her head. Review of the 03/23/20 hospital discharge supervision and Accountability monitoring sheets revealed there was documentation the resident was checked on every thirty-minutes from 03/01/20 through 03/31/20. Review of the exident #2/s March 2020 eMAR revealed there was doccumentation Resident #2/s	{D 270}	Continued From page	e 6	{D 270}			
	{D 270}	Telephone interview v at 4:23pm revealed: -In March 2020 (unak thought it was after th Resident #2 was mov station. -It was the facility's put the resident's vital sig -This should have be medical administration Review of Resident # 03/23/20 at 11:04am -Resident #2 was obs her bed. -The resident was ho -The resident was ho -The resident stated -A bump was observe -Resident #2 was ser evaluation. Review of Resident # dated 03/23/20 at 7:1 Resident #2 lying on her head. Review of the 03/23/2 summary report reve encounter was a fall. noted. Review of the facility' Supervision and Acce revealed there was d was checked on evel 03/01/20 through 03/	with the MCUC on 04/15/20 oble to recall exact date), but he second fall in March 2020 yed closer to the nurse's rotocol after a fall to monitor gns for 72 hours. en noted on the electronic in record (eMAR). 42's Progress Note dated revealed: served lying on the floor by Iding her head. she fell and hit her head. ed on the resident's head. ht to the hospital for an 42's Accident/Incident report 15 am revealed a PCA found the floor holding the front of 20 hospital discharge aled Resident #2's initial There were no injuries 's March 2020 Increased pountability monitoring sheets locumentation the resident ry thirty-minutes from '31/20.	{D 270}			
		revealed there was d	locumentation Resident #2's				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		СОМ	SURVEY PLETED
		HAL034093	B. WING		CORRECTION (X5) ION SHOULD BE COMPLE HE APPROPRIATE DATE	
AME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
DANBY H	DUSE		IRKE MILL ROAD			
			ON SALEM, NC 2710			
(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	COMPLET
{D 270}	Continued From page	97	{D 270}			
	on 03/23/20.					
	9:04am revealed: -When doing rounds a (after 7:00am) on 03/2 #2 on the floor. -Resident #2 was hold -She called the MA from and assist the resider -Staff got Resident #2 emergency responde -She usually worked to Resident #2 every thi -Resident #2 returned day.	om the third shift to come of. 2 off the floor and called rs. the first shift and checked rty-minutes. I from the hospital the same oeen given to supervise quently than every				
	the MCUC revealed: -After the fall on 03/23 being checked every -She had not conside -She had not consulte Provider (PCP) regark keep the resident from -After this fall the resident from -After the fall on 03/23 being checked every Review of Resident # 04/08/20 at 3:48pm resident	3/20 Resident #2 continued thirty-minutes. red increasing the checks. ed with the Primary Care ding other alternatives to n falling. dent was moved closer to 3/20 Resident #2 continued thirty-minutes.				

L3W712

If continuation sheet 8 of 19

STATEMENT	of Health Service Regu r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		HAL034093	B. WING			२ 16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		RKE MILL ROAD N SALEM, NC 271	02		
	CLIMMADY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page	9 8	{D 270}			
	actual date of the inci 11:34pm.	dent was 04/05/20 at				
		2's Accident/Incident report 34pm revealed Resident #2				
	Supervision and Accorrevealed there was de	s April 2020 Increased ountability monitoring sheets ocumentation Resident #2 hirty-minutes from 04/01/20				
	the MCUC revealed: -On 04/08/20 a PCA was found on the floor -The PCA reported the completed the incident because the incident was a weekend. -After the fall on 04/0 supervision of the res	e incident to her and she				
	nurse's station and the checks no other alter to prevent falls. -She had not conside supervision checks. -She had not consulte	irty-minute supervision natives had been considered				
	-She was aware the l three weeks ago for l -She thought hospice Resident #2's falls. -As of today's, date (picked up Resident #	e would be able to assist with 04/15/20), hospice had not 2 as a client. ered systems to put in place				

STATE FORM

	f Health Service Regu of DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY
			A. BUILDING:			
		HAL034093	B. WING		04	R / 16/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE		
DANBY HO	DUSE		RKE MILL ROAD	1500		
			N SALEM, NC 2710			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page	9 9	{D 270}			
	contracted Physical/C on 04/16/20 at 10:12a -Resident #2 was pic (PT) and Occupation 2020. -Resident #2 required to cognitive deficit. -The resident exhibited due to cognitive deficit. -Resident #2 had der supervision to ensure due to fall risk. -Due to the resident's unable to retain, reca -Resident #2 was dis 03/25/20 and OT on Telephone interview v 04/16/20 at 12:36pm -She was aware that falls. -Initially, she thought but due to the resident she could not retain a -Due to the resident's concerned the falls w frequently. -After the resident's f hospice in hopes the assist the facility with -She was not aware 04/05/20. -She had not conside facility regarding wha until hospice picked of	ked up for Physical Therapy al Therapy (OT) in February d maximum verbal cues due ed limited activity tolerance cit. mentia and required e safety with all ambulation a cognitive deficit she was all and verbalize progress. charged from PT on 03/30/20. with Resident #2's PCP on revealed: Resident #2 had frequent PT would help Resident #2 nt's diagnosis of dementia anything taught by PT. s dementia and age she was yould happen more fall on 03/23/20 she ordered y would provide systems to a the resident's falls. that Resident #2 had a fall on ered or consulted with the at measures to put in place up the resident.				
	Attempted telephone 1:19pm, 04/14/20 at alth Service Regulation	nterviews on 04/14/20 at 3:32pm, 04/15/20 at				

A. BOILDING:	STATEMEN"	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C			SURVEY PLETED
HAL034093 B. WNG				A. BUILDING:			
DAMARY HOUSE SUMMARY STATEMENT OF DEFICIENCY PERCENT PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST DE PRECEDED BY FULL (EACH DEPICENCY OR USC DERITIVING INFORMATION) PRETRX PRECENT CONCORRECTION (EACH DEPICENCY OR USC DERITIVING INFORMATION) PRETRX PRECENT CONCORRECTION (EACH DEPICENCY) (D 270) Continued From page 10 (D 270) (D 270) DEFICIENCY (11:34am, 04/16/20 at 10:15am, and 04/16/20 at 11:34am, 04/16/20 at 10:15am, and 04/16/20 at 11:34am, 04/16/20 at 00:15am, and 04/16/20 at 9:43am. PRETRX PRETRX 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: Diagnoses included dementia, hypothyroidism, insomma, allergic thrinits, and major depressive disorder. PREVIEW of Resident #1's current FL2 dated 04/03/20 revealed: Diagnoses included dementia, hypothyroidism, insomma, allergic thrinits, and major depressive disorder. Review of Resident #1's Care Plan dated 03/31/20 revealed: Resident #1 was constantly disoriented. Resident #1 was totally dependent on staff for ambulation and needed extensive assistance with ambulation. Review of Resident #1's Licensed Health Professional Support (LIPS) dated 04/03/20 revealed: Resident #1 required 2 staff to assist with transfers. Resident #1 required 2 staff to push her wheelchair. Image: Professional Support (LIPS) dated 04/03/20 revealed: Resident #1 required astaff to push her wheelcha			HAL034093	B. WING		04	R /16/2020
DAMEY HOUSE WINSTON SALEM, NC 27103 (24)10 PREPIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CERTICIENT WASTE BE REACED BY FULL REGULATORY OF LSC IDENTIFYING NETORMATION) ID PREVX PREFX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ATTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIDIENCY) (D 270) Continued From page 10 (D 270) (D 270) 11:54am, 04/16/20 at 10:15am, and 04/16/20 at 11:13am with Resident #2's family member was unsuccessful. (D 270) Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 04/16/20 at 9:43am. 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 was constantly disoriented. -Resident #1 was ano-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 was advays disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LIPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfers. -Resident #1 required 2 staff to assist with transfers. -Resident #1 required 2 staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her	IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WINSTON SALEM, NC 27103 PREVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULTORY OR LSC IDENTIFYING INFORMATION) PREVIEW PRETRX TAG PROVIDER'S FLAN OF CORRECTION (EACH ORDERTORY AND LD BE CROSS-REPRENCED TO THE APPROPRIATE DEFICIENCY) (D 270) Continued From page 10 (D 270) (D 270) 11:54am, 04/16/20 at 10:15am, and 04/16/20 at 11:13am with Resident #2's family member was unsuccessful. (D 270) Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 04/16/20 at 9:43am. Preview of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomma, allergic trinitis, and major depressive disorder. -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 was notally dependent on staff for ambulation. -Resident #1 was totally dependent on staff for ambulation. -Resident #1 was always disoriented, -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) datel 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfors. -Resident #1 required 2 staff to push her wheelchair. Review of Resident #1's licensed Health Professional Support (LHPS) datel 04/03/20 revealed: -Resident #1 required 2 staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her	ANRY H	OUSE	3150 BL	JRKE MILL ROAD			
IEBCH OURCH LSC IDENTIFYING INFORMATION) PREFX TAG IEBCH OURCH CATE AND RECEIDED BY FULL PREFX TAG IEBCH OURCH CATE AND RECEIDED BY FULL TAG IEBCH OURCH CATE AND RECEIDED BY FULL CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) (D 270) Continued From page 10 (D 270) (D 270) 11:54am, 04/16/20 at 10:15am, and 04/16/20 at 11:13am with Resident #2's family member was unsuccessful. (D 270) Image: Continued From Page 10 (D 270) 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insommia, allergic rhinitis, and major depressive disorder. . Review of Resident #1's Care Plan dated 03/12/20 revealed: -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/12/20 revealed: -Resident #1 was always disoriented, had significant memory loss, and had to be directed. . Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required staff to push her wheelchair. . Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational herapy (OT) to evaluate and treat due to instances of sliding out of her .		0001	WINSTO	ON SALEM, NC 271	03		
11:54am, 04/16/20 at 10:15am, and 04/16/20 at 11:13am with Resident #2's family member was unsuccessful. Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 04/16/20 at 9:43am. 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. -Resident #1 was constantly disoriented. -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 was totally dependent on staff for ambulation. -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to push her wheelchair. -Resident #1 required 2 staff to push her wheelchair. -Resident #1 required staff to push her wheelchair.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
11:13am with Resident #2's family member was unsuccessful. Refer to telephone interview with the Memory Care Unit Coordinator (MCUC) on 04/16/20 at 9:43am. 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. -Resident #1 was constantly disoriented. -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 had a wheelchair. -Resident #1 was totally dependent on staff for ambulation. -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to push her wheelchair. -Resident #1 required 2 staff to push her wheelchair. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her	{D 270}	Continued From page	e 10	{D 270}			
Care Unit Coordinator (MCUC) on 04/16/20 at 9:43am. 2. Review of Resident #1's current FL2 dated 04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. -Resident #1 was constantly disoriented. -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 had a wheelchair. -Resident #1 had a wheelchair. -Resident #1 was totally dependent on staff for ambulation and needed extensive assistance with ambulation. -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfers. -Resident #1 required staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her		11:13am with Resident #2's family member was					
04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. -Resident #1 was constantly disoriented. -Resident #1 was non-ambulatory. Review of Resident #1's Care Plan dated 03/31/20 revealed: -Resident #1 had a wheelchair. -Resident #1 had a wheelchair. -Resident #1 was totally dependent on staff for ambulation and needed extensive assistance with ambulation. -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfers. -Resident #1 required staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her		Care Unit Coordinato					
03/31/20 revealed: -Resident #1 had a wheelchair. -Resident #1 was totally dependent on staff for ambulation and needed extensive assistance with ambulation. -Resident #1 was always disoriented, had significant memory loss, and had to be directed. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfers. -Resident #1 required staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her		04/03/20 revealed: -Diagnoses included dementia, hypothyroidism, insomnia, allergic rhinitis, and major depressive disorder. -Resident #1 was constantly disoriented.					
Professional Support (LHPS) dated 04/03/20 revealed: -Resident #1 required 2 staff to assist with transfers. -Resident #1 required staff to push her wheelchair. Review of Resident #1's physician's orders dated 03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her		03/31/20 revealed: -Resident #1 had a w -Resident #1 was tota ambulation and need ambulation. -Resident #1 was alw	/heelchair. ally dependent on staff for led extensive assistance with vays disoriented, had				
03/17/20 revealed an order for physical therapy (PT)/occupational therapy (OT) to evaluate and treat due to instances of sliding out of her		Professional Support revealed: -Resident #1 required transfers. -Resident #1 required	t (LHPS) dated 04/03/20 d 2 staff to assist with				
		03/17/20 revealed ar (PT)/occupational the treat due to instance	n order for physical therapy erapy (OT) to evaluate and				
Review of Resident #1's physician's orders dated			#1's physician's orders dated				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	ST OCHAED HON	BEITH IOAHON NOMBER.	A. BUILDING:		COMPLETED	
		HAL034093	B. WING		04	R / 16/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
DANBY H		3150 BL	JRKE MILL ROAD			
DANDIII	0032	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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 11	{D 270}			
	03/17/20 revealed an PT/OT evaluation ord receiving hospice ser					
	Notes dated 03/06/20 -A medication aide (N room to administer m	1A) entered Resident #1's				
	back. -Resident #1 was trar medical services (EM evaluation. -There was no docum supervision to be prov	ned of pain in her neck and nsported by emergency S) to a local hospital for nentation of any increased vided to Resident #1 to				
	Resident #1 dated 03 -Resident #1 had an u room. -Resident #1 had no u -Resident #1 was fou front of her wheelchai -Resident #1 was tran via EMS.	unwitnessed event in her				
	supervision provided on 03/06/20. Review of Resident # Summary dated 03/00	en in the hospital emergency				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING		04	/16/2020
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		IRKE MILL ROAD	03		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	-	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COMPLETE
{D 270}	Continued From page	12	{D 270}			
	-On 03/06/20, Reside was attempting to get -The intervention was -Resident #1's behave intervention.	for Resident #1 revealed: nt #1's identified behavior				
	9:15am with the MA w	ote and Incident Accident				
	03/12/20 revealed: -Resident #1 slid out floor. -There was no docum	1's Progress Notes dated of her wheelchair onto the nentation of any increased to Resident #1 after her fall				
	Resident #1 dated 03 -Resident #1 had an u found on the floor in h -No injuries were note complain of pain. -Resident #1 was not room. -Resident #1's physic were notified.	unwitnessed event and was her bedroom. ed and Resident #1 did not sent out to the emergency ian and responsible party				
	supervision provided on 03/12/20.	nentation of any increased to Resident #1 after her fall				
	Review of a Mood/Be Communication form	havior Monitoring and for Resident #1 revealed:				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
						R
		HAL034093	B. WING		04	1/16/2020
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE		JRKE MILL ROAD DN 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
{D 270}	Continued From page	9 13	{D 270}			
	was attempting to get -The intervention was -Resident #1's behave intervention.	nt #1's identified behavior out of her chair/bed. direct staff interaction. for decreased after the ian and hospice provider				
	the MA who documer Note and the Incident 03/12/20 revealed: -She did not observe out of her chair on 03 -Resident #1 did not I was not sent out to a -Staff was having a pi sliding out of her whe her new wheelchair. -Resident #1 sat a litt wheelchair than she of slid out of her chair w feet to the floor. -The wheelchair leg r	have any noted injuries and local hospital. roblem with Resident #1 elchair after she received le higher in her new did in the old wheelchair and hen she tried to touch her ails were placed on the				
	(She did not state wh on the wheelchair.) -She thought Resider 30-minute checks afte -The memory care un	er her fall on 03/12/20. hit coordinator (MCUC) was nining when a resident was checks and how long				
	03/16/20 revealed: -Resident #1 slid out 03/16/20. -Resident #1 was add	1's Progress Notes dated of her wheelchair twice on ded to the increased for 30-minute checks due to				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL034093	B. WING		04	R / 16/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
DANBY H	OUSE	3150 BU	RKE MILL ROAD			
	0032	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 AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From page	e 14	{D 270}			
	her wheelchair and be the past week. -Thirty-minute checks shift on 03/16/20 and Review of the Inciden Resident #1 dated 03 -Resident #1 had an found in the hallway. -Resident #1 was obs sliding from her chair. -No injuries were note complain of pain. -Resident #1 was not room. -Resident #1's physic were notified. -There was no docum	at and Accident Report for 1/16/20 at 4:30pm revealed: unwitnessed event and was served on the floor after ed and Resident #1 did not sent out to the emergency tian and responsible party mentation of any increased to Resident #1 after her fall				
	Resident #1 dated 03 -Resident #1 had an iday room. -Resident #1 slid out floor. -There were no noted did not complain of pa -Resident #1 was not room. -Resident #1's physic were notified. -There was no docum	sent out to the emergency ian and responsible party nentation of any increased to Resident #1 after her fall				
	Review of a Mood/Be	havior Monitoring and for Resident #1 revealed:				

STATE FORM

L3W712

If continuation sheet 15 of 19

	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		HAL034093	B. WING		04	R / 16/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
		3150 BU	IRKE MILL ROAD			
DANBY H	DUSE		N SALEM, NC 271	03		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	THE APPROPRIATE	COMPLETE DATE
{D 270}	Continued From page	e 15	{D 270}			
	-There was one entry	on 03/16/20 at 4:00pm				
	•	esident #1's identified				
	behavior as wheeling					
		direct staff interaction.				
		ior decreased after the				
	intervention.					
	 -Resident #1's hospice provider was made aware. 					
	aware.					
	Telephone interview on 04/16/20 at 4:45pm with					
	the MA who completed the Resident Progress					
	Note and Incident Accident Reports dated					
	03/16/20 at 4:30pm and 03/16/20 at 6:50pm					
	revealed:					
	-She remembered Re	esident #1 sliding out of her				
	wheelchair twice on C					
	-Resident #1 did not I	have any injuries after either				
	fall.					
		16/20, staff made sure				
		ble, placed leg rests in				
	30-minute checks.	nd placed Resident #1 on				
	50-minute checks.					
	Review of the Increas	sed Supervision and				
		list for Resident #1 revealed:				
	-	ocumented supervision of				
		minutes from 7:00am until				
		o Incident Accident Reports				
	Resident #1's falls we	ere documented as taking				
		6:50pm on 03/16/20; The				
		d 03/16/20 documented the				
		n checklist would begin on				
	03/16/20 on second s					
		04/08/20, staff documented				
	7:00am until 6:30am.	ent #1 every 30 minutes from				
	Telephone interview	with Resident #1's hospice				
	nurse on 04/15/20 at					
		her regarding Resident #1's	1			

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
					D	
		HAL034093	B. WING		R 04/16/2020	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ANBY H	OUSE	3150 BU	RKE MILL ROAD			
		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 AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From page	e 16	{D 270}			
	falls.					
	1.0.800000000000	ident #1 on today, 04/15/20.				
		esident #1 was usually in				
	common areas where	•				
	-Resident #1 had rec	eived a new wheelchair				
	through hospice services.					
	-She thought the facility had ordered PT for					
	Resident #1 for trunc	al support.				
	Telephone interview	Telephone interview with Resident #1's				
	Responsible Party on 04/15/20 at 12:15pm					
	revealed:					
	-Staff contacted him when Resident #1 slid out of					
	her wheelchair.					
	-He did not know why of her wheelchair.	y Resident #1 was sliding out				
	사람이 그의 가격하는 것 때마다 지지 않는 것 같아야 한 것 같아? 아니	assistance with getting in				
	and out of her wheel	chair and her bed.				
		ed any injuries and he had				
	not observed any inju visits with Resident #	uries or bruising during his				
		through a window at the				
		nd "she looked good."				
		with the MCUC on 04/15/20				
	at 4:20pm revealed:					
	-Resident #1 slid out					
	03/06/20, 03/12/20, a	and she had 2 falls on				
		II on 03/06/20, Resident #1				
		om close to the nurse's				
	station.					
	-After Resident #1 fe	ll on 03/12/20, Resident #1				
		ner old room to see if her falls				
		ause staff thought she may				
		d about being in a new room.				
		II on 03/12/20, staff checked				
		utes and laid her down				
	between meals.					
	alth Service Regulation	red a new wheelchair on				

	of Health Service Regu r of DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL034093	B. WING			R
	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE			/16/2020
NAME OF PI	ROVIDER OR SUPPLIER		RKE MILL ROAD	, ZIF CODE		
DANBY H	OUSE		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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From page	e 17	{D 270}			
	the ground in a seate #1 to attempt to stand -She thought Resider supposed to get Resi but she thought they -There was an order	nt #1's hospice provider was dent #1 a new wheelchair,				
	physician on 04/16/20 -She knew Resident a -She expected staff to determine what cause residents out to the lo head. -Resident #1's wheel to her increase in falls health.	ocal hospital if they hit their chair could have contributed s along with a decline in staff could provide 30 or				
	Refer to telephone in 04/16/20 at 9:43am.	terview with the MCUC on				
	at 9:43am revealed: -When a resident had 30-minute checks for -If a resident continue resident's 30-minute another month. -She had never incre checks for residents 15-minutes. -Before initiating or ir checks, she consulte director to determine	ed to have falls, the				

	OF DEFICIENCIES OF CORRECTION	Ation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034093	B. WING		04	R I/16/2020
AME OF PI	ROVIDER OR SUPPLIER	STREET	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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 18	{D 270}			
	on 30-minute checks.					

STATE FORM

	Petty Cash Receipt Sheet	
Date		
Staff Receiving Money	Signature	
Amount Given	Change	
Department		
	Attach Receipt	
	Petty Cash Receipt Sheet	
Date	· ·	
Staff Receiving Money	Signature	
Amount Given	Change	
Department	Item Purchased	

Attach Receipt