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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: ______ B. WING ______	R-C 01/25/2022

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

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation onsite on January 19,2022, January 20, 2022, and January 24, 2022 and desk review on January 21, 2022 and January 25, 2022 with an exit conference via telephone on January 25, 2022. The complaint investigation was initiated by the Forsyth County Department of Social Services on January 11, 2022.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 residents sampled (#3 and #5) related to a resident who had multiple falls in 3 months resulting in injuries and 10 emergency department (ED) visits (#5) and a resident who wandered into other residents' rooms and wandered around the dining room during the lunch meal touching other residents' plates (#3). The findings are: 1. Review of the facility's undated Resident Fall Policy and Procedure/Fall Intervention Guidelines revealed:	D 270	**D270** THE COORDINATOR WILL REVIEW ALL RESIDENTS CURRENT CONDITIONS TO IDENTIFY ANY RESIDENT THAT IS NEEDING INCREASED SUPERVISION INCLUDING ROUTINE 15 MINUTE CHECKS AND / OR ADDITIONAL SUPERVISION ALL WHILE BEING IN COMMUNICATION WITH THE RESIDENTS PHYSICIAN. THE RESIDENT CARE STAFF WILL DOCUMENT ALL CHECKS IN THE APPROPRIATE BINDERS ADHEARING TO FACILITY POLICY. ADMINISTRATOR WILL MONITOR WEEKLY TO MAKE SURE THAT ALL SUPERVISION CHECKS ARE BEING COMPLETED. QI Training on Fall Prevention Policy will be done for all resident care staff at the staff meeting to be held on March 3. →	2/21/2022

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	2/18/22

reviewed and acknowledged
04/01/22 hrp

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D 270	Continued From page 1 -Residents with a fall which included the possibility of head trauma were to be sent to the emergency department (ED) of a local hospital for evaluation and treatment. -Staff were to assess the resident's environment for hazards. -Staff were to obtain the resident's vital signs. -Staff were to notify the physician for a review of medications and evaluation for repeated falls. -Staff were to refer the resident to home health for physical therapy (PT) evaluation if the resident had a fall while ambulating or a fall from a wheelchair. -Staff were encouraged to anticipate the needs of residents and act proactively before an incident occurred. -Any staff who was admitted with notation or suspicion of being a fall risk would be automatically referred to home health for evaluation. -Follow up would be completed utilizing the 24 hour Post Fall Checklist. -There was no information regarding increasing supervision of a resident after a fall. Review of Resident #5's current FL2 dated 03/03/21 revealed: -Diagnoses included Alzheimer's disease, insomnia, lack of coordination, abnormalities of gait and mobility, and muscle weakness. -Resident #5 was constantly disoriented. Review of Resident #5's care plan dated 03/22/21 revealed: -Resident #5 ambulated independently with no problems. -There was no documentation Resident #1 required any assistance or supervision with ambulation or transferring.	D 270	All RC Management and Supervisors will receive restraint training at the RC staff meeting to be held on March 3. Including in the training is that residents will only be used with the permission of the RC Director or the Administrator. As Resident Review are completed, Care plans will be update and going forward will be updated with any significant change.Quarterly SCU Resident Assessments will be reviewed as they are updated throughout the year by the RCD.Outside agencies will be consulted on safety issues but the facility will retain the decision making in order to keep residents safe following the policy on Restraints and Alternative restraints. Resident 3 – Resident has had a room change in order to move her away from the resident that she had an issue with. She has been seen by Psych and had a medication review to prevent any further occurrence. She remains on 15 minute checks. Detail how these are documented – don't over promise. family has moved back to using the facility pharmacy to ensure correct packaging. Marketing /admissions will advise families at time of admissions that if they choose to use an outside pharmacy that they are required to sign a Medipck contract to be used as back up. Staff will be trained to order medications from Medipack when families fail to supply medications. Calls to families will be documented. Medication will be ordered in for 10 days to give the family time to bring the medication. If they fail to bring it in, the facility will then order a month worth at a time.	

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D 270	Continued From page 2 Observation of Resident #5 on 01/19/22 at 12:33pm revealed bruising under his left eye and a small cut on the right side of his forehead. Observation of Resident #5 on 01/19/22 at 5:09pm reveled: -Resident #5 was walking down the hallway and his pants were hanging down to his thighs. -Resident #5 was trying to hold his pants up with one hand. Observation of Resident #5 on 01/20/22 at 11:43am revealed: -Resident #5 entered the dining hall with a laceration 1 to 1.5 inches vertically down the middle of his forehead covered with steri-strips. -Resident #5 had on long pajama pants and regular socks with no shoes. Interview with a personal care aide (PCA) on 01/20/22 at 11:45am revealed: -Resident #5 fell on 01/19/22 on second shift. -"He never sits down." -She could not find Resident #5's shoes, but he had them on earlier this morning. Interview with a second PCA on 01/20/22 at 11:49am revealed: -Resident #5 had a cut to his right temple from a fall on 01/19/22. -She thought Resident #5 got bruising on his left eye over the past weekend, but she did not know what happened. -Staff tried to keep an eye on him; when staff saw him walking, they tried to assist him and redirect him to sit down in the family room. -There was a notebook to document 15-minute checks for some residents, but Resident #5 had not been on 15-minute checks. -She tried to check on all residents every	D 270	Resident 6 – Resident Care managers and SIC's have been retrained to request orders that provide backup orders for treatments to include what to do with non-compliant residents. Resident 4 – skin assessments are now done weekly for all Diabetics on AL and SCU side.	

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D 270	Continued From page 3 15-minutes, including Resident #5, but all residents did not have documented 15-minute checks. a. Review of Resident #5's Incident/Accident Report dated 11/08/21 at 3:00pm revealed: -Resident #1 had a fall. -There was documentation the fall was witnessed, and Resident #5 had not been walking straight. -Emergency Medical Services (EMS) was called and Resident #5 was transported to a local hospital. Review of Resident #5's progress notes dated 11/08/21 revealed: -He had a to be sent out to the hospital due to a witnessed fall and he could not stand straight. -Staff was unable to obtain the resident's vitals due to him being anxious and moving a lot. Review of a Per PCA's written statement dated 11/08/21 revealed he was attending to another resident when Resident #5 fell. Review of a second PCA's written statement dated 11/08/21 revealed she was attending to another resident when Resident #5 fell. Review of a local EMS report for Resident #5 dated 11/08/21 at 3:25pm revealed: -Resident #5 was found alert and standing in his room with staff. -He was agitated and uncooperative at first, but he was able to be redirected to sit on the stretcher. -The facility staff reported Resident #5 had a witnessed fall around 3:00pm, and he fell on his bottom and did not hit his head. -Staff reported Resident #5 had abnormal gait	D 270		

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D 270	Continued From page 4 after the fall. Review of a local hospital emergency department (ED) record dated 11/08/21 at 4:26pm revealed: -Resident #5 presented with a fall and agitation. -Per EMS report, Resident #5 was witnessed falling onto his back at the facility and complained of buttock and back pain. -Mild discoloration was noted around Resident #5's left eye. -The fall occurred while the resident was walking and he fell from a height of 3 to 5 feet landing on a hard floor on his buttocks. -Resident #5 was noted to be a significant fall risk. -X-rays revealed no acute fractures. Review Resident #5's Post Fall Checklist dated 11/08/21 at 3:40pm revealed: -Resident #5 did not have any injuries. -Resident #5's PCP and responsible party were notified of the fall and he was sent out to the ED for evaluation. -Resident #5 did not complain of any pain or discomfort, have changes in ambulation, have outward rotation of the legs or arms, did not have increased drowsiness, and did not have trouble getting out of bed for 8, 16, and 24 hours after his fall on 11/08/21. Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #5 after his fall on 11/08/21. b. Review of Resident #5's Incident/Accident Report dated 11/26/21 at 1:15pm revealed: -Resident #5 was coming down the hall when staff noticed that he was leaning to his left side and could not keep his balance.	D 270		

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D 270	Continued From page 5 -The incident was documented as a sudden illness. -Resident #5's responsible party and PCP were notified, and he was sent to the local hospital ED. Review of Resident #5's progress notes dated 11/26/21 revealed: -Staff reported to the SCUC that Resident #5 had been seen walking down the hallway leaning to his left side and had not been able to keep his balance. -Resident #5's responsible party and PCP were notified, and he was sent to the local hospital ED. Review of a local EMS report for Resident #5 dated 11/26/21 revealed: -Staff stated Resident #5 had multiple falls on 11/26/21 and had a chronic history of falling. -Resident #5 did not hit his head or have loss of consciousness during his falls, but staff requested that he be sent out for further evaluation. Review of a local hospital ED record dated 11/26/21 at 2:12pm revealed: -Resident #5 presented to the ED with a fall. -EMS reported Resident #5 had 4-5 falls at his facility on 11/26/21. -Per facility staff, Resident #5 had multiple recent falls and had been evaluated in the ED twice over the past few weeks. -Facility staff reported Resident #5 continued to have difficulty walking, falling towards his left side. -Resident #5 fell 4 times on 11/26/21, ground level falls, with no head trauma or loss of consciousness. -A 5th fall was caught by a staff member and no injures were noted by staff after the falls.	D 270		

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D 270	Continued From page 6 Review of Resident #5's Post Fall Checklists revealed there was no checklist for 11/26/21. Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #1 after his fall on 11/26/21. c. Review of Resident #5's Incident/Accident Report dated 12/03/21 at 12:23am revealed: -Resident #5 had a fall with a skin tear. -Resident #5 was wandering the halls and was seen by a PCA tripping on his clothes and hit his head on the edge of the handrail. -Resident #5's responsible party and PCP were notified, and he was sent to the local hospital ED. Review of Resident #5's progress notes dated 12/03/21 at 12:23am revealed: -Resident #5 was seen by a PCA tripping over his clothes and hitting his head on the handrail. -Resident #5's responsible party and PCP were notified, and he was sent to the local hospital ED. Review of the local EMS report for Resident #5 dated 12/03/21 at 12:40am revealed: -Resident #5 was walking around his room with staff when EMS arrived. -Staff advised Resident #5 was walking down the hall when he tripped on his gown and hit his head on the floor. -Staff advised the fall was witnessed and Resident #5 never lost consciousness. -Resident #5 was found to be confused and withdrawing from touch. -Resident #5 had minor bleeding coming from a hematoma located on the top of his forehead. -He was also found to have several bruises all over his body from what appeared to be previous trauma.	D 270		

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D 270	Continued From page 7	D 270		

-Resident #5 was transported to a local hospital.

Review of a local hospital ED record for Resident #5 dated 12/03/21 at 1:30am revealed:
-Resident #5 presented to the ED with a fall.
-Resident #5 had intermittent confusion and required frequent redirection.
-The facility staff reported that Resident #5 was found on the floor with a laceration on his forehead.
-The 3-centimeter laceration to Resident #5's forehead was repaired with glue and there were no acute abnormalities found on the imaging scan of his head.

Review Resident #5's Post Fall Checklist dated 12/03/21 at 12:23am revealed:
-Resident #5 had bleeding and there was a scrape or skin tear.
-Resident #5's PCP and responsible party were notified of the fall and he was sent out to the ED for evaluation.
-Resident #5 did not complain of any pain or discomfort, have changes in ambulation, have outward rotation of the legs or arms, did not have increased drowsiness, and did not have trouble getting out of bed for 8, 16, and 24 hours after his fall on 12/03/21 at 12:12am.

Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #1 after his fall on 12/03/21 at 12:23am.

d. Review of Resident #5's Incident/Accident Reports revealed there was not a second report dated 12/03/21.

Review of Resident #5's progress notes revealed there was not a second entry documented for

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D 270	Continued From page 8 12/03/21. Review of the local EMS report for Resident #5 dated 12/03/21 at 7:53am revealed: -EMS found Resident #5 walking out of his room and he was not cooperative with staff or EMS. -According to staff, Resident #5 had a fall the night prior and was seen at the hospital. -He returned to the facility where he was noted to be altered from his baseline as he was irritable and not following commands; staff reported this was not his normal. -Staff reported Resident #5 had a fall and did not lose consciousness. -EMS noted Resident #5 had a scab on his head as well as an actively bleeding laceration on his ear. -EMS transported Resident #5 to a local hospital ED. Review of the local hospital after visit summary dated 12/3/21 revealed: -Resident #5 was seen in the ED due to a fall. -Diagnoses included agitation, gait disturbance, fall, and laceration of the left ear. -The laceration was sutured, and a urinalysis was performed. Review of Resident #5's Post Fall Checklists revealed there was no checklist for 12/03/21 around 7:53am. Telephone interview with a medication aide (MA) on 01/25/22 at 11:02am revealed: -She thought Resident #5 fell on third shift of the previous day and was sent out to the hospital ED -When she started her shift, she noticed Resident #5's ear was bleeding and was told Resident #5 came back from the ED and his ear was not stitched.	D 270		

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D 270	Continued From page 9 -She sent Resident #5 back out to the hospital because his ear was still bleeding and needed to be stitched up. -She was told to keep an eye on Resident #5 to make sure he did not fall, stumble, or trip over anything. -There had not been any previous increase in supervision for Resident #5 after his falls, but he was currently on 15-minute checks as of 01/20/22. Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #1 after his second fall/incident on 12/03/21 around 7:53am. e. Review of Resident #5's Incident/Accident Report dated 12/11/21 at 10:45am revealed: -Staff was getting Resident #5 ready for lunch and saw that his hand and finger were swollen, and his ring finger looked displaced. -There was no documentation EMS was called. Review of Resident #5's progress note dated 12/11/21 revealed when staff was getting Resident #5 ready for lunch, staff saw Resident #5's hand was swollen, and his ring finger seemed to be displaced. Review of a local hospital ED record dated 12/11/21 at 7:49pm revealed: -Resident #5 presented to the ED with a fall. -EMS reported Resident #5 had baseline weakness and poor coordination. -Resident #5 had a fall after leaning forward unable to control his balance. -Resident #5 had another fall 1 week prior where he struck his head.	D 270		

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D 270	Continued From page 10 -Resident #5 had dried blood on his forehead, but he was unable to tell ED staff whether he hit his head when he fell. -There were no lacerations or bruising. -Resident #5 had an image scan of his head and there was no acute abnormality or hemorrhage. -Resident #5 had significant right-hand swelling. -Resident #5 had an x-ray of his right hand and wrist and results were soft tissue swelling over the hand, but there were no acute fractures. Review of Resident #5's Post Fall Checklists revealed there was no checklist for 12/11/21. Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #1 after his fall/incident on 12/11/21. f. Review of Resident #5's Incident/Accident Report dated 12/20/21 at 9:00am revealed: -Resident #5 was walking around on the hall in the Special Care Unit (SCU) and had a fall. -Resident #5's responsible party and PCP were notified, and EMS was called to transport him to a local hospital ED. Review of Resident #5's progress note dated 12/20/21 revealed: -Resident #5 was sent out to the ED due to a fall. -He was walking around in the hallway when the incident happened. -Resident #5's responsible party and PCP were notified. Review of the local EMS report for Resident #5 dated 12/20/21 revealed: -Resident #5 was assessed and EMS staff observed a bruise in the middle of his forehead which resulted from a fall.	D 270		

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D 270	Continued From page 11 -Staff advised they were walking down the hall with Resident #5 and he accidentally fell. -Resident #5 also had a swollen right hand and staff advised they were unsure what happened to his hand. -Resident #5 was transported to the local hospital ED. Review of a local hospital after visit summary dated 12/20/21 revealed: -Resident #5 was seen in the ED due to a fall. -His diagnoses included closed head injury and abrasion of the face. Review Resident #5's Post Fall Checklist dated 12/20/21 at 12:23am revealed: -Resident #5 hit his head and was bleeding. -Resident #5 did not complain of any pain or discomfort, have changes in ambulation, have outward rotation of the legs or arms, did not have increased drowsiness, and did not have trouble getting out of bed for 8, 16, and 24 hours after his fall on 12/20/21 at 12:12am. Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #1 after his fall on 12/20/21. g. Review of Resident #5's Incident/Accident Reports revealed there was no report for the morning of 12/30/21. Review of Resident #5's progress notes revealed there was no progress note documenting a fall on the morning of 12/30/21. Review of the local EMS report for Resident #5 dated 12/30/21 at 7:30am revealed: -EMS staff found Resident #5 laying supine on	D 270		

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(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 270	Continued From page 12 the cold wet concrete ground in the facility courtyard (enclosed). -It was unclear how long Resident #5 had been on the ground; estimated from 30 minutes to 2 hours. -Bruising was noted to both eye sockets, the right buttock, and tops and bottoms of both feet. -No obvious injuries were found. -Wet clothing was removed and Resident #5 was covered with blankets. -Resident #5 was transported to a local hospital ED. Review of a local hospital After Visit Summary dated 12/30/21 revealed: -The reason Resident #5 was seen in the ED was due to a fall. -Resident #5's diagnoses included dementia without behavioral disturbance and an unwitnessed fall. Telephone interview with the Special Care Unit Coordinator (SCUC) on 01/25/22 at 10:55am revealed: -Resident #5 had an unwitnessed fall in the SCU courtyard on 12/30/21. -She did not know how long Resident #3 had been outside in the courtyard, but it was no more than a couple of minutes. -Resident #5's clothes were not wet so he could not have been out there that long. -A personal care aide (PCA) was walking by and noticed Resident #5 on the ground of the courtyard. Review of Resident #5's Post Fall Checklists revealed there was no checklist for 12/11/21. Based on record reviews, there was no documentation of increased supervision or other	D 270		

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interventions implemented for Resident #5 after his fall on the morning of 12/30/21.

h. Review of Resident #5's Incident/Accident Report dated 12/30/21 at 5:40pm revealed:
-Resident #5 was in the family room when he tried to sit down, tripped, and hit his head.
-Resident #5 was sent to the ED.

Review of Resident #5's progress notes dated 12/30/21 at 5:46pm revealed:
-Resident #5 was sent to the hospital due to a witnessed fall where he hit his head.
-Resident #5's vitals were taken.

Review of the local EMS report dated 12/30/21 at 6:14pm revealed:
-EMS staff found Resident #5 sitting upright on the floor with staff at his side who reported a witnessed fall from a chair.
-Resident #5 fell in the early morning of 12/30/21, was sent out to the hospital ED for evaluation, and he returned without any new diagnoses.
-Resident #5 was at dinner on this evening, 12/30/21, and fell from a seated position from a dining chair to his buttocks.
-Resident #5 had no obvious injury and reported no pain or discomfort.
-The staff requested Resident #5 be sent out to a different hospital ED than he was sent to earlier on 12/30/21.

Review of the local hospital ED record for Resident #5 dated 12/30/21 revealed:
-Resident #5 presented to the ED with a fall.
-The fall occurred 1 to 2 hours prior to arriving at the ED.
-The fall occurred while sitting on the toilet and Resident #5 landed on the floor on his bottom per the hospital report.

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D 270	Continued From page 14 -The facility staff was unable to say whether Resident #5 hit his head or not. -On record review, Resident #5 was noted to have almost weekly visits to the ED and other local EDs for similar occurrences, most if not all without traumatic findings. -Resident #5 was evaluated at another local hospital this morning, 12/30/21, for a fall after he was found outside at his facility in the rain covered in mud and debris. Review Resident #5's Post Fall Checklist dated 12/30/21 at 5:55pm revealed: -Resident #5 hit his head. -Resident #5's 's PCP and responsible party were notified of the fall and he was sent out to the ED for evaluation. -Resident #5 did not complain of any pain or discomfort, have changes in ambulation, have outward rotation of the legs or arms, did not have increased drowsiness, and did not have trouble getting out of bed for 8, 16, and 24 hours after his fall on 12/30/21 at 5:40pm. Based on record reviews, there was no documentation of increased supervision or other interventions implemented for Resident #5 after his fall on 12/30/21 at 5:40pm. i. Review of Resident #5's Incident/Accident Report for 01/19/22 at 8:30am revealed: -Resident #5 had an unwitnessed incident on the hall and showed signs of a possible fall due to unstable gait. -Resident #5 was assessed and sent to the local hospital ED. -Resident #5's responsible party and PCP were notified. Review of 3 PCAs' written statements dated	D 270		

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D 270	Continued From page 15 01/19/22 revealed the PCAs were assisting another residents at the time of the incident. Review of Resident #5's progress note dated 01/19/22 at 2:23pm revealed: -Resident #5 had an unwitnessed incident on the hall and showed signs of a possible fall due to unstable gait. -Resident #5's responsible party and PCP were notified. Review of the local EMS report dated 01/19/22 at 8:24pm revealed: -The chief complaint was a fall with head injury. -EMS staff found Resident #5 seated upright in a chair in the dining hall. -Facility staff were with Resident #5 and reported he had been having multiple falls and injuries resulting from falls. -Resident #5 had a minor abrasion to his right temple and bruising to his left eye. -The facility staff were uncertain of the timeframe of the fall or how he fell. -Resident #5's injuries were noticed this morning while completing morning checks. -Resident #5 was transported to the ED for evaluation. Review of a hospital ED After Visit Summary for Resident #5 dated 01/19/22 revealed: -Resident #5 was seen at the hospital ED for a fall. -Resident #5's diagnoses included a fall, closed head injury, acute UTI, and hypothermia. Review Resident #5's Post Fall Checklist dated 01/19/22 at 8:30am revealed: -Resident #5 hit his head and had bleeding. -Resident #5's 's PCP and responsible party were notified of the fall and he was sent out to the ED	D 270		

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for evaluation.

Review of the 15-minute Check Log Binder on 01/20/22 revealed there was a 15-minute check log for Resident #5 dated 01/20/22 with checks documented every 15-minutes between 6:00am and 12:30pm.

Interview with a personal care aide (PCA) on 01/20/22 at 11:45am revealed:
-Resident #5 fell on 01/19/22 while she was in the dining room assisting with breakfast.
-She saw him bleeding from a cut on the right side of his head.
-Resident #5 also had a bruise on his left eye probably from a fall on Monday, 01/17/22, but she was not sure.
-She had not been told to do anything differently for Resident #5 after his fall on 01/19/22, but Resident #5 was placed on 15-minute checks starting at 6:00am on 01/20/22.

Interview with a second PCA on 01/20/22 at 11:49am revealed:
-She was assisting another resident on the morning of 01/19/22 when Resident #5 fell during shift change.
-"He moves so fast."
-The MA on duty on the morning of 01/19/22 told her to "keep an eye" on Resident #5, but did not tell her how often to check on him.
-She usually checked on residents, including Resident #5, every 15 minutes.
-There was a notebook with 15-minute check logs for some residents, but every resident did not have documented 15-minute checks.
-Staff started documenting 15-minute checks for Resident #5 on today, 01/20/22.

Interview with a MA on 01/20/22 at 12:20pm

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D 270	Continued From page 17 revealed: -When she came into the dining hall on 01/19/22, Resident #5 was bleeding from the right side of his forehead. -She did not see him when he fell, and she did not know when he fell; there was no witness to tell where he fell. -She sent him out to the hospital ED for evaluation. -When Resident #5 returned from the ED, he was cleaned up and his vital signs were taken. -Staff were told to watch him every time he moved and to walk behind him to make sure he was safe. -All residents were supposed to be checked on every 15-minutes, but there was no documentation of the 15-minute checks for all residents. -She checked on all residents during her medication pass. -There was a notebook that documented 15-minute and 30-minute checks for some residents. -She did not know if Resident #5 was on documented 15-minute or 30-minute checks or if he had previously been on increased checks. -The Special Care Unit Coordinator (SCUC) was responsible for determining when residents were to be on 15-minute or 30-minute checks. -Resident #5 sometimes fell twice a week and sometimes more than that. -The third shift staff reported to her at the start of her shift Resident #5 went to the hospital on the night of 01/19/22. j. Review of Resident #5's Incident/Accident Report dated 01/19/22 at 6:35pm revealed: -Resident #5 was walking too fast when he fell in the family room and hit his head. -Resident #5's responsible party and PCP were	D 270		

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D 270	Continued From page 18 notified, and he was sent to a local hospital ED. Review of a PCA's written statement on 01/19/22 revealed the PCA was helping another resident at the time of the incident. Review of a second PCA's written statement on 01/19/22 revealed the PCA was in the storage room (outside of, but adjacent to the room where Resident #5 fell) when she witnessed Resident #5 fall and his head in the family room. Interview with a PCA on 01/20/22 at 5:05pm revealed: -She was in the storage room on the evening of 01/19/21 with the door open when she saw Resident #5 walking really fast into the family room. (The family room is located directly beside the storage room.) -Resident #5 lost his balance after entering family room and hit his head on the floor near a window. -Resident #5 was sent out to the local hospital ED. Review of Resident #5's progress note dated 01/19/22 at 8:08pm revealed: -Resident #5 was being sent to the hospital due to a witnessed fall where he hit his head and started bleeding. -The bleeding was under control. -Resident #5's responsible party and PCP were notified. Review of the local EMS report dated 01/19/22 at 8:13pm revealed: -EMS staff observed Resident #5 lying on the ground on his left side; facility staff was at his side. -Facility staff stated Resident #5 stood up and fell face forward.	D 270		

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-Resident #5 had dementia and a history of falls.
-The facility requested EMS to transport Resident #5 to the local hospital ED.

Review of the local hospital ED record dated 01/19/22 at 9:03pm revealed:
-Resident #5 presented to the hospital with a fall.
-The fall was witnessed, and Resident #5 did not have loss of consciousness.
-Resident #5 had a 3 cm laceration to his forehead.
-He had a small 1 cm abrasion and hematoma present.
-Bruising was present around the left eye which was purple and yellow in color.

Review Resident #5's Post Fall Checklist dated 01/19/22 at 7:10pm revealed:
-Resident #5 hit his head and had bleeding.
-Resident #5's 's PCP and responsible party were notified of the fall and he was sent out to the ED for evaluation.

Review of the 15-minute Check Log Binder on 01/20/22 revealed there was a 15-minute check log for Resident #5 dated 01/20/22 with checks documented every 15-minutes between 6:00am and 12:30pm.

Interview with a medication aide (MA) on 01/19/22 at 4:52pm revealed:
-Resident #5 had fallen often lately.
-Resident #5 was usually sent to the local hospital ED after his falls and the ED sent him back saying everything was fine.
-She was told by first shift staff Resident #5 was sent out to the ED this morning after a fall and came back with new medication orders.
-She was told by a first shift MA that Resident #5 fell and busted his ear and had to be sent out to

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D 270	Continued From page 20 the ED to get stitches, but she did not remember when. -She sent Resident #5 out to the ED after she saw him fall and hit his head in December 2021. -She may have sent Resident #5 out to the ED two other times, but she did not remember when. -After a fall, staff was to monitor the resident for changes, and assess for unusual pain or changes in gait. -There was no increase in supervision put in place for Resident #5 after his falls and she was not aware of any interventions put in place for him other than him being on hospice. Interview with the SCUC on 01/20/22 at 12:45pm revealed: -Staff checked on residents all day long. -There were residents who were on 15-minute checks, but Resident #5 had not been on 15-minute checks after any of his falls because his falls were spaced out. -She considered Resident #5 a high fall risk as of December 2021 due to him having multiple falls. -She requested a physician's order for physical therapy, occupational therapy and Resident #5 was also placed on hospice services. -As of 01/20/22, staff was providing 1 on 1 supervision for Resident #5 until he was transferred to another facility. Telephone interview with the Coordinator at Resident #5's home health agency on 01/21/22 at 11:09am revealed: -Resident #5 was admitted to occupational therapy (OT) services and PT services with diagnoses of Alzheimer's disease and repeated falls on 01/03/22. -Resident #5 was evaluated for OT services on 01/05/22 and had OT visits on 01/11/22 and 01/12/22.	D 270		

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D 270	Continued From page 21 -Resident #5 was evaluated for PT services on 01/07/21 and had PT visits on 01/10/22 and 01/13/22. -Education was provided to the facility staff, but no specific instructions were given. -Resident #5 had not received PT or OT services prior to 01/03/22. Telephone interview with the Clinical Director at Resident #5's hospice agency on 01/21/22 at 12:46pm revealed: -When admitted to hospice services on 01/07/22, Resident #5 had an abnormal gait and mobility. -Resident #5 received follow-up nursing visits on 01/08/22, 01/10/22, 01/13/22, and 01/20/22; the hospice medical director assumed care for Resident #5 on 01/11/21. -The facility staff provided information that Resident #5 chronically wandered and sometimes in the nude. -The hospice provider was looking at possibly increasing Resident #5's dosage of an antianxiety medication. -Resident #5 ambulated constantly during visits. -On 01/10/22, Resident #5 had no skin tears or wounds noted. -On 01/13/22, Resident #5 was restless and minimally cooperative; he was wandering around the day room touching all the tables and chairs and walking very briskly. -The hospice agency was not notified until 01/20/22 that Resident #5 had two falls on 01/19/22 and was sent to the hospital after each fall. Telephone interview with a nurse at Resident #5's hospice agency on 01/21/22 at 1:25pm revealed: -She had concerns for Resident #5 as he was very agitated, restless, compulsive, and ran around the facility.	D 270		

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D 270	Continued From page 22 -She told the SCUC Resident #5 was a huge fall risk and noticed he just had on white socks during her visit on 01/13/22. -Resident #5 did not have bruising to his left eye during her visit on 01/13/22. -An antianxiety medication (Ativan) and a sleeping aide (Restoril) were put in place for Resident #5 on 01/14/22. -She was visiting Resident #5 once a week, but she increased her visits to twice a week after he had two falls on 01/19/22. -Education she provided to staff included Resident #5 wearing shoes or non-skid socks, and not running at Resident #5. Telephone interview with Resident #5's previous primary care provider (PCP) on 01/25/22 at 11:42am revealed: -He knew about Resident #5's multiple falls. -He made changes in his medications and ordered PT consultations, but he did not have access to dates at the present time. -Resident #5's brain trauma, lack of impulse control, and his overlying dementia made him difficult to treat. Telephone interview with Resident #5's guardian on 01/25/22 at 1:26pm revealed: -The facility made her aware of Resident #5's falls. -She had concerns with Resident #5 falling, but his overall decline and chronic swelling on the brain made his gait unsteady. -Resident #5 was currently on hospice services and she entrusted them to make decisions for Resident #5 regarding his level of care. Telephone interview with the Administrator on 01/25/22 at 4:12pm revealed: -She knew Resident #5 had two falls on 01/19/22,	D 270		

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but there were no other days when Resident #5 had multiple falls in the same day.
-Resident #5's local hospital report dated 12/03/21 was wrong because the only laceration he had to his head was on 01/19/21.
-The hospital sent Resident #5 back from the first hospital visit on 12/03/21 without stitching his ear.
-When a resident fell, staff was to assess the resident's vitals and if the fall was unwitnessed, she expected staff to send the resident out to the local hospital ED.
-Staff was to contact the resident's physician, home health, and/or hospice and follow orders.
-She expected staff to increase supervision for residents who had multiple falls.
-There were several instances when Resident #5 fell, and staff "had eyes" on him.
-Resident #5 was not on 15-minute checks prior to 01/20/22; he currently had a staff with him at all times and there was now no need for 15-minute checks.
-Resident #5 started declining at the end of November 2021 and the facility got home health and hospice involved with his care; there were also medication changes.

2. Review of Resident #3's FL2 dated 07/28/21 revealed:
-Diagnoses included dementia.
-Resident #3 was ambulatory and intermittently disoriented.

Review of Resident #3's care plan dated 07/27/21 revealed:
-Resident #3 did not require any assistance with ambulation or transfers.
-Resident #3 went in and out of other residents' rooms and had to be redirected by staff.

Review of Resident #3's Quarterly Resident

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D 270	Continued From page 24 Assessment dated 07/06/21 revealed: -Resident #3 was combative with other residents and staff. -Resident #3 wandered in and out of other residents' rooms. Review of Resident #3's Quarterly Resident Assessment dated 10/15/21 revealed: -Resident #3 was very combative and tried to fight staff. -Resident #3 wandered around stating someone stole her baby. Review of Resident #3's Incident/Accident Report dated 01/06/22 at 3:30pm revealed: -Resident #3 abused another resident. -Resident #3 got into a physical altercation with another resident in the other resident's room, and she (Resident #3) was the aggressor. -Resident #3 was sent to the hospital. Review of Resident #3's Behavior Incident Report dated 01/06/22 at 3:30pm revealed: -Second shift staff were gathering residents for dinner on the 300 hall of the Special Care Unit (SCU) when they heard a commotion on the 400 hall. -Staff found Resident #3 in another resident's room and Resident #3 had already hit the other resident. Review of Resident #3's progress notes dated 01/06/22 revealed Resident #3 was sent to the hospital due to physically assaulting a resident. Observation of the SCU on 01/20/22 between 12:26pm and 12:40 revealed: -Resident #3 finished her meal in the dining area then got up and wandered around the dining room.	D 270		

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	HAL034098	A. BUILDING: ______ B. WING ______	R-C 01/25/2022

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D 270	Continued From page 25 -Resident #3 went to the table of 2 residents who were eating and touched one of the plates. -Resident #3 picked up a resident's cup from another table. -Resident #3 wandered the hallways. Interview with a resident on 01/19/22 at 12:09pm revealed Resident #3 came into her room all times of the day and night and she did not like it. Interview with two other residents on 01/19/22 at 4:37pm revealed: -Resident #3 wandered into one of the residents' rooms often. -Both residents were in a room reading the Bible when Resident #3 came in and she did not want to get out; no staff came in to get Resident #3 out of her room on that day. -"She will hit you." Interview with a personal care aide (PCA) on 01/19/22 at 4:17pm revealed: -He was providing personal care to a resident when he heard yelling and went to the resident's room where he heard the yelling coming from. -The resident who was yelling was sitting on her bed with her eye welted and bruised and said she was hit by Resident #3. -Resident #3 was up the hall somewhere when he arrived at the room where he heard the yelling. -Resident #3 had been aggressive to other residents and staff. -He thought Resident #3 had hit another resident in the past and had bitten him on his hand and tried to hit him. -Resident #3 was sent to the hospital for evaluation, but he was not told to do anything differently for her when she returned to the facility.	D 270		

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D 270	Continued From page 26 Interview with a medication aide (MA) on 01/19/22 at 4:52pm revealed: -She was assisting with getting other residents ready to go to the dining room when a PCA came and got her on 01/19/22. -She was told Resident #3 had been in another residents' room and the resident tried to redirect Resident #3 out of her room; Resident #3 hit the other resident. -Resident #3 would argue, but she usually did not hit anyone. -This incident was her first time hitting anyone. -Resident #3 had tried to hit staff before, but not other residents. -She did not know of any increase in supervision for Resident #3 after the incident. Interview with a fourth resident on 01/19/22 at 5:22pm revealed: -She got into a fight with Resident #3 in the SCU. -Resident #3 had come in her room and she was trying to get her out of the room. -Resident #3 left her room and went back to her own room which was right next door. -She knocked on Resident #3's door to tell her not to come back into her room. -When Resident #3 opened her door, she tried to step in and Resident #3 slammed the door in her face and the door hit her in the head. Interview with another PCA on 01/19/22 at 5:38pm revealed: -She was providing personal care to a resident on 01/06/22 when she heard a resident yelling and telling Resident's #3 to get out of her room. -She came down the hallway a few minutes later and found a resident on the floor near her bed. -The resident's roommate told her Resident #3 hit the resident in the eye. -Resident #3 was in the doorway when she got to	D 270		

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D 270	Continued From page 27 the room. -Resident #3 occasionally went into residents' rooms. -There was no increase in supervision for Resident #3 after the incident on 01/06/22. Interview with the Special Care Unit Coordinator (SCUC) on 01/20/22 at 10:22am revealed: -Staff had to constantly redirect Resident #3 from going in and out of other residents' rooms. -Staff had put objects on her door to remind her where her room was located. -She did not know of any residents who complained about Resident #3 going in and out of their rooms. -The incident that happened on 01/06/22 was the first time Resident #3 hit another resident. Second interview with the SCUC on 01/20/22 at 12:45pm revealed: -Resident #3 experienced sundowning (confusion occurring in the late afternoon into the night and could could behaviors such as anxiety, aggression, pacing, and wandering) and during those times Resident #3 was more active and wandered more looking for stuff. -Staff checked on residents all day long. -Residents told her Resident #3 was in their room and staff and redirect her out of the room. -She decided when residents were to be placed on 15-minute checks. -Resident #3 had not been on 15-minute checks and she did not know why. Interview with Resident #3's responsible party on 01/20/22 at 11:08am revealed: -She received two different stories from the facility about the incident that happened on 01/06/22 with Resident #3. -The facility staff first told her that Resident #3 hit	D 270		

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someone in the day room and there was no staff around who witnessed the incident.
-She was also told by staff Resident #3 went into another resident's room, the resident tried to take Resident #3 back to her room, and Resident #3 hit the other resident.
-Staff never seemed to know what happened when there were incidents with Resident #3.
-Staff informed her on a Sunday evening in 2021 Resident #3 was being sent out to the ED because she had a black eye, but none of the staff knew what happened; she was told Resident #3 had a fall.
-She had taken Resident #3 out of the facility in 2021 and noticed a knot behind her ear; when she touched the knot, Resident #3 flinched. She looked at Resident #3's scalp and saw a small tear on her scalp.
-Staff told her they did not know anything about the knot behind Resident #3's ear or the tear on her scalp.
-Staff informed her in the past Resident #3 became agitated at times, but she was never informed Resident #3 ever hit anyone prior to the incident on 01/06/22.
-Staff had not informed her that they were increasing supervision or doing anything differently for Resident #3.

Interview with another MA on 01/20/22 at 12:20pm revealed:
-Resident #3 had to be redirected a lot.
-She wandered throughout the SCU and in and out of other residents' rooms.
-She did know of Resident #3 to be aggressive.
-She did not know if Resident #3 was on 15-minute or 30-minute checks, but she should be due to her wandering and confusion.

Interview with a third PCA on 01/20/22 at

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D 270	Continued From page 29 12:34pm revealed: -Some residents were on 15-minute checks. -She did not remember Resident #3 ever being on 15-minute checks in the past. -She rounded the halls to check on residents every 15 to 30-minutes anyway. Telephone interview with the Administrator on 01/25/22 at 4:12pm revealed: -The incident on 01/06/22 with Resident #3 hitting another resident was her first incident. -Neither Resident #3 nor the other resident felt like they were in danger of the other. -Resident #3's room and the other residents' room (whom she had the incident with on 01/06/22) were next door to each other and there were currently room changes taking place. -Resident #3 wandered the hall and in and out of other residents' rooms, but she was not a threat to any of the residents. -There was no reason for Resident #3 to be on increased supervision of 15-minute checks prior to 01/06/22 because she had not been involved in any other incidents. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. ____________ The facility failed to provide supervision fie 2 of 5 sampled residents (#5 ad #3) resulting in a resident who had diagnoses of Alzheimer's disease, muscle weakness, lack of coordination, and abnormalities of gait, sustaining multiple falls from 11/08/21 through 01/19/22, and the resident experiencing a closed head injury and abrasion of the face, lacerations, a hematoma, and bruising (#5); and a resident who had a diagnosis of dementia and wandered throughout the dining hall during meals from table to table and in and	D 270		

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D 270	Continued From page 30 out of other residents' rooms and was in an altercation with another resident causing the resident to have an injury to her head (#3). The facility's failure to provide adequate supervision was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. ______________ The facility provided a plan of protection on 01/20/22 in accordance with G.S.131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2022.	D 270		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 6 sampled residents (Residents #4 and #6) related to not notifying the primary care provider (PCP) and wound treatment center when the resident removed wound dressings on bilateral lower leg wounds (#6) and not notifying the PCP for a recent blister to the lower right leg (#4). The findings are: 1. Review of Resident #6's current FL2 dated	D 273	**D273** THE COORDINATOR WILL THOROUGHLY CHECK ALL RESIDENT ORDERS TO SEE IF ANY ORDERS NEED CLARIFICATION OR PHYSICIAN CONTACT CONCERNING THE ORDER. IF RESIDENT IS NON COMPLIANT WITH THE PHYSICIAN ORDER THEN THE COORDINATOR WILL REACH OUT TO THE PRESCRIBING PHYSICIAN TO GET A CLARIFICATION ORDER ON HOW TO PROCEED WITH FOLLOWING THE ORIGINAL ORDER OF TREATMENT UNTIL PHYSICIAN IS ABLE TO SEE RESIDENT OR GIVE INSTRUCTIONS ON HOW THEY WANT THE FACILITY TO TREAT UNTIL THE FOLLOW UP WITH THE PHYSICIAN. ADMINISTRATOR WILL MONITOR WITH ALL NEW ORDERS.	2/21/2022

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D 273	Continued From page 31 04/09/21 revealed diagnoses included Alzheimer's Dementia without behaviors, Diabetes Mellitus Type II, and stasis dermatitis of both legs. Observation on 01/19/22 at 4:30pm of Resident #6 in the dining room in the Special Care Unit revealed: -A personal care aide (PCA) was standing in front of Resident #6 holding a white blood-stained gauze and tan colored leg bandage that was still wrapped around the resident's foot and ankle. -The PCA asked the resident if he had tried to remove his leg wrap. -The PCA instructed the resident to sit still in the chair while she got the medication aide (MA) to assist her. -The PCA draped the gauze and leg wrap over the resident's leg and went to get the MA. -The MA donned gloves and asked the resident if he had tried to remove his bandages (no response from the resident). -The MA proceeded to re-wrap the bloody gauze around and around Resident #6's right leg starting at the ankle working toward the knee. -The MA did not straighten the gauze, but wrapped the folded and creased gauze up to Resident #6's right knee, and tucked the end of the gauze inside the last wrap. -The MA then re-wrapped the 4 inch tan colored stretch wrap starting from the ankle to just below the knee and affixed the bandage, just below the knee, with the velcro type fastener. Interview with the MA on 01/19/21 at 5:05pm revealed: -Resident #6 routinely picked at his legs and had for a long time. -The MAs applied cream to his legs twice a day for ongoing dermatitis, but not when his legs were	D 273		

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wrapped.
-The Home Health nurse (HHN) dressed his wounds.
-Resident #6 removed bandages that were applied by the HHN.
-The facility did not have instructions regarding what to do if Resident #6 removed leg bandages or wraps; she re-wrapped the bandage so the resident did not trip on the dangling wraps.
-MAs were not supposed to remove or change dressings as far as she knew.

Review of Resident #6's appointment referral form dated 01/13/22 revealed:
-The HHN was to assist with dressing changes to the left and right legs.
-The HHN was to use Medihoney gel (a healing gel) to all open areas 2 times a week.
-There was a note to return to appointment in one week.

Review of Resident #6's after visit summary from the wound center dated 01/13/21 revealed:
-The next office visit was scheduled for 01/20/22.
-There were no orders for the facility to treat the resident's wounds.
-There were instructions stating if you have removed your wrap when the wound center was not open to cover the wound with a temporary dressing, then notify the office upon re-opening or go to the Emergency Department.

Review of Resident #6's wound center progress notes from 01/13/22 revealed:
-There was no information regarding the facility treating removed bandages.
-"If after hours or on a weekend and you have a wound care need, please proceed to the nearest urgent care or the emergency department for care. Please notify the wound center of the event

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upon re-opening" was documented.

Interview with the Special Care Unit Coordinator (SCUC) on 01/19/22 at 5:20pm revealed:
-Staff did not wrap Resident #6's legs.
-The HHN was currently responsible for wrapping the resident's legs.
-The HHN changed Resident #6's dressing the first time earlier on 01/19/22.
-The HHN did not provide instructions for the facility if leg wraps were removed by the resident.
-She had not contacted the HHN, wound care clinic, or the primary care provider (PCP) for instructions on how to handle the wound care if the resident removed the dressing and wraps.
-The SCUC was informed of the incident that just occurred in the dining room (01/19/22 at 4:30pm) where the MA re-wrapped Resident #6's bandages.
-The SCUC was asked by staff to evaluate the bandage re-wrap due to the resident being diabetic, and observation of the bandage being constrictive, creased, and uneven.

Interview with the PCA who attended to Resident #6 in the dining room on 01/19/22 at 5:30pm revealed:
-Resident #6 came to the dining room with the right leg wraps dragging on the floor.
-She requested the MA to assist with determining what should be done regarding the leg wrap.
-Resident #6 had partially removed the leg wrap on his right leg.

Observation of the SCUC in Resident #6's room on 01/19/22 at 5:35 pm revealed:
- The SCUC donned examination gloves, removed Resident #6's slide-on shoe, raised Resident #6's right pant leg and examined the leg wraps.

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D 273	Continued From page 34 -The SCUC removed the tan outer elastic wrap stating that the wrap was "a little too tight". -She observed the gauze wrapping the right legs and confirmed the gauze was rolled, wrinkled and "too tight". -She removed all the bandages and loosely applied gauze wraps. Second interview with the SCUC on 01/19/22 at 5:45pm revealed: -Resident #6 had gone to the wound center on 01/13/22 and was to return to the center on 01/20/22. -The HHN provided dressing changes Resident #6 for the first time earlier on 01/19/22. -She did not know why Resident #6 had a compression stocking over the leg wraps. -She received the summary of the resident's visit to the wound center when the resident returned from the wound center visit on 01/13/22, but there was no information regarding the facility's care for Resident #6's wound, only orders for HHN treatment. -Resident #6 did not have orders for facility staff to provide wound care or information regarding what to do if the resident removed dressings or the dressing came off. - "Resident #6 picked at his legs all the time". He had frequent occurrences with irritated legs and would never keep bandages on his legs. -She had not contacted the wound care center, the home health agency or Resident #6's primary care provider (PCP) regarding what the facility should do when the resident removed the bandage. -She would contact Resident #6's PCP regarding further instructions prior to the resident's appointment tomorrow (01/20/22) at the wound treatment center.	D 273		

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D 273	Continued From page 35 Review of Resident #6's HHN notes dated 1/20/22 revealed: -There was documentation home health services began on 01/19/22. -The HHN documented dressing changes/wound care. Review of Resident #6's physician's after visit summary dated 01/20/22 revealed: -There was documentation for "an order has been placed to Home Health to assist with dressing changes." -There was no order for the facility to treat the wounds. -There were instructions stating if you have removed your wrap when the wound center was not open to cover the wound with a temporary dressing, then notify the office upon re-opening or go to the Emergency Department. Review of Resident #6's wound care progress notes dated 01/20/22 revealed: -There was no information regarding how the facility staff was to care for the wound and dressings. -There were instructions as follows: "If after hours or on a weekend and you have a wound care need, please proceed to the nearest urgent care or the emergency department for care." "Please notify the wound center of the event upon re-opening" was documented. Telephone interview with Resident #6's PCP on 01/21/22 at 10:10am revealed: -Resident #6 had been treated off and on for years for wounds on his legs. -Resident #6 had a history of picking at his legs which aggravated any open wounds and caused additional wounds. -Resident #6 had a history of removing wound	D 273		

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bandages in one or two days of placement and sometimes the same day.
-Resident #6's legs had recently become very irritated and inflamed and the facility arranged for the resident to be seen at the wound care center.
-He was aware home health (HH) was contacted for assistance with the current wound care.
-The facility had not contacted him regarding care for the wounds when Resident #6 removed bandages between HHN visits and wound care center visits.
-He would not have expected the MA to re-wrap the resident's leg with a soiled bandage and no wrinkles or twists in the gauze or elastic wrap should have occurred.
-He would be concerned for possible infection from re-wrapping soiled bandages.

Telephone interview with the coordinator of the HH agency on 01/21/22 at 11:31am revealed:
-HH received the order requesting assistance with wound care for Resident #6 on 01/13/22.
-The HHN assessment was not completed until 01/19/22 because of staffing issues at the HH agency.
-There was no wound care performed, just an assessment as best he could tell from the notes by the assessment nurse.
-There was no documentation the facility had contacted the HH agency for guidance if the resident removed the leg wraps placed by the wound center on 01/13/21.

Attempted telephone interview with a representative from Resident #6's wound care clinic on 01/21/22 at 11:36am was unsuccessful.

Interview with the SCUC on 01/24/22 at 12:00pm revealed:
-She did not work over the weekend (01/22/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 37 and 01/23/21). -Resident #6 did not have his leg bandage or wraps on when she got to work this morning (01/24/22). -She notified the PCP this morning. -She had not notified the wound care center. -She did not have an answer from the wound care center, PCP, or HHN for how the facility was to treat Resident #6's leg wounds when the resident removed the bandages. Telephone interview with a MA on 01/25/22 at 10:49am revealed: -Resident #6 removed the bandages from his legs and would leave the bandages on the floor in his room or place the bandages on his night stand next to his bed. -She had not re-wrapped Resident #6's legs. -The HHN would be responsible to re-wrap the resident's legs. -She had informed the SCUC when she found the leg wraps on the floor. -She had not informed the PCP, HHN, or the wound care center because the SCUC routinely handled notifying them. Telephone interview with a personal care aide (PCA) on 01/25/22 at 11:22am revealed: -Resident #6 left the leg wraps on about 48 hours from application most of the time. -Resident #6 removed the leg wraps (placed on at wound center visit 01/20/22) on 01/23/22. -She found the leg wraps on the floor in his room on second shift between 7:00pm and 11:00pm (not sure of exact time). -She let the MA know when she found the leg wraps on the floor. -She was not responsible to notify the PCP or wound care center.	D 273		

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D 273	Continued From page 38 Based on observation, interviews and record reviews, it was determined Resident #6 was not interviewable. 2. Review of Resident #4's current FL2 dated 02/09/21 revealed diagnoses that included type 2 diabetes mellitus with hyperglycemia, major depressive disorder, hyperlipidemia, chronic kidney disease, essential primary hypertension, and muscle weakness. Review of Resident #4's Care Plan revealed she required limited assistance from facility staff with bathing. Review of Resident #4's most recent LHPS evaluation on 01/20/22 revealed: -The LHPS evaluation was dated 12/15/21. -The evaluator documented that Resident #4 had "no visible skin breakdown at this time." Observation of Resident #4 on 01/20/22 at 10:58am revealed a large blister on the right lower leg that had opened and formed a scab. Interview with Resident #4 on 01/20/22 at 10:46am revealed: -She had a large blister on her right lower leg. -The blister had been on her right lower leg for three weeks. -She was told by facility staff that she would see the doctor, but she had not seen him yet. -She showed two medication aides (MAs) and the Resident Care Coordinator (RCC) the blister on her right lower leg. -The blister was painful when it formed, but it was not painful now that it had popped. Interview with a medication aide (MA) on 01/20/22 at 3:38pm revealed:	D 273		

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-Resident #4 had let the MA know about the blister on 01/19/22.
-Facility staff had placed Resident #4 on a list of residents for the doctor to see when he came to the facility.

Telephone interview with Resident #4's PCP on 01/21/22 at 12:15pm revealed:
-The facility sent him a picture of the blister on Resident #4's leg.
-He did not recall the date when the facility had let him know about the blister but thought they had let him know last weekend.
-He suspected it was a blood blister.
-He had not physically been at the facility in a couple of weeks.
-He instructed the facility staff to let the blister form a scab since the blister did not look infected, red, or open.

Interview with the Resident Care Coordinator (RCC) on 01/20/22 at 5:25pm revealed:
-Resident #4 had the blister for a while before letting facility staff know.
-Facility staff did skin assessments on admission for residents.
-She had found out about the blister some time during the week of 01/10/22 to 01/14/22.
-She had written a request the previous week for Physical Therapy/Occupational Therapy (PT/OT) and skilled nursing to evaluate the blister on the right lower leg.
-She placed the request in a box at the facility for Resident #4's PCP to see when the PCP arrived at the facility.
-She would have sent Resident #4 out to the hospital if she thought the blister needed immediate attention.
-The blister was dry, was not open, and was not weeping.

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D 273	Continued From page 40 -Resident #4's PCP was not able to see Resident #4 in the facility that week due to inclement weather. -Resident #4's PCP was supposed to come to the facility the following Monday on 01/24/22. -Observation of the written request for PT/OT to evaluate the blister on Resident #4's leg on 01/20/22 at 5:32pm revealed that there was no date recorded on the request. Interview with the Administrator on 01/20/22 at 5:21pm revealed: -She was not aware Resident #4 had a blister on her right lower leg. -Facility staff helped Resident #4 set-up for bathing by giving her towels. -Resident #4 bathed herself once she was given towels. -Resident #4 usually told facility staff if something was wrong with her skin. -The facility staff did not normally do regular skin assessments for residents with diabetes. A second telephone interview with the Administrator on 01/25/22 at 5:25pm revealed the RCC was responsible for notifying the doctor of the blister. ____________ The facility failed to ensure referral and follow up for 2 of 5 sampled residents by not notifying the PCP and wound clinic when a resident continually removed leg bandages and picked at leg wounds which could lead to extensive tissue damage and skin infections (Resident #6); and a resident who developed a blister on the lower right leg (Resident #4). This failure was detrimental to health and safety of the residents and constitutes a Type B Violation. ____________	D 273		

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D 273	Continued From page 41 The facility provided a plan of protection on 01/20/22 in accordance with G.S.131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2022.	D 273		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone. (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and (3) It is not the home's obligation to pay for a resident's toll calls This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents had access to a telephone to privately make and receive calls as evidenced by residents using the telephone in the Special Care Unit (SCU) medication room without privacy. The findings are: Observation of the SCU medication room on 01/24/22 between 6:15pm and 6:40pm revealed: -There was a land line telephone in the SCU medication room.	D 324	**D324** ALL CARE STAFF AND COORDINATORS WILL BE MADE AWARE BY THE ADMINISTRATOR THAT RESIDENTS IN THE (SCU) WILL NO LONGER USE A TELEPHONE IN THE MED ROOM. ALL RESIDENTS WILL START USING THE TELEPHONE IN THE COORDINATOR OFFICE WHERE THEY CAN HAVE TOTAL PRIVACY WHILE USING THE PHONE.	2/21/2022

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-There was a resident sitting in the SCU medication room and he was using the telephone.
-There was a medication aide (MA) seated in the medication room near the resident who was on the telephone.

Interview with a personal care aide (PCA) on 01/19/22 at 4:30pm revealed:
-Residents used the telephone in the medication room.
-He never left a resident alone in the medication room to use the telephone.

Telephone interview with a morning shift MA on 01/25/22 at 10:49am revealed:
-The facility did not have a telephone available for residents to use except the telephone in the SCU medication room.
-Residents were not allowed to use the telephone alone because it was in an area that could not be left unattended or unlocked.
-The MA received incoming resident calls, placed the caller on hold, and brought the resident to the telephone in the medication room.
-The MA stayed with the resident until the resident completed the call and then escorted the resident out of the medication room.
-If the resident requested to have a personal conversation, the MA would stand outside the medication room with the door open until the call was completed.
-There was one more telephone accessible to residents in the Special Care Unit Coordinator's (SCUC) office, however the residents did not routinely use that telephone.

Telephone interview with an evening shift MA on 01/25/22 at 3:20pm revealed:
-When a resident wanted to place a call, the resident came to the SCU medication room or the

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SCUC's office.
-Staff assisted the residents with calls from the medication room telephone.
-Staff remained with the resident while on the telephone in the medication room.
-She did not know a place the resident could be left completely alone unless the resident had their own cellular telephone (some residents had their own), or used another resident's cellular telephone to place a call.
-Staff may not know about calls placed and received using personal cellular phones.
-When residents received a call, the MA placed the caller on hold and brought the resident to the telephone in the SCU medication room.

Telephone interview with the Administrator on 01/25/22 at 4:12pm revealed:
-Residents in the SCU received and made calls using the telephone located in the SCU medication room.
-The only other telephone outlet accessible to residents in the SCU was in the family room.
-There had been a telephone in the family room previously, but it was removed due to residents' behaviors.
-A SCU resident once picked up the telephone in the family room and threw it at another resident.
-She had replaced at least 7 telephones in the SCU family room after residents destroyed them.
-Residents could use the telephone in the medication room on any given day at any time, but they could not be left unattended because of medications being in the room.
-Most SCU residents had cellular telephones.
-When a resident had a telephone call, the staff stepped out of the medication room.

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#1) observed during the medication pass including errors with crushing 2 long acting medications that should not be crushed, and 2 of 5 residents (#3 and #6) sampled for record review including errors with a laxative medication unavailable for administration and the wrong dose of a medication for lowering cholesterol(#3) and the facility applied compressions stockings when they should not have been applied (#6). The findings are: 1. The medication error rate was 7 % as evidence by the observation of 2 errors out of 27 observations during the 8:00am medication pass on 01/20/22. a. Review of Resident #1's current FL2 dated 10/28/21 revealed diagnoses included Alzheimer's Dementia, hypertension, and hyperlipidemia. Review of Resident #1's electronic Medication	D 358	**D358** All Med Aides will complete all necessary steps when passing our medications. They will compare the MAR to the medication in the cart related to strength, dosage, instructions including timing for administering the medication. Staff was instructed to call the residents personal physician if they are unsure of an order to get clarification. Documentation on the process will be completed prior to the end of the shift. Documentation to include medication in question, name of physician and name of physicians representative if applicable. If medication is missed during this time period, Med Aide will follow procedure for Physician Notification of Missed or Refused Medication. Physician will be notified immediately if there is a change in the Resident's status or if the medication is unavailable to the resident.	2/21/2022

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Administration Records (eMAR) for November 2021, December 2021, and January 2022 revealed diagnoses included history of aortocoronary bypass graft (heart surgery) and chest pain.

Review of Resident #1's physicians' orders or signed medication renewal orders revealed there was no current order to crush medications for Resident #1 available for review

Continued review of Resident #1's current FL2 dated 10/28/21 revealed an order for isosorbide mononitrate (used to treat angina pain in coronary artery disease) extended release [ER] twice a day. (Extended release tablets should not be crushed so as not to compromise the slow release mechanism of action and cause the absorption of an increased amount of medication in a shorter time frame than designed by the manufacturer.)

Observation of medication administration on 01/20/22 revealed:
-At 8:35am, the morning shift medication aide (MA) pulled 13 oral medications for Resident #1 from the medication cart.
-She punched the medications from the bubble cards supplied by the contracted pharmacy, including isosorbide dinitrate, into a plastic souffle cup.
-The MA transferred the 13 medications to plastic sleeve and crushed the medications using a commercial medication crushing device.
-The MA emptied the contents of the plastic sleeve back into the plastic souffle cup.
-The MA added 2 teaspoonfuls of applesauce to the plastic souffle cup, poured an 8 ounces cup of cold water, and entered Resident #1 room.
-The MA informed Resident #1, who was seated

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D 358	Continued From page 46 on the side of her bed, that she was going to administer her morning medications. -The MA was stopped from administering the applesauce containing crushed isosorbide mononitrate ER 60mg after scooping a small portion to give to the resident but before the resident opened her mouth. Observation on 01/20/22 at 8:38am of the bubble card for Resident #1's isosorbide mononitrate ER 60mg used to prepare the medication for administration revealed: -The bubble card was labeled card 2 of 2 dispensed on 12/20/21 for a quantity of 60 tablets with zero tablets remaining. -The bubble card was labeled with direction for one tablet twice daily "DO NOT CRUSH". Observation of the medication cart at 8:40am revealed there was no list or available information regarding medications that should not be crushed available for review on the medication cart. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for isosorbide mononitrate ER 60mg twice daily scheduled for administration at 9:00am and 9:00pm. - Isosorbide mononitrate ER 60mg was documented as administered at 9:00am on 01/20/22. -The current morning MA documented administration at 9:00am on 01/04/22, 01/05/22, 01/06/22, 01/07/22, 01/11/22, 01/12/22, 01/13/22, 01/15/22, 01/16/22, 01/18/22, and 01/19/22. Interview 01/20/22 at 9:02 with the MA revealed: -She routinely crushed Resident #1's medications when she worked the medication cart. -There was not a reference sheet for medications	D 358		

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that should not be crushed available for her to review.
-Resident #1 preferred her medications be crushed and added to apple sauce because she had so many medications to take at one time.
-She did not realize isosorbide mononitrate ER 60mg was not supposed to be crushed.
-She overlooked the "DO NOT CRUSH' information on the medication label for Resident #1's isosorbide mononitrate ER 60mg.
-She had not attempted to administer isosorbide mononitrate ER 60mg to Resident #1 without crushing the medication.

Interview on 01/20/22 at 9:40am with the Special Care Unit Coordinator (SCUC) revealed Resident #1 had been receiving isosorbide mononitrate ER 60mg crushed for a long time.

Telephone interview on 01/20/21 at 12:45pm with a pharmacist at the contracted pharmacy revealed isosorbide mononitrate 60mg ER should not be crushed due to a time release formulation that crushing would result in more of the medication being released in a short period of time which could result in dizziness, headache, or lightheadedness.

Interview on 01/20/22 at 9:40am with the Special Care Unit Coordinator (SCUC) revealed:
-Resident #1 had an order to crush medications but she was not able to locate the order.
-Resident #1 requested her medications be crushed and added to applesauce since she received so many medications.
-She occasionally worked as a MA for staff shortages and crushed all Resident #1's medications when she administered medications.
-She recalled MA training that medications that should not be crushed maybe could be changed

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D 358	Continued From page 48 to a different strength or medication. -She had not seen a list of medications that should not be crushed available for MAs to review. -She had not requested a "DO NOT CRUSH" list from the contracted pharmacy. -She had not contacted the contracted pharmacy or the resident's provider regarding crushing a long acting medication. Telephone interview on 01/20/21 at 12:45pm with a pharmacist at the contracted pharmacy revealed: -The pharmacy did not have an order for the Resident #1 to crush medications. -The pharmacy had not attempted to change the medication to a form that could be crushed because they were not aware Resident #1's medications were being crushed. Telephone interview on 01/21/22 at 10:10am with Resident #1's primary care provider (PCP) revealed: -Medication aides should not be crushing medications that were not supposed to be crushed according to the manufacturer. -The facility could contact the PCP regarding crushing long acting or time release medications and the medication could be changed to another form that could be crushed or a different medication ordered. -He did not know Resident #1's medications that should not be crushed were being crushed. -Crushing time release medications would affect the amount of medication absorbed into the resident's system and could affect the effectiveness of the medication. b. Review of Resident #1's current FL2 dated 10/28/21 revealed diagnoses included	D 358		

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D 358	Continued From page 49 Alzheimer's Dementia, hypertension, and hyperlipidemia. Review of Resident #1's physicians' orders or signed medication renewal orders revealed there was no current order to crush medications for Resident #1 available for review Continued review of Resident #1's current FL2 dated 10/28/21 revealed an order for metoprolol succinate (used to treat high blood pressure and regulate heart rate) extended release [ER] daily. (Extended release tablets should not be crushed so as not to compromise the slow release mechanism of action and cause the absorption of an increased amount of medication in a shorter time frame than designed by the manufacturer.) Observation of medication administration on 01/20/22 revealed: -At 8:35am, the morning shift medication aide (MA) pulled 13 oral medications for Resident #1 from the medication cart. -She punched the medications from the bubble cards supplied by the contracted pharmacy, including metoprolol succinate 25mg ER, into a plastic souffle cup. -The MA transferred the 13 medications to plastic sleeve and crushed the medications using a commercial medication crushing device. -The MA emptied the contents of the plastic sleeve back into the plastic souffle cup. -The MA added 2 teaspoonfuls of applesauce to the plastic souffle cup, poured an 8 ounces cup of cold water, and entered Resident #1 room. -The MA informed Resident #1, who was seated on the side of her bed, that she was going to administer her morning medications. -The MA was stopped from administering the applesauce containing crushed metoprolol	D 358		

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succinate 25mg ER after scooping a small portion to give to the resident but before the resident opened her mouth.

Observation on 01/20/22 at 8:38am of the bubble card for Resident #1's metoprolol succinate 25mg ER used to prepare the medication for administration revealed:
-The bubble card was dispensed on 01/05/22 for a quantity of 30 tablets with 13 tablets remaining.
-The bubble card was labeled with direction for one tablet once daily.
-There was no information related to the medication should not be crushed observed on the packaging (bubble card).

Observation of the medication cart at 8:40am revealed there was no list or available information regarding medications that should not be crushed available for review on the medication cart.

Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol succinate 25mg ER once daily scheduled for administration at 9:00am.
-The current morning MA documented administration at 9:00am on 01/04/22, 01/05/22, 01/06/22, 01/07/22, 01/11/22, 01/12/22, 01/13/22, 01/15/22, 01/16/22, 01/18/22, 01/19/22 and 01/20/22.

Interview 01/20/22 at 9:02 with the MA revealed:
-She routinely crushed Resident #1's medications when she worked the medication cart.
-Resident #1 preferred her medications be crushed and added to apple sauce because she had so many medications to take at one time.
-She did not realize metoprolol succinate 25mg

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ER was not supposed to be crushed.
-There was not a reference sheet for medications that should not be crushed available for her to review.
-She had not attempted to administer metoprolol succinate 25mg ER to Resident #1 without crushing the medication.

Interview on 01/20/22 at 9:40am with the Special Care Unit Coordinator (SCUC) revealed Resident #1 had been receiving metoprolol succinate 25mg ER crushed for a long time.

Telephone interview on 01/20/21 at 12:45pm with a pharmacist at the contracted pharmacy revealed metoprolol succinate 25mg ER should not be crushed due to a time release formulation that crushing would result in more of the medication being released in a short period of time which could result in dizziness or lightheadedness.

Interview on 01/20/22 at 9:40am with the Special Care Unit Coordinator (SCUC) revealed:
-Resident #1 had an order to crush medications but she was not able to locate the order.
-Resident #1 requested her medications be crushed and added to applesauce since she received so many medications.
-She occasionally worked as a MA for staff shortages and crushed all Resident #1's medications when she administered medications.
-She recalled MA training that medications that should not be crushed maybe could be changed to a different strength or medication.
-She had not seen a list of medications that should not be crushed available for MAs to review.
-She had not requested a "DO NOT CRUSH" list from the contracted pharmacy.

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-She had not contacted the contracted pharmacy or the resident's provider regarding crushing a long acting medication.

Telephone interview on 01/20/21 at 12:45pm with a pharmacist at the contracted pharmacy revealed:
-The pharmacy did not have an order for the Resident #1 to crush medications.
-The pharmacy had not attempted to change the medication to a form that could be crushed because they were not aware Resident #1's medications were being crushed.

Telephone interview on 01/21/22 at 10:10am with Resident #1's primary care provider (PCP) revealed:
-Medication aides should not be crushing medications that were not supposed to be crushed according to the manufacturer.
-The facility could contact the PCP regarding crushing long acting or time release medications and the medication could be changed to another form that could be crushed or a different medication ordered.
-He did not know Resident #1's medications that should not be crushed were being crushed.
-Crushing time release medications would affect the amount of medication absorbed into the resident's system and could affect the effectiveness of the medication.

2. Review of Resident #6's current FL2 dated 04/09/21 revealed diagnoses included Alzheimer's Dementia without behaviors, Diabetes Mellitus Type II, and stasis dermatitis of both legs.

Observation on 01/19/22 at 4:30pm of Resident #6 in the dining room in the Special Care Unit

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revealed:
-The MA did not straighten the gauze, but wrapped the folded and creased gauze up to Resident #6's right knee, and tucked the end of the gauze inside the last wrap.
-The MA then re-wrapped the 4 inch tan colored stretch wrap starting from the ankle to just below the knee and affixed the bandage, just below the knee, with the velcro type fastener.
-The MA pulled a tight black knee-high stocking/sock over the bandages.

Review of Resident #6's physician's orders dated 01/13/22 revealed:
-Resident #6 was ordered compression stockings 20-30 mmHg associated with lymphedema of both lower extremities.
-The order included measurements for the left and right calves and ankles.

Review of Resident #6's appointment referral form dated 01/13/22 revealed "Please obtain 20-30 mmHg compression stockings for BLE (both lower extremities) and send with patient to next visit. Do Not Apply" was documented.

Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for knee high compression socks, apply in the morning and remove in the evening, scheduled for 8:00am and 8:00pm.
-Compression socks were documented for application on 01/19/21 at 8:00am, removal at 8:00pm; and on 01/20/22 application on 01/20/22 at 8:00am.

Review of Resident #6's physician's after visit summary dated 01/20/22 revealed there was information regarding the use of compression

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stocking included with the summary.

Review of Resident #6's wound care progress notes dated 01/20/22 revealed "We will also order 20 to 30 mmHg compression stockings and see if the nursing staff at the memory care unit will be able to help him with these".

Interview with the Special Care Unit Coordinator (SCUC) on 01/20/22 at 12:00pm revealed:
-Resident #6's compression stockings were ordered from the contracted pharmacy on 01/13/22.
-The pharmacy was responsible to add medication and treatment orders to the eMAR.
-The pharmacist told her that the pharmacy added the order for compression stockings on 01/13/22 but overlooked adding the stockings should not be applied until directed by the wound center per the order.
-The hold order was not applied to the eMAR.
-She was responsible for double checking orders entered by the pharmacy but missed seeing the pharmacy did not add to hold the order to the instructions.
-Resident #6's compression stockings were received late by the facility on 01/18/22 and were applied per the entry on the eMAR beginning on 01/19/22.
-MAs applied the compression stockings according to the eMAR entry because the compression stockings were received and were on the eMAR for administration.

Telephone interview with Resident #6's primary care provider on 01/21/22 at 10:10am revealed:
-Resident #6 had been treated off and on for years for wounds on his legs.
-The order to hold the compression stockings until the wound care center notified the facility to

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D 358	Continued From page 55 apply certainly sounded reasonable; the facility must have missed it. 3. Review of Resident #3's current FL2 dated 07/28/21 revealed: -Diagnoses included dementia, encephalopathy, and hypertension. -There was an order for Pravachol 20mg (used to treat symptoms of high cholesterol) 1 tablet at bedtime. a. Review of Resident #3's electronic Medication Administration Record (eMAR) for November 2021 revealed: -There was an entry for Pravachol 20mg 1 tablet at bedtime scheduled for administration at 9:00pm. -Pravachol 20mg was documented as administered for 30 of 30 opportunities. -There was no entry for Pravachol 40mg. Review of Resident #3's eMAR for December 2021 revealed: -There was an entry for Pravachol 20mg 1 tablet at bedtime scheduled for administration at 9:00pm. -Pravachol 20mg was documented as administered for 31 of 31 opportunities. -There was no entry for Pravachol 40mg. Review of Resident #3's eMAR for January 2022 revealed: -There was an entry for Pravachol 20mg 1 tablet at bedtime scheduled for administration at 9:00pm. -Pravachol 20mg was documented as administered for 22 of 23 opportunities. -Pravachol 20mg was documented as not administered on 01/06/22 due to Resident #3 being at the hospital.	D 358		

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-There was no entry for Pravachol 40mg.

Observation of Resident #3's medications on hand on 01/20/22 at 4:45pm revealed:
-There was a bottle of Pravachol 40mg 1 tablet daily.
-Pravachol 40mg was dispensed to the facility on 11/19/21 with a quantity of 90 tablets and it could not be determined how many tablets were remaining.
-Pravachol 20mg was not available for administration on the medication cart.

Observation of Resident #3's medications on hand on 01/24/22 at 3:53pm revealed:
-Pravachol 20mg was not available on the medication cart.
-Pravachol 40mg tablets 1 tablet daily was available on the medication cart and there were 85 of 90 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 01/21/22 at 1:01pm revealed:
-There was a past order for Pravachol 40mg dated 07/20/20; this order was discontinued on 03/24/21.
-There was a current order for Pravachol 20mg dated 03/24/21 written by Resident 3's previous Primary Care Provider (PCP).
-Pravachol 20mg was dispensed on 11/15/21 and 12/09/21 with a quantity of 30 tablets on each date.
-The facility requested refills of Pravachol 20mg on 11/15/21 and 12/09/21.
-There were no other dispense dates after 12/09/21.

Telephone interview with Resident #3's pharmacy on 01/24/22 at 1:18pm revealed:

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D 358	Continued From page 57 -There was an order dated 11/18/21 for Pravachol 40mg 1 tablet once daily dispensed to the facility on 11/18/21. -There were no other dispensed dates for Pravachol 40mg. -Pravachol 40mg would have to be reordered. Telephone interview with Resident #3's previous PCP on 01/25/21 revealed he could not confirm whether Resident #3 should have been administered Pravachol 20mg or Pravachol 40mg. Telephone interview with Resident #3's primary care physician (PCP) on 01/25/22 at 10:36am revealed: -Resident #3 should have been administered Pravachol 40mg 1 tablet daily for hyperlipidemia. -The PCP did not know Resident #3 was not being administered Pravachol 40mg as ordered. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Interview with a Medication Aide (MA) on 01/20/22 at 4:46pm revealed: -Resident #3's responsible party brought in all her medication. -There were 40mg tablets of Pravachol on the medication cart. -There were not any 20mg tablets of Pravachol on the medication cart. -She last administered Pravachol 20mg to Resident #3 on 01/19/22 or 01/18/22. -She told the Special Care Unit Coordinator (SCUC) a few days ago Resident #3 was out of Pravachol 20mg so the SCUC could contact the Resident #3's family member to bring in more Pravachol 20mg.	D 358		

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-She did not administer the 40mg tablets of Pravachol because the order for 20mg was on the eMAR.

Interview with the SCUC on 01/24/22 at 3:20pm revealed:
-Resident #3's responsible party requested to get Resident #3's medication at a pharmacy different than the facility's contracted pharmacy.
-The facility was having problems with getting medications from the other pharmacy.
-She told Resident #3's responsible party she was going to start using the facility's contracted pharmacy again due to the issues with receiving medications.
-According to the eMAR, Resident #3 should be on Pravachol 20mg.
-She did not know there was a current order for Pravachol 40mg.
-She did not know the order for Pravachol on the eMAR was for 20mg and the medication on the cart was 40mg.
-The MAs were responsible for comparing the medications dispensed to the facility to the order for medication on eMAR.
-No one told her that Pravachol 20mg on Resident #3's eMAR did not match the order for Pravachol 40mg on the medication cart.
-Resident #3 used to be on Pravachol 40mg (she did not remember when), but it was changed to 20mg.
-The facility had not been out of Pravachol 20mg that long, but there was no documentation of when the 20mg ran out and there was no documentation of the conversations with Resident #3's responsible party.
-She contacted Resident #3's responsible party on last Friday, 01/21/22, and she was supposed to bring in the Pravachol 20mg on Friday.
-Staff did not let her know Resident #3's

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responsible party did not bring in the Pravachol 20mg on 01/21/22.
-If she had known the Pravachol 20mg was not brought to the facility, she would have contacted the facility's contracted pharmacy to order the Pravachol 20mg.
-She was responsible for clarifying medication orders with residents' physicians. She did not remember contacting Resident #3's PCP regarding the order for Pravachol 20mg and Pravachol 40mg.
-She was responsible for sending new orders to the pharmacy so the medication order could be entered and updated on the eMAR.

Telephone interview with Resident #3's responsible party on 01/25/22 at 9:28am revealed:
-Initially, the facility was filling the prescriptions through their pharmacy, but she kept receiving bills.
-She moved Resident #3's medication to a different pharmacy who was delivering them to the facility and the facility stated they were having trouble with the deliveries.
-She was now responsible for picking up and delivering medication to the facility for Resident #3 through a third pharmacy.
-She was contacted by the SCUC two weeks ago to refill Resident #3's Depakote, Vitamin B12, and one other medication, but she could not remember which one; she delivered the requested medications to the facility.
-The SCUC called her on last Thursday, 01/20/22, or last Friday, 01/21/22, about Resident #3's order for Pravachol.
-The SCUC requested that she refill Pravachol 20mg for Resident #3 and asked if she was supposed to be on 20mg or 40mg.
-She emailed Resident #3's PCP to clarify

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D 358	Continued From page 60 whether Resident #3 should be administered 20mg or 40mg and was told she should be on Pravachol 40mg. -The facility had not contacted her prior to last week regarding Pravachol Telephone interview with a medication aide (MA)/personal care aide (PCA) on 01/25/22 at 11:02am revealed: -She worked the previous weekend and Resident #3 was out of Pravachol 20mg. -She did not administer Pravachol 40mg because the order on the eMAR was for Pravachol 20mg. -She tried to reorder Pravachol 20mg through the eMAR system, but there was a note that Pravachol was in the process of being reordered. -Resident #3's responsible party brought her medication to the facility, but she did not know when she was notified that she needed Pravachol 20mg. Telephone interview with the Administrator on 01/25/22 at 4:12pm revealed: -She did not know the Pravachol 40mg which was on the medication cart differed from the order for Pravachol 20mg on Resident #3's eMAR. -She expected staff to reorder medications for residents within 7 to 10 days prior to the medications running out. -Staff should contact Resident #3's responsible party within 7 to 10 days prior to her medications running out so she could bring the medication to the facility. -The facility's contracted pharmacy would not refill medication for Resident #3 because Resident #3's responsible party voided the contract with the facility's contracted pharmacy in January 2022. -The facility could not do anything about Resident #3 not being administered her medication if her	D 358		

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responsible party did not bring her medications into the facility.
-The SCUC was responsible for comparing the medications received in the facility to the medication orders entered on the eMAR and following up with the resident's physician if there were discrepancies.

b. Review of Resident #3's current FL2 dated 07/28/21 revealed:
-Diagnoses included dementia, encephalopathy, and hypertension.
-There was an order for Metamucil 0.52 grams (used to treat constipation) 1 capsule at bedtime.

Review of Resident #3's electronic Medication Administration Record (eMAR) for November 2021 revealed:
-There was an entry for Metamucil 0.52 grams 1 capsule at bedtime scheduled for administration at 9:00pm.
-Metamucil was documented as administered for 30 of 30 opportunities.

Review of Resident #3's eMAR for December 2021 revealed:
-There was an entry for Metamucil 0.52 grams 1 capsule at bedtime scheduled for administration at 9:00pm.
-Metamucil was documented as administered for 30 of 30 opportunities.

Review of Resident #3's eMAR for January 2022 revealed:
-There was an entry for Metamucil 0.52 grams 1 capsule at bedtime scheduled for administration at 9:00pm.
-Metamucil was documented as administered for 22 of 23 opportunities.
-Metamucil was documented as not administered

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 62 on 01/06/22 due to Resident #3 being at the hospital. Observation of Resident #3's medications available for administration on 01/20/22 at 4:45pm revealed Metamucil 0.52 grams 1 capsule at bedtime was not available on the medication cart. Telephone interview with the facility pharmacy on 01/21/22 at 1:01pm revealed: -There was an order dated 03/24/21 for Metamucil 0.54 grams 1 capsule daily. -Metamucil was dispensed on 11/15/21 with a quantity of 30 tablets and on 12/08/21 with a quantity of 30 tablets. -There were no requests to refill Metamucil in January 2022. Telephone interview with Resident #3's pharmacy on 01/24/22 at 1:18pm revealed there were no current orders for Metamucil capsules. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Interview with a Medication Aide (MA) on 01/20/22 at 4:46pm revealed: -Resident #3's responsible party brought in all her medication. -She told the Special Care Unit Coordinator (SCUC) a few days ago Resident #3 was out of her Metamucil so the SCUC could get in touch with the resident's responsible party to bring in more. Interview with the SCUC on 01/24/22 at 3:20pm revealed: -Resident #3's responsible party requested to get	D 358		

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D 358	Continued From page 63 Resident #3's medication at a pharmacy different that the facility's contracted pharmacy. -The facility was having problems with getting medications from the other pharmacy. -She told Resident #3's responsible party she was going to start using the facility's contracted pharmacy again due to the issues with receiving medications. -She did not know Resident #3 did not have Metamucil available on the medication cart for administration. -She contacted Resident #3's responsible party on 01/20/22 and she was supposed to bring medication to the facility on 01/21/22. -Staff did not let her know Resident #3's responsible party did not bring in Metamucil capsules on 01/21/22. Telephone interview with Resident #3's responsible party on 01/25/22 at 9:28am revealed: -Initially, the facility was filling the prescriptions through their pharmacy, but she kept receiving bills. -She moved Resident #3's medication to a different pharmacy who was delivering them to the facility and the facility staff stated they were having trouble with the deliveries. -She was now responsible for picking up and delivering medication to the facility for Resident #3 through a third pharmacy. -She was contacted by the SCUC two weeks ago to refill Resident #3's other medications, but she could not remember which ones; she delivered the requested medications to the facility. -The SCUC called her on last Thursday, 01/20/22, or last Friday, 01/21/22, about Resident #3's Metamucil. -The facility had not contacted her prior to last week regarding Metamucil.	D 358		

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D 358	Continued From page 64 Telephone interview with a medication aide (MA)/personal care aide (PCA) on 01/25/22 at 11:02am revealed: -She worked the previous weekend and Resident #3 was out of Metamucil. -She tried to reorder Metamucil .52 grams through the eMAR system, but there was a note that Metamucil was in the process of being reordered. -Resident #3's responsible party brought her medication to the facility, but she did not know when the responsible party was notified Resident #3 needed Metamucil. Telephone interview with Resident #3's primary care physician (PCP) on 01/25/22 at 10:36am revealed: -Resident #3 should be on Metamucil .52 grams 1 capsule daily; this order was changed to 1 capsule daily as needed on 01/24/22. -The PCP did not know Resident #3 had not been administered Metamucil capsules daily as previously ordered. Telephone interview with the Administrator on 01/25/22 at 4:12pm revealed: -She did not know Resident #3's Metamucil capsules were not available on the medication cart for daily administration. -She expected staff to reorder medications for residents within 7 to 10 days prior to the medications running out. -Staff should contact Resident #3's responsible party within 7 to 10 days prior to her medications running out so she could bring the medication to the facility. -The facility's contracted pharmacy would not refill medication for Resident #3 because Resident #3's responsible party voided the contract with	D 358		

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D 358	Continued From page 65 the facility's contracted pharmacy in January 2022. -The facility could not do anything about Resident #3 not being administered her medication if her responsible party did not bring her medications into the facility. -The SCUC was responsible for comparing the medications received in the facility to the medication orders entered on the eMAR and following up with the resident's physician if there were discrepancies.	D 358		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by	D 612	**D612** Administrator will make sure all proper Forms and guidelines are put in place to Make sure all staff are following all CDC And DHHS guidelines on proper screening, Documentation, and wearing the masks properly. Administrator will make sure this documentation and Policy is being followed daily.	2/21/2022

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D 612	Continued From page 66 the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to Assisted Living (AL) and Special Care Unit (SCU) residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Nursing Homes and Long-Term Care Facilities dated 09/10/21 revealed staff should wear source control when they are in areas of the healthcare facility where they could encounter residents and a facemask should not be worn under the nose or mouth. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 09/10/21 revealed: -Source control measures were to be implemented for Healthcare Personnel. -Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when the person was breathing, talking, sneezing, or coughing. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. -Staff were to be screened upon arrival at the facility.	D 612		

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D 612	Continued From page 67	D 612		

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities updated 11/19/21 revealed:
-Facilities should adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.
-All staff should be screened for symptoms prior to every shift.

Review of the facility's Infection Prevention and Control Policy and Procedures dated 05/01/17 revealed:
-Surgical masks or cloth masks depending on availability needed to be worn by all staff at all times.
-Masks were to be put on before entering the building.
-There was no information on how to wear facemasks.

Interview with the Administrator on 01/19/22 at 1:12pm revealed:
-The facility had 3 residents that tested positive for COVID-19 on 12/28/21.
-The facility contacted the infection control nurse at the local health department (LHD) on 12/28/21 to report the outbreak.
-The facility began weekly testing of negative residents and staff per instruction of the LHD, and tracking COVID-19 cases within the facility.
-The facility had 4 residents and no staff positive for COVID-19 on 01/04/22.

Interview with the Administrator on 01/24/22 at 11:00am revealed:
-The facility retested residents and staff who had previously tested negative on 01/13/22 and 01/20/22 with no new cases of COVID-19

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identified.
-There were no residents on quarantine as of 01/14/22 (10 days after the last positive test).

Attempted telephone interview with the local health department on 01/19/22 at 8:31am was unsuccessful.

1. Observation of the assisted living (AL) side of the facility and the Special Care Unit (SCU) on 01/24/22 between 3:10pm and 3:19pm revealed:
-The Special Care Unit Coordinator (SCUC) was observed on the AL side without a mask and then walked to the SCU.
-The SCUC was approached by a resident as she was entering her office in the SCU and met with the resident in her office while continuing not to wear a mask.

Interview with the Special Care Unit Coordinator (SCU) on 01/24/22 revealed:
-Staff were supposed to wear masks when they entered the facility and she usually wore her mask anytime she was outside of her office.
-She forgot to put her mask on in the AL side of the facility and on the SCU.

Observation on the AL side of the facility on 01/24/22 at various times between 9:05am and 5:49pm revealed:
-At 9:05am, there was staff walking down the hall with her mask below her nose and chin.
-At 9:09am, there were two staff at the nurse's station with no masks on.
-At 10:59am, there were 3 staff sitting behind the nurse's station with no mask on.
-At 11:00am, there were 2 staff walking down the hallway with no masks on.
-At 12:22pm, the Administrator was walking through the halls with no mask on and interacting

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D 612	Continued From page 69	D 612		

with residents.
-At 12:37pm, a housekeeper was walking down the hall with her mask below her chin.
-At 5:48pm, a housekeeper was standing in the doorway of a resident's room with no mask on.
-At 5:49pm, a staff brought the housekeeper a mask.

Observation of the SCU on 01/24/22 at 4:13pm revealed the Administrator was in the hallway near the medication cart with her mask below her nose and mouth.

Interview with a MA on 01/24/22 at 4:47pm revealed she did not have a mask on at the nurse's station because she pulled it down so she could breath.

Interview with the Director of Maintenance on 01/24/22 at 4:51pm revealed:
-He felt like it was his right whether he wanted to wear a mask or not.
-He did not know what the facility policy was regarding wearing a mask.
-He tried to keep his mask on, but he forgot to put it on from time to time.

Interview with a housekeeper on 01/24/22 at 5:49pm revealed:
-She was not wearing a mask because she left her mask in the car.
-She usually came into the facility with a mask or put one on once she entered the facility.

Interview with the Administrator on 01/24/22 at 5:52pm revealed:
-The proper way to wear a mask was to cover the nose and the mouth.
-She did not see anything wrong with staff taking their masks down below their nose and mouth as

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D 612	Continued From page 70 long as they could social distance. -"If staff social distance 4 to 6 feet apart and want to pull their mask down to take a breather that's okay." -She could not stop staff from pulling their masks down below their noses and mouths. -Staff wore their masks 90% of the time. -"If my people can't breathe, then they need to pull it down. I can not tell my people they can not pull their mask down if they can not breathe." -She had staff who were not able to breathe, and emergency medical services had to be called. -She was familiar with the latest COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 11/19/2021 and had shared the guidance with her staff. 2. Review of the Health Personnel Screening logs for January 2022 revealed: -The screening log was kept at the nurse's station and there was a thermometer on the wall near the log. -There was a space to record staff's name, temperature, and symptoms of COVID-19. -Temperatures over 100.4 and/or other symptoms listed restrict entrance. -There was a screening log dated 01/03/22 and there was 1 staff name, temperature and documentation of no symptoms of COVID-19. -There was a screening log dated 01/04/22 and there was 1 staff name, temperature and documentation of no symptoms of COVID-19. -There was a screening log dated 01/11/22 and there were 2 staff names, temperatures and documentation of no symptoms of COVID-19. -There was a screening log dated 01/21/22 and there was 1 staff name, temperature and documentation of no symptoms of COVID-19. -There was a screening log dated 01/11/22 and there were 4 staff names, temperatures and	D 612		

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documentation of no symptoms of COVID-19.
-There were no other staff screening logs for the month of January 2022.

Interview with the Special Care Unit Coordinator (SCU) on 01/24/22 revealed:
-She clocked in and took her temperature at the front desk.
-She did not complete a COVID-19 screening form when she signed in and no one asked her screening questions.
-She had COVID-19 training at the beginning of the pandemic in 2020.

Interview with the Director of Maintenance on 01/24/22 at 4:51pm revealed:
-Staff entered the facility through a side entrance and took their temperatures by the nurse's station.
-He checked his temperature when he entered the facility to screen for COVID-19.
-He did not complete a screening questionnaire, and no one asked him questions when he arrived to work.

Interview with the medical records staff on 01/24/22 at 4:55pm revealed:
-When staff entered the facility, they were to wash their hands, take their temperatures, and complete the screening log.
-She did not know why all staff had not completed screening for COVID-19 daily prior to the start of their shift.

Interview with a housekeeper on 01/24/22 at 5:49pm revealed:
-When she entered the facility, she clocked in and took her temperature.
-If her temperature was over 96.1, she would tell someone.

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D 612	Continued From page 72 -She did not complete a COVID-19 screening form, and no one asked her screening questions. Interview with the Administrator on 01/24/22 at 5:52pm revealed: -When staff entered the facility, she expected them to take their temperature, wash their hands and if they have symptoms fill out a screening form. -If staff was not having any symptoms of COVID-19, they did not have to complete a screening form. -All residents and staff had been vaccinated. -She was familiar with the latest COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 11/19/2021 and had shared the guidance with her staff. ______________________ The facility failed to implement and maintain the most recent COVID-19 guidance from the NC DHHS and the CDC which resulted in staff not wearing facemasks or wearing facemasks incorrectly, and staff not screening for COVID-19. This failure 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 01/24/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2022.	D 612		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:	D911		

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D911	Continued From page 73 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, dignity, and full recognition of his or her right to privacy related to a resident wandering in and out of other residents' rooms and to other residents' tables during meals (#3) and residents were not provided tables for in-room dining. 1. Review of Resident #3's current FL2 dated 07/28/21 revealed: -Diagnoses included dementia. -Resident #3 was ambulatory and intermittently disoriented. Review of Resident #3's care plan dated 07/27/21 revealed: -Resident #3 did not require any assistance with ambulation or transfers. -Resident #3 went in and out of other residents' rooms and had to be redirected by staff. Observation of the Special Care Unit (SCU) on 01/20/22 between 12:26pm and 12:40 revealed: -Resident #3 finished her meal in the dining area then got up and wandered around the dining room. -She went to the table of 2 residents who were eating and touched one of the resident's plates. -She picked up a cup from the table of another resident. -She wandered the hallways. Interview with a SCU resident on 01/19/22 at	D911	**D911** THE COORDINATOR WILL REVIEW ALL RESIDENTS CURRENT CONDITIONS TO IDENTIFY ANY RESIDENT THAT IS NEEDING INCREASED SUPERVISION INCLUDING ROUTINE 15 MINUTE CHECKS AND / OR ADDITIONAL SUPERVISION ALL WHILE BEING IN COMMUNICATION WITH THE RESIDENTS PHYSICIAN. THE RESIDENT CARE STAFF WILL DOCUMENT ALL CHECKS IN THE APPROPRIATE BINDERS ADHEARING TO FACILITY POLICY. STAFF WILL ALSO BE EDUCATED BY THE ADMINISTRATOR THAT IF A RESIDENT IS FINISHED WITH A MEAL, THE RESIDENT IS TO RETURN TO THE HALL OR FAMILY ROOM WITH OTHER RESIDENTS AND STAFF OR CAN REMAIN IN THE DINING ROOM TO CONTINUE TO CONVERSATE WITH OTHERS AS LONG AS RESIDENT IS NOT INTERUPTING OTHER RESIDENTS MEAL TIME. ADMINISTRATOR WILL MONITOR WEEKLY TO MAKE SURE THAT ALL SUPERVISION CHECKS ARE BEING COMPLETED.	2/21/2022

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D911	Continued From page 74 12:09pm revealed Resident #3 came into her room all times of the day and night and she did not like it. Interview with two SCU residents on 01/19/22 at 4:37pm revealed: -Resident #3 wandered into one of the residents' rooms often. -Both residents were in a room reading the Bible when Resident #3 came in and she did not want to get out; no staff came in to get Resident #3 out of her room on that day. -"She will hit you." Telephone interview with a resident's responsible party on 01/24/22 at 4:37pm revealed: -Residents wandering into her family member's room was her main concern. -She was concerned about residents coming in her family member's room and "messing with her things" and possibly spreading COVID-19. -Her family member should have the right to her privacy. Interview with two additional SCU residents on 01/24/22 between 6:13pm and 6:31pm revealed: -Staff did not seem to do anything about other residents coming in their rooms. -One resident was tired of people coming in her room all hours of the night; a resident came in her room all the time and it was a "nuisance". Telephone interview with a medication aide (MA)/personal care aide (PCA) on 01/25/22 at 11:02am revealed: -Resident #3 wandered in and out of other residents' rooms. -When she went into other residents' rooms, she sometimes sat on their bed or chair, but staff redirected her.	D911		

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	HAL034098	A. BUILDING: ______ B. WING ______	R-C 01/25/2022

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

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-During meals, Resident #3 sometimes walked to other residents' tables and looked over their shoulders, but she did not try to eat anyone's food.
-She only knew of one resident who complained about Resident #3 coming into their room throughout the night.

Telephone interview with a MA on 01/25/22 at 4:04pm revealed:
-Resident #3 wandered in and out of other residents' rooms and wandered in the dining hall during meals.
-There were two residents who she knew of who complained about Resident #3 coming in their room unannounced and coming up to their tables during meals.
-There were no other residents whom she knew of who complained.
-When Resident #3 wandered into other residents' rooms and around the dining room, staff redirected her.

Telephone interview with the Administrator on 01/25/22 at 4:12pm revealed:
-Resident #3 wandered through the halls and into other residents' rooms, but she was not a threat to any of the residents.
-All residents go into each others' rooms and to each others' table during meals.
-When staff noticed them, the residents were redirected.

2. Interview with a resident on 01/19/22 at 11:50am revealed:
-The residents were served meals in their rooms.
-The residents held resident council meetings in the dining room but did not eat in there.

Interview with a second resident on 01/19/22 at

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D911	Continued From page 76 11:58am revealed: -The dining room was only open for special occasions. -The residents were eating meals in their rooms. Interview with a third resident on 01/19/22 at 12:02pm revealed the dining room was still closed. Observation of a resident on 01/19/22 at 12:02pm revealed he was eating his food out of a container on his lap while sitting in a wheelchair. Observation of another resident on 01/19/22 at 12:08pm revealed the resident was eating lunch sitting on his bed in his room. Interview with a fourth resident on 01/19/22 at 12:12pm revealed: -The dining room was closed and had been for a long time. -The residents ate meals in their rooms. Interview with a fifth resident on 01/19/22 at 12:16pm revealed: -The dining room was still closed. -The residents ate meals in their rooms. Interview with a sixth resident on 01/19/22 at 12:25pm revealed the residents ate meals in their rooms and not in the dining room. Observation of a resident in the resident's room on 01/19/22 at 12:25pm revealed that the resident had spilled some of the food from lunch on the floor. Interview with a seventh resident on 01/19/22 at 12:28pm revealed the dining room had been closed for about two years.	D911		

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Interview with an eighth resident on 01/19/22 at 12:32pm revealed the dining room was closed.

Interview with a ninth resident on 01/19/22 at 12:50pm revealed the dining room was closed and the residents ate meals in their rooms.

Interview with a tenth resident on 01/19/22 at 12:53pm revealed the dining room was closed.

Interview with an eleventh resident on 01/19/22 at 1:06pm revealed the dining room was closed and the residents ate meals in their rooms.

Interview with two additional residents on 01/24/22 between 3:46pm and 3:59pm revealed that the two residents ate meals off of their bed.

Interview with a cook on 01/24/22 at 2:58pm revealed:
-The dining room had been closed since the beginning of the pandemic, for about two years.
-The facility was doing construction repairs on the dining room that were now completed.

Interview with the Director of Resident Care (DRC) on 01/24/22 at 5:00pm revealed:
-A lot of the residents chose not to eat in the dining room.
-The residents were able to eat in the dining room if they wanted.
-About 75% of the residents did not want to use the dining room.
-He told the residents that they could eat in the dining room.

Interview with the Administrator on 01/24/22 at 5:15pm revealed:
-Most of the residents said that they preferred to

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D911	Continued From page 78 eat in their room when there was discussion about reopening the dining room. -The facility would have to do two meal service times in order to properly socially distance in the dining room on the Assisted Living side of the facility. -The residents only wanted one meal service time. Telephone interview with the Administrator on 01/25/22 at 5:25pm revealed: -The dining room was not closed. -She was unable to get bedside tables for the residents. -She would have to have an order for bedside tables. -The facility planned to resume serving food on regular silverware and plates once they were out of COVID-19 outbreak status. -The residents did not want to eat in the dining room. -She would encourage residents to eat in the dining room once the COVID-19 outbreak status had ended.	D911		
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 observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate,	D912	**D912** Resident Care Management and Resident Care Staff were instructed on Resident Rights by the Administrator. The State Ombudsman has been asked to come to do a formal in-service on Resident Rights.	2/21/2022

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appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, personal care and supervision, and infection prevention and control program.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 residents sampled (#3 and #5) related to a resident who had multiple falls in 3 months resulting in injuries and 10 emergency department (ED) visits (#5) and a resident who wandered into other residents' rooms and wandered around the dining room during the lunch meal touching other residents' plates (#3). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 6 sampled residents (Residents #4 and #6) related to not notifying the primary care provider (PCP) and wound treatment center when the resident removed wound dressings on bilateral lower leg wounds (#6) and not notifying the PCP for a recent blister to the lower right leg (#4). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].

3. Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to Assisted

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D912	Continued From page 80 Living (AL) and Special Care Unit (SCU) residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff. [Refer to Tag 0612, 10A NCAC 13F .1801(c) Infection Control and Prevention (Temp) (Type B Violation)].	D912		