STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 01/15/20 through 01/17/20. The complaint was initiated on 12/14/20 by the Forsyth County Department of Social Services.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to provide supervision needed for 1 of 5 sampled residents (Resident #1) with a diagnosis of schizophrenia and had destructive behaviors and injurious to herself. The findings are: Review of Resident #1's current FL2 dated 12/05/19 revealed: -Diagnoses included schizophrenia, Alzheimer's dementia, diabetes mellitus type II, chronic obstructive pulmonary disease, hepatitis C, thrombocytopenia and osteoarthritis.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ___ B. WING ___	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 1	D 270		

-Resident #1 was constantly disoriented.
-Resident #1's recommended level of care was memory care unit (MCU).

Review of Resident #1's Care Plan dated 12/31/19 revealed:
-Resident #1 required supervision with toileting.
-Resident #1 required limited assistance with ambulation, bathing, dressing, grooming, and transfers.
-Resident #1 was injurious to self and property.

Review of Resident #1's quarterly profile dated 01/07/20 revealed:
-Resident #1's behavior pattern was verbally abusive, with screams and aggression.
-Resident #1 was incontinent and required staff assistance with toileting needs and hygiene.
-Resident #1 required limited assistance with bathing, dressing, grooming and hygiene, and transferring.

Review of Resident #1's progress note dated 09/03/19 at 2:12pm revealed Resident #1 was agitated and started arguing with other residents.

Review of Resident #1's progress note dated 09/11/19 at 2:47pm revealed Resident #1 had a vase with rocks and bowel movement (BM) in the vase. The resident told staff the rocks and BM came out of her.

Review of Resident #1's Body Evaluation and Observation sheet dated 09/19/19 revealed the resident had bruises on the right side of her face. There was no documentation how the bruises occurred.

Review of Resident #1's Body Evaluation and Observation sheet dated 09/26/19 revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 2	D 270		

resident had bruises on her face. There was no documentation how the bruises occurred.

Review of Resident #1's progress note dated 09/27/19 at 3:35pm revealed Resident #1 became combative and tried to choke staff. The resident was sent to the hospital for mental health evaluation.

Review of Resident #1's hospital discharge summary report dated 09/27/19 revealed Resident #1 was seen for aggressive behavior and pain of left lower extremity.

Review of an incident report for Resident #1 dated 10/25/19 revealed the resident was observed breaking items in her room and complaining of hallucinations.

Review of Resident #1's hospital discharge summary report dated 10/25/19 revealed Resident #1 was seen for aggressive behaviors, hallucinations, agitation and delusions. The resident reported she was treated poorly at the facility and reacted by throwing everything in her room. It was recommended the resident to be transferred to a local acute geriatric psychiatric hospital.

Review of Resident #1's progress note dated 10/25/19 at 1:14pm revealed Resident #1 was observed damaging items in her room, pulling blinds off the wall and pulling the mattress off the bed. The resident told staff her mattress was full of blood and snakes. The physician was not notified.

Review of an incident report for Resident #1 dated 11/01/19 revealed the resident was in an altercation with another resident and was thrown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 3	D 270		

Continued From page 3

to the floor. The resident complained of hip pain and was sent to the hospital. The resident had a contusion of the left hip.

Review of Resident #1's progress note dated 11/01/19 at 2:31pm revealed Resident #1 was observed in an altercation with another resident and got thrown into the floor.

Review of Resident #1's progress note dated 11/04/19 at 2:24pm revealed Resident #1 staff observed Resident #1 lying in the floor and appeared to have fallen while trying to get into her wheelchair. The resident did not go out to the hospital.

Review of Resident #1's progress note dated 11/11/19 at 1:17pm revealed Resident #1 was observed moving the furniture in her room and removing her mattress.

Review of Resident #1's progress note dated 11/15/19 at 3:25pm revealed Resident #1 family member arrived, and the resident's room was a mess. The Director of Resident Care (DRC) wrote on the progress note that Resident #1 moved her room around, pulled her clothes out throwing them around the room and pulled all the sheets off her bed throwing them around the room.

Review of Resident #1's progress note dated 11/19/19 at 5:57pm revealed Resident #1 had BM on her hands, fingers, socks and clothes. The resident continued to have delusions that things were in her rectum. The resident was placing her fingers in her rectum and digging.

Review of Resident #1's hospital discharge summary report dated 11/20/19 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 4	D 270		

Resident #1 was seen for altered mental status and to obtain an ammonia level. The ammonia level was "normal".

Interview with Resident #1's Mental Health Provider (MHP) on 01/16/20 at 10:06am revealed:
-She was notified that Resident #1 was having more aggressive behaviors, screaming loudly, throwing things, and crying.
-She was aware that sometimes when the ammonia level was high a person with mental health behaviors can exhibit more aggressive behaviors.
-She suggested the facility send Resident #1 to the hospital to have her ammonia level tested.
-The ammonia level came back normal.

Review of Resident #1's Body Evaluation and Observation sheet dated 11/21/19 revealed the resident had scabs on her back and bruises on her side. There was no documentation how the resident obtained the bruises.

Review of Resident #1's Body Evaluation and Observation sheet dated 11/24/19 revealed the resident had bruises purple and red on her arm and buttocks. There was no documentation how the resident obtained the bruises.

Review of Resident #1's progress note dated 11/26/19 at 3:47pm revealed Resident #1 had pulled her bed apart and trash was thrown about the room. The DRC documented on the progress note that Resident #1 tore the room apart two to three times per day.

Review of Resident #1's Body Evaluation and Observation sheet dated 11/28/19 revealed the resident had bruises on her arm and buttocks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 5	D 270		

There was no documentation how the resident obtained the bruises.

Review of Resident #1's Body Evaluation and Observation sheet dated 11/30/19 revealed the resident's bottom was red and she had scratches on her back. There was no documentation how the resident obtained the scratches on her back.

Review of Resident #1's progress note dated 12/01/19 at 5:52pm revealed Resident #1 was lying in the floor and wouldn't get up because she was in too much pain.

Review of Resident #1's progress note dated 12/02/19 at 9:15am revealed Resident #1 pulled items off the counter and her bed throwing things in the floors.

Review of Resident #1's progress note dated 12/03/19 at 12:43pm revealed Resident #1 was observed playing in her own feces, wrapped the dirty incontinent brief around her foot. The resident would not allow staff to assist in cleaning the room or her.

Review of an incident report dated 12/11/19 revealed Resident #1 was complaining of back pain and was sent to the hospital.

Review of Resident #1's hospital discharge summary report dated 12/11/19 revealed Resident #1 had a fall a few days ago that was described as falling out of a wheelchair. Resident #1 had a contusion to her left forehead/temple region from that fall.

Interview with the Memory Care Manager (MCM) on 01/16/20 at 4:11pm revealed:
-She was responsible for monitoring staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 6	D 270		

ensure they were doing what they were supposed to do.
-On 12/11/19, she sent Resident #1 to the hospital because the resident complained of back pain.
-When Resident #1 returned from the hospital she did not read the discharge report.
-She did not know if X-rays were completed at the hospital or not.
-The resident had orders for treatment of a urinary tract infection and she assumed that was the cause of the resident's back pain.
-She did not know why the hospital report documented the resident had a fall.
-She had not considered Resident #1 might have fractures.

Review of Resident #1's Body Evaluation and Observation sheet dated 12/12/19 revealed the resident had redness on buttocks and scrapes on her back and bruises on her right arm.

Review of Resident #1's progress note dated 12/14/19 at 6:50am revealed the MA changed Resident #1's soiled bed and the resident complained about back pain all night long.

Review of Resident #1's progress note dated 12/15/19 at 2:15pm revealed the resident complained of pain in her hips.

Review of Resident #1's progress note dated 12/17/19 at 2:38pm revealed the resident was in bed with no clothes on. The resident had taken all the sheets off the bed and thrown the pillows and trash all over the floor.

Review of Resident #1's Body Evaluation and Observation sheet dated 12/17/19 revealed the resident had red "dots" on her chest.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	**3150 BURKE MILL ROAD WINSTON SALEM, NC 27103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 7	D 270		

Review of Resident #1's hospital report dated 01/11/20 revealed:
-Resident #1 was admitted to the hospital due to pneumocystis coli, rectal prolapsed, multiple pelvic and rib fractures.
-Resident #1's multiple rib and pelvic fractures raised potential for clinical concern about neglect or abuse.
-Resident #1 had extensive fracturing of the sacrum and associated bilateral pubic rami fractures in various stages of healing.
-It was likely Resident #1 sustained additional fractures one week ago resulting from a fall reported by the resident.
-The hospital report documented "there was a concern for potential abuse/assault, and it does seem unlikely that simple falls may result in such extensive old and new injuries".
-Resident #1 reported she did not want to go back to the facility because staff was mean to her and staff had thrown her down and hit her.

Interview with the case manager at local hospital on 01/15/20 at 3:11pm revealed:
-When Resident #1 came to the hospital on the morning of 01/11/20, the attending nurse and physician both reported to her they suspected neglect and abuse.
-The medical staff reported the resident had multiple old and new fractures that were doubtful obtained from simple falls.

Interview with a third shift personal care aide (PCA) on 01/15/20 at 2:34pm revealed:
-On 01/11/20 around 5:00am, she observed Resident #1 sitting in her wheelchair outside her room door.
-The resident asked for her for assistance.
-She observed Resident #1's pants and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 8	D 270		

incontinent brief were on, but only pulled to up midway of the resident's legs.
-She took the resident back to her room and when the resident stood up there was blood all over the pillow that was in the wheelchair.
-There was also blood coming from the resident's rectum.
-Resident #1 stated she had been trying to get the tissue out of her rectum.
-She yelled for the PCA that was in another resident's room.
-When the PCA came and saw the blood she yelled for the medication aide (MA).
-Resident #1 did not complain of pain.

Interview on 01/15/20 at 4:32pm with the third shift MA in the memory care unit (MCU) revealed:
-Resident #1 had not walked since November 2019 when she was thrown to the floor by another resident.
-Since then, Resident #1 had complained about being in pain in her rectal area and in her abdomen.
-Resident #1 was able to express when she was in pain, and when given pain medication, if the medication did not work the resident would let her know.
-Most times Resident #1 complained that the pain medication given to her did not work, but she was unable to give more medication than what was ordered.
-She did not notify the physician when the resident still complained of pain, but "I should have."
-No one had assessed why the resident always complained about being in pain.
-Prior to the incident in November 2019, when a male resident threw Resident #1 on the floor Resident #1 was able to walk.
-After the incident Resident #1 no longer walked,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 9	D 270		

but used a wheelchair.
-It was normal for Resident #1 to get herself out of bed.
-The resident ambulated and transferred herself most of the time.
-Some days the resident took herself to the bathroom and some days she asked for staff assistance with going to the bathroom.
-Resident #1 had complained for at least two weeks about something coming out of her rectum.
-She had not checked to see if there was something coming out of Resident #1's rectum.
-Resident #1 was always "digging" in her rectum and a lot of times had blood on her hands.
-She told the MCM about the resident's "digging" in her rectum.
-She did not notify the physician about Resident #1 "digging" in her rectum because the MCM did not give the okay.
-For the past couple of months, she had observed Resident #1 always had bruises that covered her body from her thighs up to her breasts.
-The bruises were on the resident's thighs inner and outer, on her stomach and covered the whole front of the resident's body.
-She told the Director of Resident Care (DRC) about the bruises, but she did not document the bruises anywhere.
-She suspected the bruises and possibly the fractures came from the resident moving her furniture.
-On 01/11/20 she was sitting at the nurse's station desk charting when the personal care aide (PCA) called her and told her to come to Resident #1's room because something was coming out of the resident's bottom.
-When she got Resident #1's room she observed two PCAs in the room and the resident was sitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 10	D 270		

down in her wheelchair.
-The resident did not have underwear or incontinent brief on.
-When the resident stood up, she observed a body part and blood were coming out of the resident's rectum.
-The item coming from the resident's rectum was about two inches long and three to four inches wide.
-She told the PCAs to assist with putting the resident in the bed on her side.
-She instructed staff to not leave the resident and she called emergency medical services (EMS).
-Resident #1 was on every thirty-minute checks and would be okay.
-Then, when staff went back to see the resident thirty-minutes later Resident #1 had BM everywhere in her room.
-No one had discussed about the resident being supervised more frequently then every thirty-minutes.

Interview with a second third shift PCA on 01/15/20 at 5:24pm revealed:
-Resident #1 was combative and sweet.
-Resident #1 quickly changed her personality and stated she was pregnant.
- Resident #1 would talk out of her head and screamed.
-Resident #1 was up all night and sometimes sat at the nurse's station.
-When the resident went to her room, she moved her furniture around, and would put the bed in front of the door.
-Resident #1 moved the furniture around every day.
-She did not know when the resident moved the furniture and did not hear the resident moving the furniture.
-Resident #1 used to get herself up out of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 11 wheelchair, but after an incident in November 2019, she was no longer able to get up out of the wheelchair and complained that she needed staffs' help going to the bathroom, showering and dressing. -Resident #1 was able to get out of bed without staff assistance and put on her blouse. -Resident #1 was not able to put on her pants and incontinent brief. -Resident #1 was scheduled to be watched every thirty-minutes to know where the resident was because she was always "into something". -She had observed Resident #1 moved her furniture around and "played" in her "butt a lot." -When she observed Resident #1 "playing" in her "butt" she verbally told the resident to stop. -She had to keep plastic bags away from Resident #1 because the resident would BM in a plastic bag and bring it to staff. -On 01/11/20 at 3:24am, Resident #1 went to her room and staff told her the resident put the bed in front of the door. -They moved the bed and a little later Resident #1 went to her room. -After 5:00am a PCA called her for assistance and told her Resident #1 was bleeding. -When she arrived in Resident #1's room she observed there was something three to four inches wide coming out of Resident #1's rectum. -The resident told her that she had been trying to get tissue out of her "butt." -This was the first time she had observed blood coming from Resident #1. -Two to three months ago Resident #1 started digging in her rectum saying something was there and she was trying to remove it. -The MCM, MAs and all staff knew about Resident #1's "digging," but nothing was done. -Resident #1 was on thirty-minute checks due to "digging" and a multitude of things.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 12	D 270		

-Resident #1 moved the bed and other furniture around in her room.
-Moving the furniture was dangerous to the resident because the furniture was big and heavy.

Review of Resident #1's Thirty-minute check Sheets from 12/01/19 through 01/11/20 revealed there was no documentation of checking on the resident as follows:
-On 12/01/19 there was no documentation of thirty-minute checks on the second shift.
-On 12/02/19 there was no documentation of thirty-minute checks on the second and third shifts.
-On 12/03/19 there was no documentation of thirty-minute checks on the second shift.
-On 12/04/19 there was no documentation of thirty-minute checks on the first, second and third shifts.
-On 12/05/19 there was no documentation of thirty-minute checks from 10:00am through 2:30pm on the first shift.
-On 12/06/19 there was no documentation of thirty-minute checks from 10:00am through 2:30pm on the first shift.
-On 12/07/19 there was no documentation of thirty-minute checks on the first and third shifts.
-On 12/08/19 there was no documentation of thirty-minute checks on the second and third shifts.
-On 12/10/19 there was no documentation of thirty-minute checks on the first shift.
-On 12/11/19 there was no documentation of thirty-minute checks on the second shift.
-On 12/12/19 there was no documentation of thirty-minutes checks on the second and third shifts.
-On 12/13/19 there was no documentation of thirty-minute checks on the first, second and third shifts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 -On 12/14/19 there was no documentation of thirty-minute checks on the second shift. -On 12/15/19 there was no documentation of thirty-minute checks on after 8:30am on the first shift, no documentation on the second and third shifts. -On 12/16/19 there was no documentation of thirty-minute checks on the second shift. -On 12/17/19 there was no documentation of thirty-minute checks on the second shift. -On 12/18/19 there was no documentation of thirty-minute checks on the second shift. -On 12/19/19 there was no documentation of thirty-minute checks on the second shift. -On 12/20/19 there was no documentation of thirty-minute checks on the second shift. -On 12/21/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second and third shifts. -On 12/22/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second and third shifts. -On 12/23/19 there was no documentation of thirty-minute checks on after 12:30pm on the first shift, no documentation on the second and third shifts. -On 12/24/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second shift. -On 12/25/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second shift. -On 12/26/19 there was no documentation of thirty-minute checks on first shift (one-hour	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 14	D 270		

checks were documented on the first shift), there was no documentation of checks on second and third shifts.
-On 12/27/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second and third shifts.
-On 12/28/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second shift.
-On 12/29/19 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on second shift.
-On 12/30/19 there was no documentation of thirty-minute checks on first shift, second and third shifts.
-On 12/31/19 there was no documentation of thirty-minute checks on first shift, second and third shifts
-On 01/01/20 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on the second shift.
-On 01/02/20 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on the second shift.
-On 01/03/20 there was no documentation of thirty-minute checks on first shift (one-hour checks were documented on the first shift), there was no documentation of checks on the second shift.
-On 01/04/20 there was no documentation of thirty-minute checks on the first, second and third shifts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 15	D 270		

-On 01/05/20 there was no documentation of thirty-minute checks on the first, second and third shifts.
-On 01/06/20 there was no documentation of thirty-minute checks on the first and second shifts.
-On 01/07/20 there was no documentation of thirty-minute checks on the first and second shifts.
-On 01/08/20 there was no documentation of thirty-minute checks on the second shift and no documentation between 3:00am and 5:00am on the third shift.
-On 01/09/20 there was no documentation of thirty-minute checks on the first and second shifts.
-On 01/10/20 there was no documentation of thirty-minute checks on the second shift.

Review of Resident #1's record, progress notes, hospital discharge reports, thirty-minute check sheets and interviews with staff revealed the resident had increased behaviors from September 2010 through January 2020 and there was no documentation of increased supervision.

Interview with a first shift MA on 01/16/20 at 8:40am revealed:
-Resident #1 had behaviors, but they were not related to Alzheimer's dementia.
-Resident #1 was injurious herself, and not to other residents.
-Last week Resident #1 had a shower and the PCA noticed blood coming from the resident's rectum.
-She was getting off duty, so she informed the MCM.
-Resident #1 had always tried to pull her BM out of her rectum.
-The resident told her there were rocks, snakes,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 16	D 270		

and babies in her rectum and she often tried to pull them out.
-Lately, Resident #1 had gotten a lot worse and staff had to constantly watch the resident because she destroyed her bedroom and had BM everywhere.
-Resident #1 put BM in cups and bags and brought them to her and other staff saying they were rocks or "after birth" and she pulled it out of her.
-Staff were required to check on Resident #1 every thirty-minutes, but the resident needed to be watched more frequently due to her behaviors.
-No one had told her to monitor Resident #1 more frequently than every thirty-minutes.
-Resident #1 still walked sometimes but not that frequently.
-In May 2019, the previous Executive Director (ED) had observed how Resident #1 destroyed her room, broke out windows and digging in her rectum.
-The ED instructed staff to keep Resident #1 in activity room or near the nurse station to be watched and the incidents decreased tremendously.
-The ED left the facility in July 2019, and Resident #1 was no longer watched in the activity room or near the nurse station, now the incidents were occurring frequent again and thirty-minute checks were not enough.

Interview with a first shift MA on 01/16/20 at 9:20am revealed:
-On a daily basis Resident #1 exhibited behavioral issues like yelling, screaming out loud and throwing herself out of her wheelchair.
-Resident #1 always imagined that "stuff" like babies and electrical items were coming out of her body.
-Resident #1 would bring BM to her at least twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 17	D 270		

per week.
-Resident #1 was combative towards other residents by hitting them, running over residents' feet with her wheelchair and purposely running into residents with her wheelchair.
-When she observed Resident #1 hitting resident with her wheelchair and running over residents' feet, she verbally told her to stop, and she would stop but she always did the same thing again.
-Resident #1 was thrown to the floor by another resident because she hit the resident with her wheelchair.
-Resident #1 was able to get herself out of bed, dress and undress herself.
-Resident #1 moved her furniture around in her room.
-She had no idea how the resident moved the big items (wardrobe closet and hutch) around in her room because they were three times bigger than the resident and heavy.
-Moving the big items around was possibly how the resident sustained fractures.
-Resident #1 was supervised every thirty-minutes but it was not often enough because Resident #1 still had time to dig out her BM and move furniture around in her room.

Interview with Resident #1's Mental Health Provider (MHP) on 01/16/20 at 10:06am revealed:
-Resident #1 had schizophrenia and while at the facility broke out windows and destroyed property.
-She saw Resident #1 once per month and staff verbally told her the resident tore up her room and was digging out bowel movement from her rectum using her hands and objects.
-The digging possibly contributed to the prolapsed rectum.
-Resident #1 had a liver disease that was caused by a diagnosed illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 18	D 270		

-The psychotropic medications the resident used for years contributed to her failing liver causing the disease to progress.
-The resident needed psychotropic medications to help the resident maintain mental stability.
-The needed medications were discontinued prior to the resident moving into the facility due to the resident's failing liver function.
-She was unable to prescribe stronger doses of the resident's psychotropic medications due to her liver condition.
-Due to the resident's mental illness she had auditory behaviors which caused the resident to be disorganized with uncontrolled schizophrenia.
-To her knowledge Resident #1's harm was self-inflicting and she did not think Resident #1 harmed other residents.
-Resident #1 needed a lot of attention with constant supervision to keep her from destroying property and excavating bowel movement from her rectum.

Interview with a first shift MA on 01/16/20 at 10:52am revealed:
-Resident #1 had good days and was okay in the morning, but as the day progressed the resident "got ugly."
-When Resident #1 got ugly she called other residents "ugly names".
-Resident #1 got ugly at least once or twice per week.
-Resident #1 had been digging out her rectum for two months.
-When the resident was in her room, she would dig out BM.
-Resident #1 would dig out BM at least two to three times per week.
-Resident #1 hallucinated, and she intentionally rolled over other residents' feet with her wheelchair and backed into residents with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19	D 270		

wheelchair.
-After the altercation with another resident in November 2019, Resident #1 was unable to toilet herself without assistance from staff.
-The PCAs checked on Resident #1 every thirty-minutes and reported to the MAs.
-She told the MCM that she had reports about Resident #1 digging out her rectum. She also told the PCP.
-Resident #1 needed supervision as often as every fifteen-minutes due to behaviors.
-No one had told her to put the resident on increased supervision.

Interview with Resident #1's Primary Care Provider (PCP) on 01/16/20 at 1:01pm revealed:
-She became Resident #1's PCP in April 2019, then another PCP took her place and she did not see the resident again until September 2019.
-When she first saw Resident #1 her first impression was the resident belonged in a psychiatric ward due to the resident's schizophrenic paranoia behaviors.
-Resident #1 had self-harming behaviors and threw herself over furniture.
-The resident previously complained of vaginal pain, which she believed was self-inflicted.
-Because Resident #1's mental illness was currently uncontrolled without the necessary medications it was possible over time digging in her rectum with objects may have contributed to the prolapsed rectum.
-She was aware of Resident #1's schizophrenia paranoia with increased behaviors.
-The resident's behaviors were hard to control due to the decrease in doses of psychotropic medications.
-Due to the resident being unable to receive the needed medication the resident needed constant supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 20	D 270		

-Recently, she had observed Resident #1 had destroyed her room, and no sheets were on the bed and things were everywhere.

Interview with a therapist at the contracted physical therapy office on 01/16/20 at 12:37pm revealed:
-He and another therapist provided physical therapy to Resident #1.
-He saw Resident #1 two to three times for physical therapy.
-He observed Resident #1 was physically able to transfer herself but required staff assistance to provide verbal queuing to prevent falls.
-Resident #1 also needed staff supervision and hand support to assist with ambulation and transfers.
-Due to Resident #1 cognitive issues she was not mentally aware that she could fall without staff assistance when ambulating and transferring.

Interview with a second therapist at the contracted physical therapy office on 01/16/20 at 12:41pm revealed:
-He provided physical therapy to Resident #1 five to six times between 12/13/19 and 01/02/20.
-He was only able to provide a small amount of therapy due to the resident's cognitive ability.
-Resident #1 was emotionally limited to contributing to the therapy.
-Resident #1 complained of extreme back pain.

Interview with the MCM on 01/16/20 at 4:11pm revealed:
-Some days Resident 1 was fine, some days the resident would say things like she was pregnant.
-Some days Resident #1 would act out by sitting in the hallway hollering and screaming out loud.
-She had never seen Resident #1 digging out BM from the rectum, but staff had verbally reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 21	D 270		

her the incidents occurred.
-She did not report to the resident's PCP each time staff reported the incidents to her.
-She did not document when the incidents were reported to her.
-She was aware that Resident #1 messed up her room daily.
-Resident #1 would take the sheets off her bed and put them in her wheelchair.
-The sheets would have feces on them.
-The resident would also move her furniture around in her room.
-She had not reported the incidents to the resident MHP or the PCP.
-One and one-half weeks ago she had realized staff did not do thirty-minute checks on Resident #1.
-She talked with staff about the holes in the logs and not documenting the thirty-minute checks.
-No staff informed her they felt the thirty-minute checks were not frequent enough for Resident #1.
-When increasing checks from thirty-minutes it had to be okayed by the Administrator or the DRC.
-However, that was not done for Resident #1 because she was not aware.
-She saw Resident #1 daily throughout her shift and she was aware the resident messed up her room daily, but she did not know the resident was digging out BM daily.
-Some days she saw Resident #1 three times daily and some days more often depending on how the resident felt.
-She had observed Resident #1 yelling and telling Residents' "get off me, don't bother me."
-Resident #1 moving her furniture could have contributed to the resident's fractures.
-Sometimes Resident #1 transferred herself, but it was not safe for the resident to do that without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ___ B. WING ___	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22	D 270		

assistance from staff.
-She had prepared Resident #1's care plan and documented the resident required limited assistance with transferring and ambulation.
-The limited assistance required staff to be present when the resident went to the bathroom and provide hands on assistance with balance, not physical weight bearing assistance.

Interview with the MCM on 01/17/20 at 12:50pm revealed:
-Her expectations for staff was when they saw something happening every day, like Resident #1 destroying her room or spreading BM everywhere they needed to let someone know.
-It it's not every day but at least three days per week events were happening staff need to let her know.
-After Resident #1's fall in December 2019, she was put on thirty-minute checks for seventy-two hours according to the facility's fall policy.
-The thirty-minute checks continued but not because the resident destroyed her room or dig BM out of her rectum.
-She was aware when Resident #1 had a bad day she tore up her room and needed more supervision, but no additional supervion was provided. She checked on Resident #1 as she had time.

Interview with Resident #1's family member on 01/17/20 at 9:10am revealed:
-When Resident #1 moved into the facility things were fine then they started going bad quickly.
-After the incident in November 2019, Resident #1 was no longer ambulatory.
-She needed staff assistance with ambulation and transfers.
-Staff should be with Resident #1 every time she went to the bathroom, but facility staff did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ____ B. WING ____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 23	D 270		

assist the resident when needed.
-Resident #1 resided in the Memory Care Unit (MCU) and had to wait long periods of time for staff to assist her.
-She visited Resident #1 at least every other day and when she visited she often found the resident soiled and dirty with her room in disarrayed.
-Staff told her that they gave the resident incontinent briefs all day and the resident kept taking the briefs off.
-She often found no sheets on the resident's bed and she had to ask staff to make the bed.
-There would be no pillows or covers for the bed.
-She felt the facility did not give Resident #1 the attention that she needed.
-Last month, Resident #1 fell to the floor when trying to transfer herself from the wheelchair to the toilet.
-When she provided incontinent care to Resident #1 her bottom was badly blistered and bruised.
-Resident #1 got a medication that caused her stool to be loose and she frequently soiled her bed and herself.
-She visited Resident #1 every other day and the resident was consistently in pain.
-Currently, Resident #1 was in the hospital in the intensive care unit.

Interview with a first shift personal care aide (PCA) on 01/17/20 at 12:26pm revealed:
-Resident #1 had good days and bad days.
-Some days the resident could use the bathroom by herself and some days she could not.
-When Resident #1 had a good day was able to lift herself out of the wheelchair and she provided supervision assistance without hands on assistance.
-The resident needed assistance because some days the resident was shaky.
-She did not help Resident #1 that much, she only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 24	D 270		

helped the resident twice per week.
-Resident #1 would call for staff assistance if she needed help.
-When she came to work at 6:30am Resident #1's room would be "disarrayed."
-Things were everywhere and the resident would be on the floor.
-She had reported the resident's room being disarrayed to management, but nothing had been done.
-She had observed that Resident #1 had bruises and scratch marks on her body all the time.
-The bruises ranged from small to big, she guessed the size depended on what the resident got into the day before.
-She had reported the bruises and scratch marks to management several times and still the second and third shifts did not watch Resident #1.

Interview with the first shift medication aide (MA) on 01/17/20 at 1:53pm revealed:
-Resident #1 was on thirty-minute checks.
-In November 2019 Resident #1 was thrown to floor by another resident and she needed fifteen-minute checks because she had a fall.
-Resident #1 frequently destroyed her room and moved furniture around.

Interview with a second shift PCA 01/17/20 at 3:40pm revealed:
-She had worked at the facility for four months and had observed Resident #1 yelling at other residents and called them names.
-Resident #1 did not hit other residents but she always yelled at them.
-The residents yelled back at Resident #1 and staff had to intervene.
-When she started to work at the facility no one told her that Resident #1 required staff assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 25	D 270		

Continued From page 25

-Resident #1 changed her own clothes and took herself to the bathroom.
-The resident barely asked for staff help.
-She only assisted Resident #1 with showers.
-On 01/08/20 she assisted Resident #1 with a shower.
-Before getting into the shower the resident had to use the toilet.
-The resident stood for her to wipe the resident's bottom and she observed there was light blood on the tissue.
-She called for the medication aide (MA) to come and see the blood.
-The MA and the MCM came to the bathroom.
-The MCM stated the resident had hemorrhoids and they were possibly bleeding.
-She was not sure if the resident's PCP was notified.
-Resident #1 always complained that something was stuck inside of her rectum.
-She had observed Resident #1 use a wheelchair and did not get out of the wheelchair unless she stood-up.
-When Resident #1 did not attempt to stand up that often, but when she stood-up she complained and said, "I can't do it - I need to sit down."
-Resident #1 was unable to stand-up for twenty seconds without needing to sit down.
-Resident #1 put things in her rectum, so she had to be cautious when giving the resident snacks like a banana.
-She had observed Resident #1 frequently putting her hand, up to her wrist in her rectum.
-She verbally told the resident do not do that.
-She did not verbally tell the medication aide (MA) each time she observed Resident #1 stick her hand in her rectum.
-She thought the MAs were aware the resident frequently stuck her hand in her rectum because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 26	D 270		

the resident often gave the MAs plastic bags filled with bowel movement (BM) in them.
-Resident #1 often "destroyed" her room by getting BM everywhere.
-The BM was on the nightstands, walls, dresser, bed, floor and the resident.
-The resident would put the mattress on the floor with BM and urine on the floor and on the mattress.
-Every time she checked on Resident #1, then Resident #1 yelled for her to get out of the room.
-She had not observed Resident #1 having any falls, if the resident had broken bones it possibly could have come from moving her furniture around in the room.
-She did not know how the resident moved the furniture being she had a difficult time standing.
-Resident #1 hallucinated and imagined things all the time, like needles were on her mattress.
-Talking to the resident did not help, the only thing that helped was to get the resident a new mattress.
-Resident #1 would carry a bath towel rolled up down the hall to the nurse station.
-The resident gave the towel to staff and told staff that she had a baby.
-When staff unrolled the towel there would be BM in the towel.
-Staff checked on Resident #1 every thirty minutes, but she believed Resident #1 was able to destroy her room within five to ten minutes and needed continual supervision.
-Resident #1 needed supervision that required the resident to stay out of her room, so staff were able to observe the resident frequently.

Interview with a second, second shift PCA on 01/17/20 at 4:40pm revealed:
-She assisted Resident #1 with putting on her clothes, briefs, and with bathing at least three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 27	D 270		

times per week.
-At least every other week she observed bruises of various sizes and color on the Resident #1.
-The last time she had observed bruises on Resident #1 was on 01/06/20.
-She told the MA on duty Resident #1 had bruises.
-It was common for Resident #1 to move the furniture around in her room often putting the bed in front of the door.
-The cabinets and hutches in Resident #1's room were tall in height and wide in length, she did not understand how the resident was able to more these items around the room.
-Resident #1 was to be checked every thirty-minutes, but she checked on the resident sometimes every fifteen minutes especially after meals because that seemed to be when the resident messed up her room.
-When the resident messed up her room, she took linen off the bed and moved furniture, got BM all over the room and on her.

Interview with a second shift MA on 01/17/20 at 4:08pm revealed:
-She worked at the facility since November 2019 and had observed that Resident #1 had "fits" when things did not go her way.
-The resident would purposely slide out of her wheelchair because she did not want staff to touch her.
-When she first started to work at the facility, staff told her to watch Resident #1 because she put things into her rectum.
-Resident #1 mostly stayed in her room and "messed" a lot.
-When Resident #1 messed she got BM everywhere, on the walls, furniture and on herself.
-The resident took her incontinent brief off and got BM everywhere in the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 28	D 270		

-The MAs and PCA cleaned up the resident and her room.
-This happened almost every day on her shift.
-She was sure management knew how often staff had to clean Resident #1's room up due to the BM being everywhere.
-Resident #1 also tore up her room and it looked like a tornado hit it.
-The bed was moved, the covers were off the bed, the mattress would be on the floor, the furniture like nightstands would be moved, and things would be everywhere.
-The resident tore up her room all day every day.
-The MCM, DRC and the previous Administrator were both aware how often Resident #1 tore up her room because she and other MAs had made them aware.
-The only issue other residents had with Resident #1 was when she rolled backwards in her wheelchair.
-Resident #1 liked to roll backwards in her wheelchair and because she was going backwards, she bumped into other residents, they might yell at Resident #1.
-No residents complained about pain or getting hurt from being bumped by Resident #1's wheelchair.
-She frequently told Resident #1 not to roll backward, but she continued to roll backward. Resident #1 was on thirty-minute checks, but she needed to be on fifteen minutes checks because she was quick to mess up her room.
-No training had been provided how to handle residents with mental health issues like Resident #1.
-She observed Resident #1 was not forgetful and confused, she did not act like a resident with Alzheimer's or dementia.
-Resident #1 had mental health issues with schizophrenia and paranoia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 29	D 270		

Interview with the DRC on 01/17/20 at 1:32pm revealed:
-There had been discussions with the previous Administrator regarding discharging Resident #1 from the facility.
-She was unable to recall when that discussion happened.
-If staff saw bloody pads in the resident's room, then they should have reported it to management.
-No staff had reported to her about bloody pads were seen in Resident #1's room.
-Resident #1 was on thirty-minute checks, but if the resident needed to supervised more frequently that should be discussed with management.

Resident #1 was unavailable for interview from 01/11/20 to 01/17/20.

Interview with the Administrator on 01/17/20 at 5:40pm revealed:
-Since November 2019, she had provided staff training related to increased supervision of residents.
-She expected staff to keep residents' in the Memory Care Unit (MCU) busy and to keep an eye on them.
-Staff should have informed management Resident #1 needed more supervision than the thirty-minute checks allotted.
-When staff realized the thirty-minute checks were not enough to effectively supervision the Resident #1 the MAs should have made management aware and the checks should have been increased to every fifteen-minute.
-The same should have happened if the fifteen-minute checks were not enough supervision to visually keep Resident #1 safe, then staff should have notified management so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

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

D 270 | D 270

Continued From page 30

other changes could have been made or the determination the resident was not a good fit at the facility.

____

The facility failed to provide supervision to Resident #1 resulting in multiple fractures from an unknown origin, constantly destroyed her room and injurious to herself by manually removing BM which caused a prolapsed rectum, exhibited aggressive behaviors by rolling over residents' feet with her wheelchair, hitting other residents with her wheelchair and yelling and screaming at other residents. This failure placed residents in serious physical harm which constitutes a Type A1 Violation.

____

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 17, 2020.

D 273 | 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 31	D 273		

Based on interviews and record reviews, the facility failed to assure physician notification for 2 of 5 sampled residents (Residents #1 and #2) regarding a resident with a diagnosis of schizophrenia and had destructive behaviors and injurious to herself (Resident #1), and a resident who was in an altercation with a staff (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 12/05/19 revealed:
-Diagnoses included schizophrenia, Alzheimer's dementia, diabetes mellitus type II, chronic obstructive pulmonary disease, hepatitis C, thrombocytopenia and osteoarthritis.
-Resident #1 was constantly disoriented.
-Resident #1's recommended level of care was memory care unit (MCU).

Review of Resident #1's Care Plan dated 12/31/19 revealed:
-Resident #1 required supervision with toileting.
-Resident #1 required limited assistance with ambulation, bathing, dressing, grooming, and transfers.
-Resident #1 was injurious to self and property.

a. Review of Resident #1's progress note dated 09/03/19 at 2:12pm revealed Resident #1 was agitated and started arguing with other residents. The primary care provider (PCP) or mental health provider (MHP) were not notified.

Review of Resident #1's progress note dated 09/11/19 at 2:47pm revealed Resident #1 had a vase that had rocks and Bowel Movement (BM) in the vase. The resident told staff the rocks and BM came out of her. The PCP or MHP were not notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 32 Review of Resident #1's progress note dated 09/27/19 at 3:35pm revealed Resident #1 became combative and tried to choke staff. The resident was sent to the hospital for mental health evaluation. The PCP or MHP were not notified. Review of Resident #1's progress note dated 11/04/19 at 2:24pm revealed staff observed Resident #1 lying in the floor and appeared to have fallen while trying to get into her wheelchair. The resident did not go out to the hospital the PCP or MHP were not notified. Review of Resident #1's progress note dated 11/11/19 at 1:17pm revealed Resident #1 was observed moving the furniture in her room and removing her mattress. The PCP or MHP were not notified. Review of Resident #1's progress note dated 11/15/19 at 3:25pm revealed Resident #1 family member complained the resident's room was a "mess." The Resident #1's room around, her clothes were thrown around the room and sheets were off the bed and thrown around the room. The PCP and MHP were not notified. Review of Resident #1's progress note dated 11/19/19 at 5:57pm revealed Resident #1 had BM on her hands, fingers, socks and clothes. The resident continued to have delusions that things were in her rectum. The resident was placing her fingers in her rectum and "digging". The MHP and PCP were not notified. Review of Resident #1's progress note dated 11/26/19 at 3:47pm revealed Resident #1 had pulled her bed apart and trash was thrown about the room. The Director of Resident Care (DRC)	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ____ B. WING ____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 33	D 273		

documented the resident tore the room apart two to three times per day. The PCP or MHP were not notified.

Review of Resident #1's progress note dated 12/01/19 at 5:52pm revealed Resident #1 was lying in the floor and would not get up because she was in too much pain. The resident got up but no pain medications were offered and the MHP and PCP were not notified.

Review of Resident #1's progress note dated 12/02/19 at 9:15am revealed Resident #1 pulled items off the dresser counter and her bed throwing things on the floors. The resident's MHP or PCP were not notified.

Review of Resident #1's progress note dated 12/03/19 at 12:43pm revealed Resident #1 was observed playing in her own feces, wrapped the dirty incontinent brief around her foot. The resident would not allow staff to assist in cleaning the room or her. The PCP or MHP were not notified.

Review of Resident #1's progress note dated 12/14/19 at 6:50am revealed the MA changed Resident #1's soiled bed and the resident complained about back pain all night long. The PCP and MHP were not notified.

Review of Resident #1's progress note dated 12/17/19 at 2:38pm revealed the resident was in bed with no clothes on. The resident had taken all the sheets off the bed and thrown the pillows and trash all over the floor. The PCP and MHP were not notified.

Review of Resident #1's progress notes, incident reports and staff interviews there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 34	D 273		

documentation the PCP and MHP were contacted regarding the resident's increased behaviors destroying her room, "digging out her BM", acting "ugly" by calling residents names, rolling over residents' feet with her wheelchair and hitting residents with her wheelchair. The PCP or MHP were not notified.

Interview on 01/15/20 at 4:32pm with the third shift medication aide (MA) in the memory care unit (MCU) revealed:
-Resident #1 complained about being in pain in her rectal area and in her abdomen.
-Resident #1 was able to tell staff when she was in pain, and when given pain medication, if the medication did not work the resident would let her know.
-Most times Resident #1 complained that the pain medication given to her did not work, but she was unable to give more medication than what was ordered.
-She did not notify the physician, but stated "I should have."
-No one had assessed why the resident always complained about being in pain.
-Resident #1 had complained for at least two weeks about something coming out of her rectum.
-Resident #1 was always "digging" in her rectum and a lot of times had blood on her hands.
-She told the Memory Care Manager (MCM) about the resident's "digging" in her rectum, nothing was done.
-She did not notify the PCP or the MHP about Resident #1's "digging" in her rectum because the MCM did not give her the okay to do so.
-For the past couple of months, she had observed Resident #1 always had bruises that covered her body from her thighs up to her breast.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 35	D 273		

-The bruises were on the resident's thighs inner and outer, on her stomach and cover the whole front of the resident's body.
-She told the Director of Resident Care (DRC) about the bruises, but she did not document the bruises anywhere.
-She suspected the bruises and possibly the fractures came from the resident moving her furniture.
-If Resident #1's PCP and MHP were notified it would be documented in the resident's record.

Interview with Resident #1's MHP on 01/16/20 at 10:06am revealed:
-She saw Resident #1 once per month.
-During her visit staff verbally made her aware that Resident #1 tore up her room and was "digging" out bowel movement from her rectum using her hands and objects.
-Staff did not tell her how often Resident #1 had those behaviors.
-She was aware Resident #1 had schizophrenia and occasionally broke out windows and destroyed property but she did not think the behaviors were frequent.
-Until this conversation, she was not aware Resident #1 rolled over other residents' feet and hit residents using her wheelchair.
-If these were Resident #1's daily behaviors, she wanted to know about them because Resident #1 was unable to consume the needed psychotropic medications.
-She wanted to know when the resident started to exhibit behaviors on a daily basis because possibly the resident's needs could no longer be met at the facility.

Interview with Resident #1's PCP on 01/16/20 at 1:01pm revealed:
-She was aware Resident #1 had schizophrenia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 36	D 273		

paranoia and due to the resident's inability to take psychotropic medications it was normal for the resident to have increased behaviors.
-Until this conversation she was not aware Resident #1 was "ugly" towards other residents calling them names, rolling over their feet with her wheelchair and hitting resident with her wheelchair.
-She expected facility staff to let her know if the resident had behaviors problems daily.
-She was not aware staff had to supervise Resident #1 every thirty-minutes due to the resident's behaviors.
-She was not made aware the resident needed more frequent supervision than every thirty-minutes.
-Facility staff needed to let the MHP know about the resident's behaviors.
-Recently, she had observed Resident #1 had destroyed her room, and no sheets were on the bed and things were everywhere.
-If Resident #1 was getting to the point that she needed more and more care she wanted to be notified.

Interview with a first shift MA on 01/16/20 at 8:40am revealed:
-Resident #1 was destructive to herself, and to other residents.
-Resident #1 had always tried to pull her BM out of her rectum.
-The resident told her there were rocks, snakes, and babies in her rectum and she often tried to pull them out.
-Lately, Resident #1 had gotten a lot worse and staff had to constantly watch the resident because she destroyed her bedroom and had BM everywhere.
-Resident #1 put BM in cups and bags and brought them to her and other staff saying they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 37	D 273		

were rocks or "after birth" and she pulled it out of her.
-The MCM, DRC and previous Administrator were aware of Resident #1's behaviors.
-The PCP and MHP had also been notified, but she did not know if they were aware how frequent the incidents occurred.

Interview with a first shift MA on 01/16/20 at 9:20am revealed:
-On a daily basis Resident #1 exhibited behavioral issues like yelling, screaming out loud and throwing herself out of her wheelchair.
-Resident #1 always imagined that "stuff" like babies and electrical items were coming out of her body.
-Resident #1 would bring BM to her at least twice per week.
-Resident #1 was combative towards other residents' by hitting them, running over resident's feet with her wheelchair and purposely running into residents with her wheelchair.
-When she observed Resident #1 hitting resident with her wheelchair and running over resident's feet, she verbally told her to stop, and she would stop but she always did the same again.
-Resident #1 was thrown to the floor by another resident because she hit the resident with her wheelchair.

Interview with a first shift MA on 01/16/20 at 10:52am revealed:
-Resident #1 had good days and was okay in the morning, but was the day progressed the resident "got ugly."
-When Resident #1 got ugly she called other residents' ugly names.
-Resident #1 got ugly at least once for twice per week.
-Resident #1 had been digging herself out for two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ________ B. WING ________	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 38	D 273		

months.
-When the resident was in her room, she would dig out BM.
-Resident #1 would dig out BM at least two to three times per week.
-Resident #1 hallucinated, and she intentionally rolled over other residents' feet with her wheelchair and backed into residents with her wheelchair.
-After the altercation with another resident in November 2019, Resident #1 was unable to toilet herself without assistance from staff.
-The PCAs checked on Resident #1 every thirty-minutes and reported to the MAs.
-She told the MCM that she had reports about Resident #1 digging. She also told the PCP.
-Resident #1 needed supervision as often as every fifteen-minutes due to behaviors.
-No one had told her to put the resident on increased supervision.

Interview with the MCM on 01/17/20 at 12:50pm revealed:
-Her expectations for staff was when they see something happening every day, like Resident #1 destroying her room or spreading BM everywhere they needed to let someone know.
-If events are not happening every day, but two to three days per week staff still need to let her know.
-She was aware when Resident #1 had a bad day she tore up her room sometimes two to three times per day and the resident yelled at other residents, but she did not contact the PCP and MHP because staff was able to clean the room and redirect the resident.
-She had not notified Resident #1's PCP or MHP regarding Resident #1 rolling over resident's feet with her wheelchair and hitting residents with her wheelchair because she was not aware those

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 39	D 273		

incidents happened.

Interview with a first shift personal care aide (PCA) on 01/17/20 at 12:26pm revealed:
-When she came to work at 6:30am Resident #1's room would be "disarrayed."
-Things were everywhere and the resident would be on the floor.
-Third shift did not care for Resident #1 and she had reported the resident's room being disarrayed to management, but nothing had been done.
-She had observed that Resident #1 had bruises and scratch marks on her body all the time.
-The bruises ranged from small to big, she guessed the size depended on what the resident got into the day before.
-She had reported the bruises and scratch marks to management several times and still the second and third shifts did not watch Resident #1.

Interview with the first shift medication aide (MA) on 01/17/20 at 1:53pm revealed:
-Resident #1 frequently destroyed her room and moved furniture around.
-This had been reported many times to the MCM, but nothing was been done.

Interview with a second shift PCA on 01/17/20 at 3:40pm revealed:
-She had worked at the facility for four months and had observed Resident #1 yelling at other residents and calling them names like "n ...ger."
-Resident #1 did not hit other residents but she always yelled at them.
-The residents yelled back at Resident #1 and staff had to intervene.
-On 01/08/20 she assisted Resident #1 with a shower.
-Before getting into the shower the resident had to use the toilet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 40	D 273		

-The resident stood for her to wipe the resident's bottom and she observed there was light blood on the tissue.
-She called for the medication aide (MA) to come and see the blood.
-The MA and the MCM came to the bathroom.
-The MCM stated the resident had hemorrhoids and they were possibly bleeding.
-She was not sure if the resident's PCP was notified.
-Resident #1 always complained that something was stuck inside of her rectum.
-Resident #1 put things in her rectum, so she had to be cautious when giving the resident snacks like a banana.
-She had observed Resident #1 frequently putting her hand, up to her wrist in her rectum.
-She verbally told the resident "that is nasty, don't do that."
-She did not verbally tell the medication aide (MA) each time she observed Resident #1 stick her hand in her rectum.
-She thought the MAs were aware the resident frequently stuck her hand in her rectum because the resident often gave the MAs plastic bags filled with bowel movement (BM) in them.
-Resident #1 often "destroyed" her room by getting BM everywhere.
-The BM was on the nightstands, walls, dresser, bed, floor and the resident.
-The resident would put the mattress on the floor and had BM and urine on the mattress and on the floor.
-Every time she checked on Resident #1 she yelled for her to get out of the room.
-Resident #1 hallucinated and imagined things all the time, like needles were on her mattress.
-Talking to the resident did not help, the only thing that helped was to get the resident a new mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 41	D 273		

-Sometimes Resident #1 carried a bath towel that was rolled up down and gave it to the MA at the nurse station.
-The resident told staff that she had a baby was in the towel.
-When staff unrolled the towel there was BM in the towel.
-The staff did not know if the resident took herself to the bathroom or if the resident was digging in her rectum and obtained the BM.

Interview with a second, second shift PCA on 01/17/20 at 4:40pm revealed:
-At least every other week she observed bruises of various sizes and color on the Resident #1.
-The last time she had observed bruises on Resident #1 was on 01/06/20.
-When the resident messed up her room, she took linen off the bed and moved furniture got BM all over the room and on her.
-She always reported the incidents to the MA on duty.

Interview with a second shift MA on 01/17/20 at 4:08pm revealed:
-When she first started to work at the facility staff told her to watch Resident #1 because she put things into her rectum.
-Resident #1 mostly stayed in her room and "messed" a lot.
-When Resident #1 messed she got BM everywhere, on the walls, furniture and on herself.
-The resident took her incontinent brief off and got BM everywhere in the room.
-The MAs and PCA cleaned up the resident and her room.
-This happened almost every day on her shift.
-She was sure management knew how often staff had to clean Resident #1's room up due the BM being everywhere.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 42	D 273		

-Resident #1 also tore up her room and it looked like a tornado hit it.
-The bed was moved, the covers were off the bed, the mattress would be on the floor, the furniture like nightstands would be moved, and things would be everywhere.
-The resident tore up her room all day every day.
-The MCM, DRC and the previous Administrator were both aware how often Resident #1 tore up her room because she and other MAs had made them aware.
-The only issue other residents had with Resident #1 was when she rolled backwards with her wheelchair hitting them.
-Resident #1 liked to roll backwards in her wheelchair which caused her to bump into other residents. The residents' yelled at Resident #1 for hitting them with her wheelchair.
-No residents complained about pain or getting hurt from being bumped by Resident #1's wheelchair.
-She frequently told Resident #1 not to roll backwards, but she continued to roll backwards.

Interview with the Administrator on 01/17/20 at 5:40pm revealed:
-She expected staff to keep residents' in the Memory Care Unit (MCU) busy and to keep an eye on them.
-Staff should have informed management and Resident #1's PCP and MHP regarding the resident's increased behaviors.

Resident #1 was unavailable for interview from 01/11/20 to 01/17/20.

b. Review of Resident #1's current FL2 dated 12/05/19 revealed diagnoses included schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 43	D 273		

Review of Resident #1's Care Plan dated 12/31/19 revealed:
-Resident #1 was injurious to self and property.

Review of Resident #1's record revealed there was no documentation the primary care provider (PCP) or mental health provider (MHP) were notified regarding seeing bloody items in the resident's room and blood on a wipe after bathroom use.

Interview with a first shift personal care aide (PCA) on 01/17/20 at 12:40pm revealed:
-A week and a half ago she saw two to three used incontinent pads that were on Resident #1's floor.
-She observed the pads were filled with blood.
-She did not get the pads off the floor, but she verbally mentioned the pads to the medication aide on duty.
-She was unable to recall the name of the MA on duty and she did not tell anyone else about the bloody pads she observed in Resident #1's room.

Interview with a second shift PCA on 01/17/20 at 3:40pm revealed:
-On 01/08/20 she assisted Resident #1 with a shower.
-Before getting into the shower the resident had to use the toilet.
-The resident stood for her to wipe the resident's bottom and she observed there was light blood on the tissue.
-She called for the medication aide (MA) to come and see the blood.
-The MA and the MCM came to the bathroom.
-The MCM said the resident had hemorrhoids and they were possibly bleeding.
-She was not aware if the MCM called the resident's PCP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 44	D 273		

Continued From page 44

Interview with Resident #1's Mental Health Provider (MHP) on 01/16/20 at 10:06am revealed:
-She saw Resident #1 once per month.
-No one from the facility had notified her that they observed blood in the resident's room or on the resident.
-She felt that was important and she expected staff to let her know when they saw blood coming from the resident, even if they were not sure where the blood originated.

Interview with Resident #1's PCP on 01/16/20 at 1:01pm revealed:
-No one at the facility had made her aware they observed blood in Resident #1's room.
-Staff should make her and/or the MHP aware of Resident #1's happenings due to the resident's uncontrolled behaviors.

Interview with the MCM on 01/17/20 at 12:50pm revealed:
-Last Wednesday (01/08/20), the PCA told that she wiped Resident #1 and saw bright red on the wipe.
-She told the PCA the resident had hemorrhoids and to let her know if the resident continued to bleed.
-The MA on duty told her the resident had hemorrhoids and the blood was common with hemorrhoids.
-She also was aware the resident had a test earlier that morning on 01/08/20, and the test could have caused some bleeding.
-She did not think to notify Resident #1's PCP regarding the bright red blood.

Interview with the Administrator on 01/17/20 at 5:40pm revealed:
-She expected staff to contact the resident's PCP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ____ B. WING ____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 45	D 273		

when the resident's behaviors increased.
-When staff realized the thirty-minute checks were not enough to effectively care for the resident the staff should have made management aware and someone should have contacted the resident's PCP.

2. Review of Staff G's personnel record revealed:
-Staff G was hired as a personal care aide on 03/11/19.
-There was documentation Staff G had a criminal background check on 03/06/19.
-There was documentation Staff G had a health care personnel registry check on 03/11/19.

Review of Resident #2's current FL2 dated 12/16/19 revealed:
-Diagnoses included dementia, glaucoma, legally blind, essential hypertension.
-Resident #2 was intermittently disoriented.

Review of Resident #2's Care Plan dated 06/26/19 revealed:
-Resident #2 had a history of wandering.
-Resident #2 was oriented, but she was forgetful and needed reminders.

Review of Resident #2's Accident/Incident Report dated 12/31/19 revealed:
-There was an altercation in a resident's room.
-Staff G was observed attempting to inappropriately restrain a combative resident. (There was no additional information regarding the incident.)
-Resident #2 complained of pain in her neck.
-There was no first aide administered and Resident #2 was not taken to the emergency room.
-Resident #2's primary care provider (PCP) and responsible party were notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 46	D 273		

Interview with a MA Supervisor on 12/16/20 at 4:43pm revealed:
-She was working on second shift in on 12/31/19.
-She was working with a resident and overheard Staff G talking offensively to a resident.
-Staff G was yelling, "You better get the (expletive) off of me."
-She did not know who Staff G was talking to so she went to the resident's room where she heard the voice.
-Staff G and Resident #2 were in the room of another resident who was not present.
-She did not know why Staff G was in the other resident's room with Resident #2.
-When she walked in the room, she found Resident #2 laying on the bed closest to the door with Staff G on top of her.
-Staff G was straddling Resident #2 with his left leg propped on the bed across Resident #2's body and his right foot was on the floor.
-Both of Staff G's hands were around Resident #2's neck.
-She pulled Staff G off Resident #2 and told him to leave the room.
-She took Resident #2 to her room and called the Memory Care Manager (MCM) to inform her of what happened.
-Resident #2 kept asking her, "What did I do wrong?"
-She did not see any marks or bruising on Resident #2's neck.
-Resident #2 did not say she was hurt or in pain and was not sent out to the hospital.
-She contacted Resident #2's PCP's on-call number and left a "FYI" message regarding the altercation.
-She had not followed up with the PCP after 12/31/19 regarding the altercation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 47	D 273		

Review of Resident #2's progress notes dated 12/31/19 revealed:
-There was no progress note dated 12/31/19.
-There was a late entry dated 12/31/19 made by the MCM on 01/03/19 which documented an altercation between a staff [Staff G] and Resident #2.
-The late entry revealed the staff was seen trying to inappropriately restrain a combative resident.
-The medication aide (MA) supervisor who witnessed the incident removed Staff G from the room.
-The MCM assessed Resident #2 and there was no visible bruising, but Resident #2 stated she had pain when the MCM touched her neck.
-Resident #2's PCP and responsible party were called and notified of the altercation and the previous Executive Director (ED) was made aware.

Review of a Body Evaluation and Observation form dated 12/31/19 revealed there were no noticeable marks on Resident #2's neck at the time of evaluation.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Interview with the MCM on 01/16/20 at 9:24am revealed:
-She was not working on the evening of 12/31/19, but she was contacted by the MA Supervisor around 9:00pm on 12/31/19 who notified her of an altercation between Staff G and Resident #2.
-The MA Supervisor reported to her she heard someone yelling "Get off of me" and walked down the hallway and found Staff G improperly restraining Resident #2 by hovering over her with his hands around her neck.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273		D 273		

Continued From page 48

-She came to the facility, asked Staff G to leave, and had staff on duty to write statements about what happened.
-She did not get a statement from Staff G.
-She assessed Resident #2 by touching and asking if her head, face, or neck hurt and Resident #2 said yes to her neck hurting.
-Resident #2's responsible party and PCP were contacted, but Resident #2 was not sent out to the emergency room.
-She did not know why Resident #2 was not sent to the emergency room.
-Resident #2 had not been seen by her PCP since the altercation on 12/31/19.

Interview with a Staff G on 01/16/20 at 12:03pm revealed:
-He was working on second shift on 12/31/19.
-He was putting a resident down for bed when he noticed Resident #2 was in another resident's room "messing."
-He tried to get Resident #2 out of the other resident's room by telling her to come out.
-Resident #2 told him "no" two times.
-Resident #2 walked up to him and grabbed him by his wrist and his jacket and had a tight grip on him.
-He was trying to back away from Resident #2 because he was not going to be aggressive with her.
-Resident #2 grabbed his hands and wrists and kept backing up towards the bed so he tried to catch her to keep her from falling back, but Resident #2 fell back on the bed.
-He kept telling Resident #2 to "calm down," but she kept saying "no."
-He did not touch Resident #2's neck and did not put his hands on her at all.
-He left the room and told a MA what happened.
-The MCD came to the facility, told him an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 49	D 273		

investigation would be completed, asked him to leave, and told him not to return to work.
-He was contacted a few days later and was told he was terminated because "something was not handled properly," but she did not say what it was.
-He was never asked to tell his side of the story to say what happened.
-In November and December 2019, staff, including him, were required to watch videos on "how to handle residents with dementia and how not to engage in a hostile manner with them."
-All staff were required to attend the trainings and he attended all required trainings.

Interview with the Director of Resident Care (DRC) on 01/16/20 at 5:31pm revealed:
-She was not working on the evening of 12/31/19 or on 01/01/20, but she was told about the altercation between Staff G and Resident #2 on 01/01/20.
-She did not assess Resident #2 when she returned to the facility on 01/02/20 or any other date.
-She looked at Resident #2, but she did not asses her.
-She did not see any marks or bruising on Resident #2's neck area.
-She asked Resident #2 if she was in pain, but she did not respond to her.
-She had not followed up with Resident #2's PCP regarding the altercation.

Interview with Resident #2's responsible party on 01/17/20 at 11:18am revealed:
-She received a call in December 2019 from facility staff in who told her Resident #2 had an incident, but staff did not tell her what the incident was.
-She was told the incident was being investigated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 50	D 273		

and staff just wanted to let her know.
-She called the facility on a later date to speak with the MCD to check on Resident #2.
-Staff told her to hold on and left the phone off the hook.
-While the phone was off the hook she overheard staff say, "(Unnamed person) wouldn't choke Resident #2. Why would (unnamed person) choke Resident #2?
-She did not know if staff was talking about another resident or a staff.

Interview with Resident #2's PCP on 01/15/20 at 12:48pm revealed:
-She did not know about the altercation between Resident #2 and Staff G.
-She did not see any notes where staff had called on 12/31/19 and left a message for her.
-They may have called the on-call person who may have forgotten to put in a note.
-She would have expected to be notified of the altercation and for Resident #2 to be sent out to the hospital if she complained of pain in her neck.

____

The facility failed to assure timely notification to the primary care provider (PCP) and mental health provider (MHP) for Resident #1 who constantly tore up her room, was digging in her rectum, rolled over residents' feet with her wheelchair, hit residents with her wheelchair and talked "ugly" to residents, and Resident #2 who was in an altercation with a staff [Staff G]. This failure 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 01/16/20 for this violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 51 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2020.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure implementation of physician's orders for 1 of 5 sampled residents (Resident #1) with orders for daily skin checks and a back brace. The findings are: a. Review of Resident #1's current FL2 dated 12/05/19 revealed: -Diagnoses included Alzheimer's dementia, diabetes mellitus II, chronic obstructive pulmonary disease, schizophrenia, hepatitis C, thrombocytopenia, and osteoarthritis.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 52 -There was an order for Lamictal (lamotrigine) (used to treat schizophrenia) 25mg 2 tablets twice daily. -There was an order for daily skin check of entire body once resident started Lamictal on 10/08/19. Review of Resident #1's physician's orders revealed: -There was an order written by a mental health provider dated 10/07/19 for Lamictal 25mg tablets 1 tablet twice daily for 14 days and after 14 days increase to 2 tablets twice daily thereafter. -There was an order written by a mental health provider dated 10/07/19 to do daily skin checks for rash once patient begins Lamictal. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2019 revealed: -There was an entry for lamotrigine 25mg 1 tablet twice daily at 9:00am and 9:00pm for 14 days with a start date of 10/07/19. -Lamotrigine was documented as administered for 27 of 28 opportunities from 10/07/19 through 10/20/19. -There was a second entry for lamotrigine 25mg 2 tablets twice a daily at 9:00am and 9:00pm with a start date of 10/21/19. -Lamotrigine was documented as administered for 20 of 22 opportunities from 10/21/19 through 10/31/19. -There was an entry for daily skin check of entire body once resident starts Lamictal on 10/08/19. -There was documentation Resident #1's entire body was checked from 10/08/19 through 10/31/19 with the exception of 10/26/19. -There was no documentation of the condition of Resident #1's skin. Review of Resident #1's eMAR for November	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 53 2019 revealed: -There was an entry for lamotrigine 25mg 2 tablets twice daily at 9:00am and 9:00pm. -Lamotrigine was documented as administered for 36 of 42 opportunities from 11/01/19 through 11/21/19. -There was a second entry for lamotrigine 25mg 2 tablets twice daily at 9:00am and 9:00pm. -Lamotrigine was documented as administered for 39 of 40 opportunities from 11/21/19 through 11/30/19. -There was documentation Resident #1's entire body was checked from 11/01/19 through 11/30/19 with the exception of 11/07/19. -There was no documentation of the condition of Resident #1's skin. Review of Resident #1's eMAR for December 2019 revealed: -There was an entry for lamotrigine 25mg 2 tablets twice daily at 9:00am and 9:00pm. -Lamotrigine was documented as administered for 38 of 39 opportunities from 11/01/19 through 11/20/19. -There was a second entry for lamotrigine 25mg 2 tabs twice daily at 9:00am and 9:00pm. -Lamotrigine was documented as administered for 23 of 23 opportunities from 11/20/19 through 11/30/19. -There was documentation Resident #1's entire body was checked twice daily from 12/01/19 through 12/31/19. -There was no documentation of the condition of Resident #1's skin. Review of Resident #1's progress notes revealed there was no documentation from 10/01/19 through 12/31/19 of a skin assessment of Resident #1's entire body or the condition of Resident #1's skin.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 54	D 276		

Interview with a medication aide (MA) on 01/17/20 at 12:25pm revealed:
-She knew Resident #1 had physician's orders for daily skin checks.
-She tried to assess Resident #1's skin daily when she worked.
-Personal care aides (PCA) assessed Resident #1's skin three times a week when they assisted her with a shower.
-She documented she completed skin assessments on the MAR, but she did not document whether Resident #1's skin was clear or if there was a rash.
-She had not been told to document the condition of Resident #1's skin after a skin assessment.
-She did not remember seeing a rash on Resident #1's skin.

Interview with the Director of Resident Care (DRC) on 01/17/20 at 12:48pm revealed:
-She knew Resident #1 had a physician's order for daily skin assessments.
-The MAs were responsible for completing the daily skin assessments and documenting the results of the skin assessment.
-MAs should have documented the results of the skin assessment in the progress notes.
-Staff had not reported to her any rashes on Resident #1's skin.
-What she considered a rash and what staff considered a rash might be different.

Interview with a PCA on 01/17/20 at 1:18pm revealed:
-She assessed Resident #1 when she gave her a shower and completed a body evaluation and observation form to document the condition of residents' skin.
-She did not document anywhere else.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ___ B. WING ___	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 55	D 276		

Continued From page 55

-She observed a rash on Resident #1's coccyx in December 2019 and let the MA on duty know, but she did not remember which MA.
-The MA was supposed to document the rash in Resident #1's progress notes and let the Memory Care Manager (MCM) and DRC know.
-She did not know if the MAs were completing a total body assessment daily for Resident #1.

Interview with the MCM on 01/17/20 at 1:29pm revealed:
-She did not know about the order for daily skin checks for Resident #1 because it was in place prior to her working at the facility.
-She had not physically seen nor had staff told her about any rashes on Resident #1's skin.
-She had reviewed the "shower sheets" completed by the PCAs in December 2019 and noticed a PCA had documented a rash on Resident #1's skin.
-When she went to assess the rash, it was gone.
-MAs should have completed daily skin checks for Resident #1.
-She did not know what instructions were given to the MAs because the daily skin checks were ordered prior to her coming to work at the facility.
-She thought it was her responsibility, but she had not made sure skin checks were completed daily and results documented.

Based on observation, interview, and record review it was determined Resident #1 was not available for interview.

Attempted interview with the prescribing mental health provider on 12/17/20 at 12:37pm was unsuccessful.

2. Review of Resident #1's current FL2 dated 12/05/19 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 56	D 276		

-Diagnoses included schizophrenia, Alzheimer's dementia, diabetes mellitus type II, chronic obstructive pulmonary disease, hepatitis C, thrombocytopenia and osteoarthritis.
-Resident #1 was constantly disoriented.
-Resident #1's recommended level of care was memory care unit (MCU).

Review of a physician's order dated 12/12/19 revealed the mental health provider (MHP) wrote an order documenting Resident #1 "needs a back brace."

Review of Resident #1's progress note dated 12/12/19 at 3:08pm revealed the Memory Care Manager (MCM) documented Resident #1 was ordered a back brace.

Review of Resident #1's record revealed there was no documentation a back brace was obtained for Resident #1.

Interview with Resident #1's MHP on 01/16/20 at 10:06am revealed:
-She ordered the back brace for Resident #1 because the resident complained of back pain.
-The resident's family member said she previously had a back brace, so she ordered physical therapy and the back brace.
-She expected the facility to obtain the back brace.
-If facility staff were not sure who was responsible for obtaining the back brace, they should have asked her.

Interview with Resident #1's primary care provider (PCP) on 01/16/20 at 1:01pm revealed:
-She gave a verbal order for physical therapy, being unaware the MHP had already given an order for therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 57	D 276		

-She did not know there was an order for a back brace.
-If facility staff did not see the back brace, they should have contacted the physician that wrote the order.

Interview with the office manager at the contract physical therapy office on 01/16/20 at 1:28pm revealed:
-The physical therapy office never received an order for a back brace.
-Resident #1 was discharged from physical therapy due to her decline in function related to dementia.

Interview with the MCM on 01/16/20 at 4:11pm revealed:
-She recalled that she faxed an order for physical therapy evaluation and the back brace to the therapy office. She was unable to recall the exact date she faxed the order to physical therapy.
-She was unable to locate documentation showing she faxed the order to physical therapy regarding the back brace.
-She had observed the for order a back brace was on the same order for physical therapy.
-She assumed the person providing physical therapy would get the back brace.
-As far as she knew nothing was done about getting the resident a back brace.
-She was responsible for following-up to ensure the back brace was obtained, but she did not think to ask about the back brace.

Interview with the DRC on 01/17/20 at 1:32pm revealed:
-She did not review the order for a back brace for Resident #1.
-She did not review orders that were processed by the MCM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ____ B. WING ____	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 58 -The MCM was supposed to follow through with the order to ensure the order was implemented. Interview with Resident #1's family member on 01/17/20 at 9:10am revealed: -Resident #1 continually complained of back pain. -She asked the MHP if Resident #1 could get a back brace. -She had never saw Resident #1 in a back brace and did not know if one was ever ordered. Interview with the Administrator on 01/17/20 at 5:40pm revealed: -She expected staff to follow-up on orders written, like Resident #1's back brace. -If there was confusion regarding who was responsible for obtaining the back brace staff should have followed-up with the provider that wrote the order.	D 276		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and review of documentation, the facility failed to assure residents were protected from abuse and neglect as related to Personal Care and Supervision, and Health Care. The findings are: 1. Based on record reviews and interviews the	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034093	A. BUILDING: ______ B. WING ______	01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANBY HOUSE	3150 BURKE MILL ROAD WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 59 facility failed to provide supervision needed for 1 of 5 sampled residents (Resident #1) with a diagnosis of schizophrenia and had destructive behaviors and injurious to herself. [Refer to Tag 0270 NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to assure physician notification for 2 of 5 sampled residents (Residents #1 and #2) regarding a resident with a diagnosis of schizophrenia and had destructive behaviors and injurious to herself (Resident #1), and a resident who was in an altercation with a staff (#2). [Refer to Tag 0273 NCAC 13F .0902(b) Health Care (Type B Violation)].	D914		