STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on June 23, 2021 through June 25, 2021 and June 28, 2021 with a telephone exit on June 29, 2021.	D 000		
D 066	10A NCAC 13F .0305(h)(3) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (3) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys; and This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure all exit door locks were easily operable by a single hand motion from inside of the facility at all times without keys related to 2 of 2 exit doors on the C Hall which would not allow residents to exit the facility in the event of an emergency. The findings are: Observation of the long hall (C Hall) on the left side of the facility on 06/23/21 at 3:24pm revealed: -There was a set of magnetic operated fire doors at the beginning of the C Hall extension. -There were 10 resident rooms (#29, #30, #31, #32, #33, #34, #35, #36, #37, and #38) occupied by residents located past the fire doors and within the space for the EXIT door. -There was one exit door at the end of the hall marked with a red EXIT sign which exited outside to the back of the facility.	D 066		

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D 066	Continued From page 1	D 066		

-There was one exit door located toward the front of C Hall about 10 feet outside the magnetic operated fire doors, which exited toward the back of the facility and marked with a red EXIT sign.
-Both doors had a single lever type door latch for opening the door.
-The doors would not release when the handles were rotated downward or upward because the handles rotated freely when depressed or raised.
-Both lever type door latches were broken in the closed position.
-Both doors had magnetic locking mechanisms located at the top of the doors.
-Both magnetic locking mechanisms were designed to hold the door shut when activated but released when a entry/exit keypad was activated or the override switch was engaged.
-The magnetic release mechanism activation did not allow for the door to be opened from the outside or inside because the single lever type door latch was broken in the closed position.

Review of the facility's fire evacuation diagram revealed resident rooms #29, #30, #31, #32, #33, #34, #35, #36, #37, and #38 were located on the C Hall and should be evacuated out of the exit door at the end of the hall that had a broken handle mechanism or the exit door at the beginning of C Hall which had a broken handle mechanism.

Review of the facility's Annual Fire Inspection report dated 12/09/20 revealed the facility had no violations found.

Interview with the Administrator on 06/23/21 at 3:35pm revealed:
-She did not know the 2 exit doors closest to the C Hall could not be opened by the door handles.
-The facility had experienced a forcible entry into

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 066	Continued From page 2	D 066		

the tool shed out back of the building a few weeks ago.
-He did not check the 2 exit doors closest to the C Hall after the storage building forcible entry.
-Staff or residents did not routinely use the doors for exiting or entering the building.
-The facility conducted a fire drill in May 2021 (no documentation provided) and no staff reported problems with the exit doors.

Interview with the Maintenance Director (MD) on 06/23/21 at 4:15pm revealed:
-He did not know the exit doors at both ends of C Hall had door handles that would not open the door from the inside or the outside until brought to his attention by the surveyor today (06/23/21).
-The facility had a breaking in the shed out back and perhaps entry into the building was attempted at the same time.
-The handles to the door were compromised to the extent that the door lever would not release the internal latches.
-He had to take the door handles completely out of the door to free up the doors for opening and closing.

Telephone interview a representative with the local Fire Department on 06/24/21 at 1:57pm revealed:
-The facility had been inspected in November 2020 and December 2020.
-There was no documentation the facility had notified the fire department that there was problems with the exits to the building.
-The fire department should be notified when fire safety was compromised like non-functioning fire alarm systems or any building issues that would increase danger to the residents.

Interview with the MD on 06/24/21 at 3:00pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 066	Continued From page 3 revealed: -He wanted to take trash out the side door and could not get out of the exit door located toward the front of C Hall about 10 feet outside the magnetic operated fire doors on 06/15/21. -He used the kitchen exit to take kitchen trash to the dumpster out back. -He assumed the door could be open with the key from the outside but he had not tried to open the door from the outside prior to 06/23/21. -Residents used the front exit doors (there was one close to the front of C Hall) to come into and go out of the building. -Staff had not reported the exit doors were not working. -He had not considered how residents would exit the building in the event of a fire toward the front of the C Hall. Interview with a personal care aide (PCA) on 06/24/21 at 3:10pm revealed: -She did not know if the exit doors on C Hall were working correctly. -She did not use either door to enter or exit the building. -She did not have reason to check the exit doors. Interview with a housekeeper on 06/25/21 at 1:15pm revealed: -He noticed about one week ago that he could not get out of the exit door at the front of the C Hall because the handle would not open the door. -He could not remember if he had tried the exit door before then. -He used the exit door at the back of the kitchen to take trash to the dumpster out back _____ The facility failed to assure that all doors were easily operable from the inside related to nonfunctioning door handles on 2 exit doors from	D 066		

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 066	Continued From page 4 the C Hall which would prevent the residents who resided on the C Hall from evacuating in the event of a fire. This failure was detrimental to the safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 06/23/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 066		
D 089	10A NCAC 13F .0306(b)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure a double chest of drawers was available for use in the bedroom for 1 of 1 resident room (#1). The findings are: Observation during the facility tour on 06/23/21 at 9:15am revealed: -Resident room #1 had two beds for residents.	D 089		

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 089	Continued From page 5	D 089		

-There was one chest of drawers facing the back wall of the room.
-There was no second chest of drawers.

Interview with one of the residents residing in room #1 06/23/21 at 9:20am revealed:
-There was only one chest of drawers in room #1.
-He had shared the chest of drawers with a former roommate and the bottom 2 drawers was used for his storage space.
-When the current roommate moved in the room (not sure how many weeks ago), the new roommate turned the dresser toward the back of the room and took all the drawers as his (roommate's).
-He currently did not have a chest of drawers for his clothes.
-He had not reported his lack of a dresser or drawer space to the facility staff.
-He did not have many clothes to put in a dresser but would like to have at least a couple of drawers for his belongings.
-He stored his clothes in the bottom of his closet in a container.

Interview with the Resident Care Coordinator on 06/25/21 at 4:00pm revealed:
-She did not know room #1 did not have a chest of drawers for one of the residents.
-She thought the residents shared a chest of drawers.
-No one checked the rooms to see if required furniture was missing.
-The Administrator ordered any furniture needed by the facility.
-The Administrator instructed maintenance staff where to add new furniture.

Attempted interview with the Administrator on 06/25/21 at 12:00pm and 4:00pm was

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 089	Continued From page 6 unsuccessful.	D 089		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Type B Violation Based on observations and interviews the facility failed to ensure hot water temperatures at 4 of 8 sink fixtures and 1 shower fixture accessible to residents (sink and shower in room 32, sinks in rooms 34, 31, and 29) were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. The findings are: Observations during the initial tour of the facility on 06/23/21 between 11:32am and 11:42am revealed: -At 11:32am, the hot water temperature at the bathroom sink in resident room 32 was 136 degrees F: the hot water temperature at the shower was 126 degrees F. -At 11:38am, the hot water temperature at the bathroom sink in resident room 34 was 136 degrees F.	D 113		

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 113	Continued From page 7 -At 11:41am, the hot water temperature at the bathroom sink in resident room 29 was 138 degrees F. -At 11:42am, the hot water temperature at the bathroom sink in resident room 31 was 134 degrees F. Interview with the resident residing in room 32 on 06/23/21 at 11:35am revealed: -The resident had not burned herself with the hot water. -The resident knew how to adjust the running water by using the faucet. -The resident would turn the cold water on then adjust to the hot water. -The resident did not use the shower in her room. Interview with the resident residing in room 34 on 06/23/21 at 11:39am revealed: -The resident had not burned himself with the hot water. -The resident knew how to adjust the running water by using the faucet. Interview with the resident residing in room 31 on 06/23/21 at 11:42 revealed: -The resident had not burned himself with the hot water. -The resident knew how to adjust the running water by using the faucet. Observation with the maintenance staff on 06/23/20 at 11:45am revealed: -The surveyor checked the water temperature at the bathroom sink in resident room 29 with a reading of 138 degrees F. -The maintenance staff checked the water temperature with the thermometer he used to check water temperatures in the same sink got a reading of 128 degrees F.	D 113		

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 113	Continued From page 8 At 11:50am, the Administrator and Maintenance Director were notified that signs should be posted at the sink and bathroom fixtures for room with hot water temperatures above 116 degrees F alerting residents that the hot water temperature was very hot and to seek staff assistance when using the hot water. A calibration of the surveyor's and facility Maintenance Director's (MD) thermometers was conducted using an icewater slurry on 06/23/21 at 12:13am with results as follows: -The surveyor's thermometer read 32 degrees F. -The MD's thermometer read 34 degrees F. Interview with the Maintenance Director (MD) on 06/23/21 at 12:00pm revealed: -The facility had hot water heaters and valves used to control hot water and cold water mixing (mixing valve) replaced for 2 sections of the facility one month ago. -The hot water heater and mixing valve used for the resident rooms 29, 31, 32, and 34 was not replaced. Interview with the Administrator on 06/23/21 at 12:03pm revealed: -She was not aware the hot water temperatures were elevated above 116 degrees F at one end of the facility. -The facility had contracted repairs for the water heaters, some water lines, and valves recently. -The recent repairs completed did not include the end of the facility with the elevated water temperatures. -The MD would adjust the hot water temperatures to be below 116 degrees F, or call the contracted repairman if the hot water temperatures could not be adjusted to the required limits.	D 113		

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 113	Continued From page 9 -The Administrator would post signs to alert residents of elevated hot water temperatures and notify the surveyors when a recheck could be done. Observation of rooms 29 and 32 0n 06/23/221 at 1:40pm revealed signs alerting residents of elevated hot water signs were posted on the mirrors above the sink fixtures. Second interview with the MD on 06/23/21 at 1:50pm revealed: -He adjusted the hot water temperature down on the water heater. -He was in the process of flowing hot water from the hot water heater to lower the water temperature. -When hot water temperatures were stable under 116 degrees F, the MD would request a recheck of the hot water temperatures. Interview with a medication aide (MA) on 06/23/21 at 2:50pm revealed: -Resident had not notified her that the hot water was too hot. -Personal care aide (PCA) staff had not informed her the hot water was too hot. -She would be responsible to notify the MD if staff or residents reported water too hot. -The MD would be responsible to monitor hot water temperatures. Interviews with 2 PCAs on 06/23/21 at 2:50pm revealed: -They were not aware the hot water temperature in rooms 29, 31, 32, and 34 were above 116 degrees F. -Residents had not complained of the hot water being too hot. -Residents had not reported that they had been	D 113		

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 113	Continued From page 10 burned by the hot water. Third interview with the MD on 06/23/21 at 3:15pm revealed: -The facility depended on the plumbing company contracted for repairs one month ago to set the hot water temperatures to the correct setting for compliance. -He was not sure of the exact temperature range for compliance with rules and regulations because he had not read the hot water temperature requirements section in the Adult Care Home rules and regulations. -He randomly checked hot water temperatures throughout the facility but had not been routinely documenting on water temperature logs. Recheck of the hot water temperatures in residents' bathroom on 06/23/21 from 3:15pm to 3:22pm revealed: -At 3:15pm, the hot water temperature at the bathroom sink in resident room 32 was 114 degrees F. -At 3:18pm, the hot water temperature at the bathroom sink in resident room 34 was 112 degrees F. -At 3:20pm, the hot water temperature at the bathroom sink in resident room 29 was 114 degrees F. -At 3:22pm, the hot water temperature at the bathroom sink in resident room 31 was 114 degrees F. Recheck of the hot water temperatures in residents' bathroom on 06/23/21 from 4:58pm to 5:02pm revealed: -At 4:58pm the hot water temperature at the bathroom sink in resident room 29 was 114 degrees F. -At 5:02pm the hot water temperature at the	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 113	Continued From page 11 bathroom sink in resident room 32 was 114 degrees F. -At 5:00pm the hot water temperature at the bathroom sink in resident room 34 was 112 degrees F. _____ The facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees F at 4 of 8 sink fixtures and 1 shower fixture resulting in hot water temperatures between 134 degrees F and 138 degrees F. This failure placed the residents at a potential risk for skin burns, which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/23/21 for this Violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 13, 2021.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 269	Continued From page 12	D 269		

reviews the facility failed to ensure personal care was provided to 1 of 1 sampled residents (#4), who was non-ambulatory, required a call bell to notify staff of her needs, and required staff assistance for turning and repositioning,

The findings are:

Review of Resident #4's FL2 dated 04/06/21 revealed:
-Diagnoses included dementia with altered mental status, hypertension, coronary artery disease, congestive heart failure, diet-controlled diabetes, hyperlipidemia.
-The resident was non-ambulatory.
-The resident was intermittently disoriented.
-The resident was incontinent of bowel and bladder.

Review of Resident #4's care plan dated 04/05/21 revealed:
-The resident required total assistance with toileting, ambulation/locomotion, bathing, dressing and transferring.
-The resident required turning and repositioning in bed.
-The resident had pressure ulcers to her buttocks.
-The resident was sometimes disoriented.

Observation of Resident #4 on 06/25/21 at 4:00pm revealed:
-Resident #4 was lying partially on her back, head of bed elevated approximately 30 degrees, with eyes opened.
-Resident #4 was receiving care from a hospice Certified Nursing Assistant.
-The resident's brief was saturated with urine.
-The cloth pad on top of the sheet, underneath the resident, was saturated with urine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 269	Continued From page 13	D 269		

-There was white, dried ointment observed of her buttocks.
-Resident #4 had one stage II pressure ulcer on each buttock.

Review of Resident #4's Licensed Health Professional Support (LHPS) assessment dated 04/06/21 revealed:
-The resident required the assistance of staff to transfer to her wheelchair.
-The resident's care was managed by hospice.

Observation of Resident #4's room on 06/24/21 at 3:30pm revealed:
-There was no call bell system in the resident's room.
-There was no bedside bell, handbell or signaling device in the resident's room.

Observation of Resident #4 on 06/25/21 at 8:34am revealed the resident was lying partially on her right side, head of bed elevated approximately 45 degrees, with eyes closed

Observation of Resident #4 on 06/25/21 at 9:10am revealed:
-The resident was lying partially on her right side, head of bed elevated approximately 45 degrees, with eyes closed.
-The PCA was at the bedside offering juice to the resident.

Observation of Resident #4 on 06/25/21 at 9:51am revealed:
-The resident was lying partially on her right side, head of bed elevated approximately 45 degrees, with eyes closed
-The MA was administering morning medications.

Observation of Resident #4 on 06/25/21 at 11:07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(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 269	Continued From page 14 revealed the resident was lying partially on her right side, head of bed elevated approximately 45 degrees, with eyes closed. Observation of Resident #4 on 06/25/21 at 12:37pm revealed the resident was lying partially on her right side, head of bed elevated approximately 45 degrees, with eyes closed. Observation of Resident #4 on 06/25/21 at 3:15pm revealed the resident was lying partially on her right side, head of bed elevated approximately 45 degrees, with eyes closed. Interviews with Resident #4 on 06/25/21 at 8:34am and 4:05pm revealed: -She could not get out of bed unassisted. -She had to "holler" if she needed something. -The staff would eventually come but at times, she would have to wait. -She could not grasp the siderail with her left hand in attempt to pull herself to her right side. -The staff would come by occasionally but mostly when she called. -She received a bath twice a week from the hospice staff. -The facility staff usually provide incontinent care at mealtimes. -The resident could not remember if incontinent care had been provided today (06/25/21). Interviews with a Personal Care Aide (PCA) on 06/25/21 at 8:39am and 10:09am revealed: -Resident #4 did not have a call bell. -Resident #4 "would holler" if she needed something. -The other residents would hear Resident #4 holler at times and told the staff. -Resident #4 would have to wait until staff made rounds if she needed something.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(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 269	Continued From page 15	D 269		

-The staff would check on Resident #4 every hour.
-Resident #4 was bathed by the hospice staff twice a week.
-Resident #4 had not been out of bed in about one week.

Interview with another PCA on 06/25/21 at 8:45am revealed:
-She knew that Resident #4 did not have a call bell.
-The staff checked on Resident #4 every 15 minutes.
-Resident #4 could not transfer unassisted and was unable to ambulate.
-Resident #4 was bathed by hospice staff twice a week.
-The facility staff was told by the hospice staff that Resident #4 was to stay in bed.
-Resident #4 would let the staff know what she needed when the staff checked on her.

Interview with a third PCA on 06/25/21 at 8:51am revealed:
-The staff checked on Resident #4 every hour.
-She knew the Resident #4 did not have a call bell.

Interview with a Medication Aide (MA) on 06/25/21 at 9:10am revealed:
-Residents were checked on every hour.
-Resident #4 could not get out of bed by herself.
-Resident #4 did not have a call bell.

Interview with another MA on 06/25/21 at 9:25am revealed:
-Resident #4 could not transfer out of bed by herself.
-Resident #4 needed assistance turning and repositioning.

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 269	Continued From page 16 -Resident #4 was checked on every hour. -Resident #4 was transferred to wheelchair three times a week. Interview with Resident Care Coordinator (RCC) on 06/25/21 at 10:27am revealed: -There was no call bell system in the facility. -Resident #4 was checked on every hour. -The staff walked the halls in between hourly checks. -Resident #4 was the only resident that could not get out of bed unassisted. Interview with Administrator on 06/25/21 at 11:16am revealed: -The facility was not required to have a call bell system. -The staff was "good" about checking on the residents. -She knew that Resident #4 could not get out of bed unassisted. -She did not know how Resident #4 would call the staff. Telephone interview with the hospice Triage Nurse on 06/25/21 at 12:58pm revealed the facility staff was educated by the hospice nurse to turn and reposition Resident #4 every two hours. Attempted telephone interviews with Resident #4's Nurse Practitioner on 06/24/21 at 12:30pm, 06/25/21 at 12:58pm, and 06/28/21 at 10:45am were unsuccessful.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 273	Continued From page 17 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mental health provider (MHP) was notified for 1 of 1 sampled residents (Resident #2) related to a referral for repeatedly removing his catheter bags, and refusing catheter care. The findings are: Review of Resident #2's current FL2 dated 09/04/20 revealed diagnoses included peripheral vascular disease, diabetes mellitus Type II, and bipolar disorder. Review of Resident #2's facility Charting Notes revealed: -On 05/19/21 at 6:44am, a personal care aide (PCA) noticed Resident #2 pulled his catheter out of the leg bag. The resident allowed staff to change the bedding and clothes and reattached catheter to the leg bag. -On 05/20/21 at 6:51am, Resident #2 pulled the catheter out of the leg bag. Resident #2 became confrontational and extremely agitated when staff attempted to provide catheter care and reattach the catheter to the leg bag. Staff attempted to provide care to the resident 5 times before eventually getting the resident cleaned up. Review of Resident #2's hospital discharge summary dated 06/02/21 revealed: -Resident #2 had a chronic indwelling catheter, and multiple recurrent urinary tract infections (UTI). -Resident #2 was discharged from a local hospital after a 9 day stay from 05/06/21 to 05/14/21 for UTI. -Resident #2 was admitted back into the hospital	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 273	Continued From page 18 on 05/20/21 for a complicated UTI. Review of Resident #2's current Licensed Health Professional Services (LHPS) evaluation dated 04/06/21 revealed position, empty, and clean around urinary catheter and leg bag was listed as a task. Review of Resident #2's home health nursing notes revealed: -On 06/18/21 (no time was documented) Resident #2 was seen by the home health nurse for routine catheter care and found with catheter tubing disconnected from leg bag with urine leaking. -On 06/25/21 (no time was documented) Resident #2 was seen by the home health nurse and had 800ml of urine in leg bag and the urine bag was not secured to his leg. Suprapubic catheter site had moderate amount of bleeding. Catheter was flushed with blood return (Blood return after flushing a catheter can indicate clotting or the necessity to clean the entire catheter system to reduce risk of blood clotting and infection). Home Health notified primary care provider (PCP) and Urology clinic notified. Review of Resident #2's mental health provider (MHP) Progress Notes revealed: -On 03/26/21, Resident #2 remained at baseline "with psych (mental status)". "No concerns per staff" and "No changes recommended". -On 06/04/21, " staff deny psych concerns" for Resident #2. "No changes recommended". Interview with Resident #2's Primary Care Provider's Nurse Practitioner (NP) on 06/24/21 at 11:00am revealed: -She was familiar with Resident #2 having multiple hospitalizations due to recurrent UTIs.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 273	Continued From page 19	D 273		

-Resident #2 was non-compliant with care for his catheter.
-Resident #2 had pulled out indwelling catheters on several occasions and detached leg urine collection bags on several other occasions.
-Resident #2 had a supra-pubic catheter placed in early June 2021.
-He picked at the catheter placement site.
-She monitored Resident #2 for signs of UTI through the facility staff information and the local home health nursing notes.
-She had spoken with Resident #2 regarding the importance of catheter care.
-She thought Resident #2's pulling out catheters, disconnecting the leg drainage bags, and yelling at staff was a behavioral issue.
-Staff should notify the mental health provider of behaviors.

Telephone interview with Resident #2's MHP on 06/24/21 at 10:15am revealed:
-She saw Resident #2 routinely every 4 weeks, unless the resident was out of the facility.
-She discontinued any as needed medication for inappropriate behaviors for not being administered many months ago.
-She did not have access to the facility Charting Notes when she came to the facility.
-She asked staff if there were any changes in behaviors for Resident #2.
-She would expect the facility staff to let her know on site or through the MHP paging system or when she visited the facility if a resident was exhibiting inappropriate behaviors.
-She considered care for the catheter to be the responsibility of the primary care provider NP.
-Inappropriate behaviors like not allowing catheter care could be a mental health issue.
-There was no documentation the MHP had been contacted by the facility regarding Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 273	Continued From page 20 disconnecting the catheter from its leg bag or provide catheter care. Interview with a medication aide (MA) on 06/25/21 at 4:05pm revealed: -She knew Resident #2 refused to allow staff to provide personal care, like cleaning his bed when he spilled urine from his leg bag, and changing his clothes after a urine spill. -He sometimes became upset toward staff and other residents and would pull at his catheter, or disconnect his leg bag. -She did not notify the MHP for pulling the catheter drainage tube from the leg bag or refusing catheter care. Interview with a personal care aide (PCA) on 06/25/21 at 5:00pm revealed: -She knew Resident #2 sometimes did not allow staff to provide personal care for his leaking urinary leg bag, change his bed occasionally, and disconnected his catheter from the leg bag. -Resident #2 made comments regarding staff "looking good" but she did not take the comments seriously, he was just being himself. -She did not need to report Resident #2's refusing catheter care to her supervisors because the supervisors had seen the behaviors. -The supervisors would be responsible to notify the MHP of behaviors.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 338	Continued From page 21 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed ensure residents were treated with respect and dignity related to the Administrator withholding the personal effects and belongings due to an outstanding bill of one resident (Resident #3) after she had been discharged to a higher level of care. The findings are: 1. Review of Resident #3's current FL2 dated 03/17/21 revealed diagnoses included diabetes mellitus type 2, hypothyroidism, anxiety, osteoporosis, and Parkinson's disease. Review of Resident #3's Resident Register revealed: -Resident #3 was admitted to the facility on 03/01/18. -Discharge/Transfer Information on page 4 of the Resident Register was blank. Observations of Resident #3's room on 06/24/21 at 9:18am revealed: -The residents clothing had been bagged up in 2 large clear plastic bags and sat inside the closet. -There was a walker, pictures and a Bible remaining in Resident #3's room. Interview with Resident #3 on 06/24/21 at 4:55pm revealed: -She was admitted to the hospital from the facility due to having some falls in March 2021. -While at the hospital it was determined she would need to go to a higher level of care for rehabilitation.	D 338		

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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 338	Continued From page 22 -While at rehabilitation facility, she decided not to return to the facility because she required more care. -She requested her clothing and personal items which included pictures of family member, a family Bible, an urn (which held a family members ashes), a walker, and some toiletries within 2 weeks after going to rehabilitation. -The Administrator told her that she could not have her personal belongings because she owed a bill at the facility and she would "have to speak with her lawyer prior to giving her the belongings. -She had to borrow clothing from rehabilitation facility, which included a bra, underwear, shirts, pants, and night cloths because the Administrator at the facility would not let her get her belongings. -She was upset and embarrassed that she had to borrow other resident's clothing from the rehabilitation facility. -She had increased anxiety due to the embarrassment, not being able to see her family members picture, or read in her family Bible. Interview with the social worker (SW) for rehabilitation facility on 06/24/21 at 11:05am revealed: -Resident #3 had to borrow all clothing because the facility would not release her clothing or belongings. -Resident #3 was embarrassed about having to borrow and wear clothing that did not belong to her. -The SW spoke with the Administrator in early April (could not recall exact date) to inform her the resident would not be returning to the facility. -She requested to pick up Resident #3's belongings, but the Administrator would not schedule a time for pick up her belongings. -The Administrator told her, Resident #3 could not have her belongings until the she spoke with her	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 338	Continued From page 23	D 338		

lawyer because the resident owed a bill.
-She requested the bill be sent to rehabilitation facility so they could pay it.
-She had contacted the facility in April 2021 and in May 2021 to obtain Resident #3's personal belongings.

Interview with Resident #3's family member on 06/24/21 at 8:19am revealed:
-Resident #3 was transferred to the hospital in March 2021 from the assisted living (AL) facility.
-Resident #3 was admitted to the rehabilitation facility after being discharged from the hospital.
-Resident #3 decided she did not want to return to the AL facility because she needed a higher level of care.
-The Administrator at the AL facility told her she could not talk to her regarding Resident #3 because she was not her guardian and she would need permission from the resident.
-The Administrator also told her, Resident #3 owed a bill and could not have her belongings until the administrator spoke with her lawyer.
-Resident #3 was having increased anxiety due to borrowing all her clothing from the rehabilitation facility because the Administrator refused to give Resident #3 her belongings.

Interview with the Administrator on 06/24/21 at 8:57am revealed:
-Resident #3 went to the hospital due to a change in mental status about 2 weeks ago.
-Resident #3's personal belongings which included clothing, pictures, a family Bible, and a walker were still in her old room.
-She was told Resident #3 would not be returning about 2 weeks ago.
-Resident #3 did not give her a written notice before moving out.
-She held Resident #3's bed so that she would

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	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 338	Continued From page 24 have somewhere to go after discharge from the hospital. -The rehabilitation facility requested an invoice of the final bill for Resident #3. -She sent the rehabilitation facility an invoice for March 2021 last week but did not recall what day it was sent. -The rehabilitation facility said they would come to the facility to pick up her clothing and personal items but never did. -A family member of Resident #3 had called and asked, what about the resident's belongings and she responded with "what about her bill". -She did not violate any resident rights. Interview with a SW with the local department of social services on 06/28/21 at 9:56am revealed: -She had received a complaint that the Administrator would not release Resident #3's personal belongings because she owed a bill. -She had spoken with the Administrator on 06/18/21 and advised her to release Resident #3's personal belongings. -The Administrator told her she was waiting on her attorney. Second interview with the SW for rehabilitation facility on 06/24/21 at 5:06pm revealed the AL facility had delivered Resident #3's clothing and personal items including a family members picture, her family Bible, and her walker. The facility failed to ensure 1 of 1 sampled residents (#3) was allowed to have her clothing, personal items, and toiletries after being transferred to a rehabilitation facility resulting in the resident having increased anxiety and embarrassment due to having to borrow and wear clothes that did not belong to her, and not being able to see photos of her family member, whom	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 338	Continued From page 25 had passed away, and not having access to her Bible. This failure was detrimental to the welfare of the resident which constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/25/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 13, 2021.	D 338		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 482	Continued From page 26 emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, of 1 of 1 sampled resident (Resident #4), the facility failed to ensure physical restraints were used only after an assessment, care and team planning, and use of alternatives were tried and documented who had half bed rail on the right side of her bed. The findings are: Review of Resident #4's FL2 dated 04/06/21 revealed: -Diagnoses of dementia with altered mental status, hypertension, coronary artery disease, congestive heart failure, diet-controlled diabetes, hyperlipidemia.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

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D 482	Continued From page 27	D 482		

-The resident was non-ambulatory.
-The resident was intermittently disoriented.
-The resident was incontinent of bowel and bladder.
-The resident's skin was intact.
-There was no order for a half bed rail.

Review of Resident #4's Physician Orders dated 12/30/21 revealed the resident had entered Hospice Care.

Review of Resident #4's Care Plan signed and dated by Resident Care Coordinator (RCC) on 04/05/21 and Hospice Nurse Practitioner (NP) on 04/06/21 revealed:
-The resident was total care with toileting, ambulation, locomotion, bathing, dressing, grooming, personal hygiene and transfers.
-The resident was limited assistance with feeding.

Review of Resident #4's Licensed Health Professional Support (LHPS) assessment dated 04/06/21 revealed:
-Resident #4 was a transfer assist to wheelchair.
-There was no documentation of a rail for assist to turn or as a restraint.

Review of Resident #4's incident and accident report on 06/24/21 revealed:
-The incident occurred on 05/01/21 at 6:00am.
-The third shift Medication Aide (MA) completed the report.
-The third shift Personal Care Assistant (PCA) told MA that the resident had fallen out of the bed while dreaming.
-The bed rail was broken.
-The resident was not transported to the hospital.
-There were no vital signs documented.
-The RCC was made aware on 05/01/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(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 482	Continued From page 28 Interview with MA on 06/25/21 at 9:15am revealed: -The MA completed the incident and accident report for Resident #4 on 05/01/21 at 6:00am. -The MA doesn't believe Resident #4 fell out of bed. -The MA found Resident #4 lying on bed after receiving report from PCA. -The PCA who reported the fall was no longer employed with facility. -The staff checked on residents every hour. -The staff checked on residents every 15 minutes for 24 hours after a fall and document findings. -The MA would assess the resident after a fall, including vital signs. -The MA would notify the administrative staff of any incident or accident. -The administrative staff would notify the Patient's Care Provider (PCP). Review of Resident #4's record on 06/25/21 revealed: -The resident had an order dated 06/25/21 for hospital bed with rails to help with turning and repositioning in bed. -The rails were not to be used as a restraint. Observation of Resident #4, her room and her bed on 06/25/21 at 4:05pm revealed: -The bed had a rail on the right, upper side of the bed, that was up. -The left side of the bed was pushed up against the wall, with no rail. -There was a rail propped up against the wall across from the resident's bed that was exactly like the rail on her bed. -The resident could not grasp rail with her left hand in attempt to pull herself on her right side. -The resident could not release rail in order to lower rail.	D 482		

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D 482	Continued From page 29 Interview with PCA on 06/25/21 at 8:39am revealed: -The PCA has never seen Resident #4 use the side rail to turn. -The staff would check on Resident #4 every hour. Interview with another PCA on 06/25/21 at 8:45am revealed: -Resident #4 cannot let the side rail up or down. -The PCA has never seen Resident #4 use the side rail to turn and reposition in bed. -The side rail is there to prevent Resident #4 from falling out of bed. -The Staff check on her every 15 minutes. Interview with a third PCA on 06/25/21 at 8:51am revealed: -The staff would check on Resident #4 every hour. -Resident #4 could not let the side rail down. -Resident #4 would hold on to rail when staff was turning her. Interviews with MA on 06/25/21 at 9:10am and 9:15am revealed: -The residents were checked on every hour. -Resident #4 could not get out of bed unassisted. -Resident #4 could not manage the siderail. -The MA completed an incident and accident report for Resident #4 on 05/01/21 at 6:00am. -The MA doesn't believe Resident #4 fell out of bed. -The MA found Resident lying on bed after receiving report from PCA. -The MA found the rail broken. -The PCA who reported the fall was no longer employed with facility. -The staff checked on residents every hour.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 482	Continued From page 30	D 482		

-The staff checked on residents every 15 minutes for 24 hours after a fall.
-The MA would assess the resident after a fall, including vital signs.
-The MA would notify the administrative staff of any incident or accident.
-The administrative staff would notify the Patient's Care Provider (PCP).

Telephone interview with Hospice Triage Nurse on 06/25/21 at 12:58pm revealed:
-The resident received the hospital bed with rails on 12/31/20.
-The nurse from hospice visits weekly and the Certified Nursing Assistant (CNA) visits twice a week.
-The nursing note from 05/18/21 indicated that the rail was broken and a new rail was ordered.

Telephone interview with Director of Hospice on 06/28/21 at 12:46pm revealed:
-She did not know why the hospital bed with rails were ordered for Resident #4.
-The rails come with all hospital beds as standard equipment.

Telephone interview with Administrator of facility on 06/29/21 at 12:12pm revealed:
-Resident #4 could let rail up and down.
-She had never seen Resident #4 let the rail up or down.
-She would not get entangled in rail because it was a half rail.

Attempted telephone interviews with Resident #4's Nurse Practitioner on 06/24/21 at 12:30pm, 06/25/21 at 12:58pm, and 06/28/21 at 10:45am were unsuccessful.

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D912	Continued From page 31	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to residents' rights, physical environment, and building service equipment. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure all exit door locks were easily operable by a single hand motion from inside of the facility at all times without keys related to 2 of 2 exit doors on the C Hall which would not allow residents to exit the facility in the event of an emergency. [Refer to Tag 0066 10A NCAC 13F .0305(h)(3) Physical Environment (Type B Violation)]. 2. Based on observations and interviews the facility failed to ensure hot water temperatures at 4 of 8 sink fixtures and 1 shower fixture accessible to residents (sink and shower in room 32, sinks in rooms 34, 31, and 29) were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. [Refer to Tag 0113 10A NCAC 13F .0311 (d) Other Requirements (Type B Violation)].	D912		

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D912	Continued From page 32 3. Based on observations and interviews the facility failed ensure residents were treated with respect and dignity related to the Administrator withholding the personal effects and belongings due to an outstanding bill of one resident (Resident #3) after she had been discharged to a higher level of care. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D912		