PRINTED: 08/26/2022 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	.D
			D WING		R	
		HAL034098	B. WING		08/05/2	2022
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA			
SALEM TE	ERRACE		SALISBURY RO			
	QUILLEN/ QT		SALEM, NC 27			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
{D 000}	D) Initial Comments		{D 000}			
	The Adult Care Licensure Section conducted a follow-up survey on 08/03/22 to 08/05/22 with an exit conference via telephone on 08/05/22.					
D 131	131 10A NCAC 13F .0406(a) Test For Tuberculosis		D 131			
	(a) Upon employment home, the administration any live-in non-reside tuberculosis disease in measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis Mail Service Center, In This Rule is not met Based on observation reviews, the facility far sampled staff (Staff D. (TB) upon hire.	ns, interviews and record				
	revealed: -Staff D's hire date wa	le (MA), personnel record				
	revealed: -Staff D was the MA o	1/22 from 3:00pm to 4:08pm on duty on second shift. d passing medications to				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	D
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		HAL034098	B. WING		08/05/2	2022
NAME OF D	DOVIDED OD SUDDI IED	etpeet Al	DDBESS CITY STAT	FF 7ID CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
SALEM TERRACE			D SALISBURY RO N SALEM, NC 27			
	CLIMMADY CT		· ·		N	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 131	Continued From page	e 1	D 131			
	Attempted interview v	vith Staff D on 08/05/22 at				
	2:56pm was unsucce					
	Telephone interview with the Administrator on					
	08/05/22 at 1:33pm revealed: -Staff D worked at the facility as a MA and as a PCAStaff D worked with the residents assisting with meals, baths/showers, transportation and with					
	ambulation care.	s, transportation and with				
		Staff D had not completed a				
	TB skin test.	•				
	-When staff were hire	d, they were required to				
	have a TB skin test.					
		hance to review Staff D's				
		nsure TB skin test was				
	completed. -The previous Rusine	ss Office Manager (BOM)				
	-	ed part-time sometime in				
	June 2022.	•				
		ntant started to help at the				
		ff records at the end of June				
	2022 or the beginning					
	-	s TB skin test was missed				
	due to the turnover in	staff in the business office.				
	Telephone interview v	with the corporate				
		22 at 3:00pm revealed:				
	-She was basically he					
	because the previous	BOM became part-time in				
	June 2022.					
		get staff records together 2				
	weeks ago.					
		staff D did not have a TB skin				
	test.					

Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed:
-She left the facility as the full-time BOM in May

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Division of	of Health Service Regu	lation		1 Ortiv	IAITROVED		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R 08/05/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	FE, ZIP CODE			
SALEM TERRACE 2609 OLD S			D SALISBURY RO	DAD			
SALEWI II	ERRAGE	WINSTO	N SALEM, NC 27	'127			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	OULD BE COMPLETE		
D 131	1 Continued From page 2		D 131				
	2022The paperwork initially went to the corporate office and then came to her at the business officeWhen Staff D was hired, she no longer worked as the BOM and was not sure why there was no TB skin test for Staff D.						
D 137	10A NCAC 13F .0407 Qualifications	7(a)(5) Other Staff	D 137				
	10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:						
		iated findings listed on the n Care Personnel Registry IE-256;					
	This Rule is not met TYPE B VIOLATION	as evidenced by:					
	facility failed to ensure	and record reviews, the e 4 of 6 sampled staff (Staff o substantiated findings arolina Health Care					

The findings are:

1. Review of Staff A's, personal care aide (PCA)/medication aide (MA) personnel record revealed:

Personnel Registry (HCPR) prior to hire.

- -Staff A was hired on 04/20/22.
- -There was documentation that a HCPR was obtained on 08/03/22. There were not findings.
- -There was no documentation that an HCPR check was done on or prior to the date of hire.

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Division of	of Health Service Regu	ılation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
SALEM TE	ERRACE		SALISBURY RO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 137	Continued From page	e 3	D 137		
	Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.				
	Coordinator (RCC) or revealed: -Staff A had worked a as a MA for over one monthsWhen Staff A was hir Manager (BOM) was a HCPR status check-She did not know wh completing the HCPR BOM. Telephone interview v 08/05/22 at 1:33pm re-She was not aware Swas completed 2 days	at the facility as a PCA and month, maybe almost two red the Business Office responsible for making sure was completed. The was responsible for R when there was no full-time with the Administrator on revealed: Staff A's HCPR status check was ago and not prior to hire.			
	to have a HCPR statustarting work.	all employees were required us check completed prior to uld have been checked upon			
		terview with the previous ager (BOM) on 08/05/22 at			
	Refer to telephone int accountant on 08/05/2	terview with the corporate /22 at 3:00pm.			
	Refer to telephone int Administrator on 08/0				
	2. Review of Staff B's (PCA)/medication aid	s personal care aide de (MA) personnel record			

revealed:

-Staff B was hired on 06/14/22.

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	of Fleatin Service Regu				1	
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	: IED
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			B. WING		R	
		HAL034098	b. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
	2000 OLD					
SALEM TI	ERRACE		SALISBURY R			
		WINSTON	I SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 137	Continued From page	_ Λ	D 137			
2 .0.						
	-There was documen	tation that a HCPR check				
	was completed on 08	/03/22. There was no				
	findings noted.					
		nentation that a HCPR check				
	was done on or prior					
	was done on or prior	to the date of fine.				
	Tolophono intonviow v	with Staff B on 08/05/22 at				
		Will Stall B OII 00/03/22 at				
	2:41pm revealed:					
	-She was a MA and sometimes she worked as a PCA.-She started working at the facility in June 2022					
	(unable to recall the e	exact date).				
	-When she started wo	orking at the facility, the only				
	thing she was asked	to provide was previous MA				
	training.	·				
	_	ned her that a HCPR check				
	would be completed.					
		previous employers that a				
		uired, but she was not				
		ry that they were going to				
	-					
	complete a HCPR ch	eck on ner.				
	•	with the Resident Care				
	Coordinator (RCC on	08/05/22 at 1:23pm				
	revealed:					
	-Staff B had worked a	at the facility as a MA and as				
	a PCA for almost two	months.				
	-Someone in the busi	ness office was responsible				
	for ensuring Staff B h	•				
	completed.					
	completed.					
	Telephone interview v	with the Administrator on				
	08/05/22 at 1:33pm re					
		Staff B's HCPR check was				
	not completed until 08					
		d Staff B's personnel record				
	-	d documents and HCPR				
	status checks were of	btained.				
	-The business office of	currently did not have a				
		e thought that contributed to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
			A. BUILDING:			_
		HAL034098	B. WING		I	R / 05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE	-	
		2609 OLD	SALISBURY RO	AD		
SALEM T	ERRACE	WINSTON	SALEM, NC 27	127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 137	Continued From page	÷ 5	D 137			
	not completing an HC	PR check for Staff B.				
	Refer to telephone interview with the previous Business Office Manager (BOM) on 08/05/22 at 3:09pm.					
	Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm. 3. Review of Staff D's personal care aide (PCA)/medication aide (MA) personnel record revealed:					
	-Staff D was hired on 06/14/22There was no documentation that a HCPR check was completed on or prior to the date of hire or thereafter.					
	Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful. Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed:					
	-Staff D had worked a	at the facility as a MA and as one month, maybe a month				
	-The business office of Staff D's HCPR checker-The business office by	was responsible for ensuring k was completed upon hire. nad been without a full-time				
		onths or more. who would be responsible for ck because there was no				
	08/05/22 at 1:33pm re	with the Administrator on evealed: a HCPR status check had				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S COMPLI	
			_		R	}
		HAL034098	B. WING		1	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE		SALISBURY R			
			SALEM, NC 2			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 137	Continued From page	e 6	D 137			
D 137	not been completed of hire. -The BOM was respon HCPR check was corshe had not reviewe to ensure the required checks were obtained. Refer to telephone into Business Office Mana 3:09pm. Refer to telephone into accountant on 08/05/20. Refer to telephone into Administrator on 08/05/20. 4. Review of Staff E's personnel record reversatiff E was hired on -There was no HCPR available for review in Telephone interview with 10:15am revealed: -She started working through a staffing age-She was offered a furth Care Unit Coordinato started her role as SO	on Staff D since her date of ensible for making sure a suppleted on Staff D. d Staff D's personnel recorded documents and status d. Starview with the previous ager (BOM) on 08/05/22 at starview with the corporate 22 at 3:00pm. Sterview with the 5/22 at 1:33pm. Sterview with the 5/22 at 1:33pm. Sterview with the 5/22 at 1:33pm. Staff E's personnel record. Staff E's personnel record. Staff E's personnel record. Staff E on 08/05/22 at start the facility as a MA ency in June 2022. Il-time position of Special respectively. Il-time position of Special respectively. Staff E on 08/01/22. Staff E facility had completed a would have been	D 137			
	Telephone interview v at 1:23pm revealed: -Staff E was the SCU	vith the SCUC on 08/05/22				

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but had previously worked with the facility through

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG CRECULATORY OR LSC IDENTIFYING INFORMATION) D 137 Continued From page 7 an agency as a MA. -When Staff E was hired, someone in the business office should have completed a HCPR check. Refer to interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the previous BOM on 08/05/22 at 3:00pm. Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was aware that all employees were required to have a HCPR check completed prior to starting work.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
SALEM TERRACE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DIPERIX TAG PREFIX TAG CONTINUED FROM INFORMATION DEFICIENCY DEFICIENC		HAL034098		B. WING		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 137 Continued From page 7 an agency as a MA. -When Staff E was hired, someone in the business office should have completed a HCPR check. Refer to interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was aware that all employees were required to have a HCPR check completed prior to starting work.						·
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 137 Continued From page 7 an agency as a MA. -When Staff E was hired, someone in the business office should have completed a HCPR check. Refer to interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the previous BOM on 08/05/22 at 3:09pm. Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was aware that all employees were required to have a HCPR check completed prior to starting work.	SALEMI	ERRACE	WINSTO	N SALEM, NC 271	27	
an agency as a MA. -When Staff E was hired, someone in the business office should have completed a HCPR check. Refer to interview with the Administrator on 08/05/22 at 1:33pm. Refer to telephone interview with the previous BOM on 08/05/22 at 3:09pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was aware that all employees were required to have a HCPR check completed prior to starting work.	PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
-She was not aware that a HCPR check was not completed on Staff A, B, D or E. -The Business Office Manager (BOM) was responsible for completing HCPR checks on new hires. -The business office currently did not have a full-time BOM and she thought that contributed to not completing an HCPR check for Staff A, B, D, or E. Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed: -She left the facility as the BOM at the end of May 2022She continued to work in the business office part-timeWorking part-time, she was not responsible for completing HCPR checks for new hiresWhen she was the BOM she did not complete HCPR checks; the corporate office was responsible for completing the paperwork.	D 137	an agency as a MA. -When Staff E was his business office should check. Refer to interview with 08/05/22 at 1:33pm. Refer to telephone int BOM on 08/05/22 at 3:33pm reaccountant on 08/05/22 Telephone interview with 08/05/22 at 1:33pm reaccountant on 08/05/22 Telephone interview with 08/05/22 at 1:33pm reaccountant on 08/05/22	red, someone in the d have completed a HCPR In the Administrator on Rerview with the previous 3:09pm. Rerview with the corporate 22 at 3:00pm. With the Administrator on evealed: all employees were required ex completed prior to starting that a HCPR check was not B, D or E. Manager (BOM) was eting HCPR checks on new currently did not have a exthought that contributed to EPR check for Staff A, B, D, with the previous BOM on evealed: a the BOM at the end of May rk in the business office The was not responsible for eacks for new hires. OM she did not complete rporate office was	D 137		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OUR MARY OTATEMENT OF DEFINITION		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 137	7 Continued From page 8		D 137			
	-The corporate office HCPR verification, shin the personnel recorder. The paperwork for pethrough several difference made it to her. She was unable to such ecks were completed documentation, then the second second of the second secon	emailed her completed e printed them, and put then rds. ersonnel records went ent "hands" and sometimes ay specifically, if the HCPR ed but if there was not they were not completed. with the corporate 22 at 3:00pm revealed: tant for the corporate office. started helping in the out together personnel rk that was required by the completed that process. ould be completed by the HCPR checks on 08/03/22 out not for all employees. Insure 4 of 6 sampled staff had a HCPR check e. This failure resulted in the staff had substantiated they were not completed by the completed that process. Insure 4 of 6 sampled staff had a HCPR check e. This failure resulted in the staff had substantiated they were not completed by the completed that process. Insure 4 of 6 sampled staff had a HCPR check e. This failure resulted in the staff had substantiated they were not completed.				

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
			SALISBURY R			
SALEM TE	ERRACE		SALEM, NC 2			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 139	Continued From page 9		D 139			
D 139	139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications		D 139			
	(a) Each staff person (7) have a criminal ba accordance with G.S. This Rule is not met a TYPE B VIOLATION Based on record revie facility failed to ensure	114-19.10 and 131D-40;				
	completed upon hire. The findings are:	oninina background check				
	1. Review of Staff A's personnel record reversations of Staff was hired on 04. There was document background check was no findings. There was no document of the staff was not document of the staff was no document of th	1/20/22.				
	Attempted telephone 08/05/22 at 1:38pm w	interview with Staff A on as unsuccessful.				
	Telephone interview v Coordinator (RCC) or	vith the Resident Care n 08/05/22 at 1:23pm				

to complete.

-Staff A had worked at the facility as a PCA and as a MA for over one month, maybe almost two

-When new hires came to the facility for an interview, the receptionist gave them paperwork

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Division o	<u>of Health Service Regu</u>	lation			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		HAL034098	B. WING		08/05/2022
		TIALOGAGO			1 00/03/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	FRRACE	2609 OL	D SALISBURY R	OAD	
OALLIN 11	INNAOL	WINSTO	N SALEM, NC 2	7127	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
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IAG			IAG	DEFICIENCY)	
			 		
D 139	Continued From page	∍ 10	D 139		
	-The paperwork inclu	ded a form to sign for the			
		check to be completed.			
	_	Manager (BOM) was			
		ng sure criminal background			
		ed and in the personnel			
	record.	·			
	-The business office h	had been without a full-time			
	BOM for almost three	e months.			
	-She did not know wh	no was responsible for			
	completing criminal b	ackground checks when			
	there was no BOM.	_			
		terview with the previous			
		ager (BOM) on 08/05/22 at			
	3:09pm.				
	· ·	terview with the corporate			
	accountant on 08/05/	22 at 3:00pm.			
	Defente talanhana in	4:			
	Refer to telephone int				
	Administrator on 08/0	15/22 at 1:33pm.			
	2 Povious of Staff D's	modication aido (MA)			
	personnel record reve	s medication aide (MA)			
	-Staff D was hired on				
		nentation that a criminal			
		as completed upon hire,			
	before hire or thereaf				
	perore nire or thereafter.				
	Attempted telephone	interview with Staff D on			
	08/05/22 at 2:56pm w				
	Telephone interview v	with the RCC on 08/05/22 at			
	1:23pm revealed:				
	-Staff D had worked a	at the facility as a MA and as			
	a PCA for a little over	one month, maybe a month			
	and a half.				
	-When Staff D came t	for an interview, the			

receptionist should have given her paperwork to complete that included signing for a criminal

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	or riealth Service Regu				T	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
AND LEWY	J. JOHNLOHON	.SERTI IOMISTRINOMISER.	A. BUILDING: _		JOINIL	
					R	
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
			SALISBURY R	,		
SALEM TERRACE		SALEM, NC 2				
	OUR MAR DV OT		, , , , , , , , , , , , , , , , , , , 			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 139	Continued From page	<u> </u>	D 139			
	background check to					
		nsible for ensuring criminal				
	background checks h					
		had been without a full-time				
	BOM for about two m	onths or more.				
	Refer to telephone int	terview with the previous				
		ager (BOM) on 08/05/22 at				
	3:09pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.					
	accountant on 08/05/.	22 at 3:00pm.				
	Refer to telephone interview with the					
	Administrator on 08/0					
	Telephone interview v	 with the previous BOM on				
	08/05/22 at 3:09pm re	•				
		s the BOM at the end of May				
	2022.	•				
	-She continued to wo part-time.	rk in the business office				
	' ·	he was not responsible for				
	completing criminal b					
		SOM she did not complete				
	criminal background	•				
	-The corporate office					
	-	ed paperwork for new hires.				
		sometimes emailed her the				
	results of completed of	criminal background checks.				
	-The paperwork for pe	ersonnel records went				
	through several differ	ent "hands" and sometimes				
	never made it to her.					
		ay specifically why the				
	criminal background	checks were not completed.				
	Telephone interview v	with the corporate				
	I	22 at 3:00pm revealed:				
		tant for the corporate office.				
		started working at the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		HAL034098	B. WING		08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
SALEMITE	SALEM TERRACE 2609 OLD			OAD	
OALLIN II		WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 139	Continued From page	e 12	D 139		
D 139	facility in the business -She had not complet checks for all employe which employees did background check. Telephone interview v 08/05/22 at 1:33pm re -She was aware all en criminal background ce -She did not why Staf check was completed hireThe business office v completing criminal be hiresThe business office of full-time BOM and she not completing a crim Staff AShe was responsible was completed, but s A's personnel record documents and crimin obtained. The facility failed to en (Staff A and Staff D) h	s office to help out. ed criminal background ees and she was not aware not have a criminal with the Administrator on evealed: mployees should have a check upon hire. if A's criminal background I yesterday and not upon	D 139		
	in the facility not know	ving if staff had criminal rimental to the safety, f the residents and			
	The facility provided a plan of protection in accordance with G.S. 131D-34 on August 5, 2022 for this violation.				
	CORRECTION DATE	EOD THE TYPE R			

Division of Health Service Regulation

VIOLATION SHALL NOT EXCEED SEPTEMBER

STATE FORM 6899 63ET13 If continuation sheet 13 of 105

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					Б	
			B. WING		R	
		HAL034098	B. WING		08/05/2022	\dashv
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	RRACE		SALEM, NC 2			
			JALLIN, NO 2			_
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 400	0 " 15	10	D 400			\Box
D 139	Continued From page	e 13	D 139			
	20, 2022.					
	,					
D 161	104 NCAC 13E 0504	I(a) Competency Validation	D 161			
0 101	For LHPS Tasks	r(a) Competency validation	5 101			
	FUI LITES TASKS					
	104 NCAC 13E 0504	Competency Validation For				
		essional Support Task				
	(a) An adult care hon					
		nel and licensed personnel				
	not practicing in their					
		ctice act and occupational				
		mpetency validated by return				
	demonstration for any					
	•	graph (a)(1) through (28) of				
	Rule .0903 of this Sul					
	performing the task a					
	-	ed through facility staff				
	oversight and supervi					
	3 1					
	This Rule is not met	as evidenced by:				
		ns, interviews, and record				
	reviews, the facility fa					
		s, Staff D and Staff E) were				
	competency validated	•				
		(LHPS) tasks by return				
		ng obtaining fingerstick				
	blood sugar checks a	nd insulin injections prior to				
	performing these task	s on diabetic residents.				
	The findings are:					
	1. Review of Staff B's					
	(PCA)/medication aid	e (MA) personnel record				
	revealed:					
	-Staff B was hired on					
		nentation of completion of a				
	LHPS competency va	alidation.				
			1	I .	1	

Division of Health Service Regulation

Review of a resident's electronic medication

STATE FORM 6899 63ET13 If continuation sheet 14 of 105

Division (of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	1
					R	
		HAL034098	B. WING		08/05/20	122
		TIAL SOTION			1 00/03/20	122
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEM II	INNACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) OMPLETE DATE
D 161	Continued From page	e 14	D 161			
	revealed Staff B docu	(eMAR) for August 2022 Imented obtaining fingerstick or 3 opportunities in August				
	Telephone interview with Staff B on 08/05/22 at 2:41pm revealed: -She was a MA and sometimes she worked as a PCAShe was checked-off for LHPS tasks at her previous employment but not at this facilityThe facility nurse had verbally told her that she					
	was going to provide completed the training	LHPS training but had not				
	administer insulinSince her employme	nt at the facility, she had not				
	received training relat	ted to LHPS tasks.				
	Telephone interview v Coordinator (RCC) or revealed:	with the Resident Care n 08/05/22 at 1:23pm				
	-Staff B worked at the	e facility as a MA and as a ne month, maybe a month				
	-There was a nurse was part-time.	ho worked at the facility				
	-She was not aware of the training provided by the facility's nurse.-She was not sure if Staff B had been checked-off					
	for LHPS tasks and c -When a MA was hire	ompetency validation. d, the only training she				
	provided was for the l for one to two weeks medication cart by he	<u>-</u>				
		vith the Administrator on				

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-She was not aware Staff B had not completed

STATE FORM 6899 63ET13 If continuation sheet 15 of 105

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL034098	B. WING		08/0	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
SALEM TE	ERRACE	2609 OLD	SALISBURY R	OAD		
	WINSTON					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 161	Continued From page	e 15	D 161			
	LHPS competency va -She had not reviewe to ensure the required including LHPS comp	s responsible for ensuring alidations were completed. d Staff B's personnel record d training was completed betency validations.				
	Refer to interview with the facility's nurse on 08/04/22 at 5:35pm.					
	Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.					
	2. Review of Staff D's personal care aide (PCA)/medication aide (MA) record revealed: -She was hired on 06/14/22There was no documentation a LHPS competency validation had been completed for Staff D.					
		O on 08/04/22 at 4:30pm ined a FSBS on a resident ulin.				
	medication administrative revealed Staff D docu and administered instance of 106/01/22 through 06/3	etic residents' electronic ation records (eMARs) imented she checked FSBS ulin 28 opportunities from 30/22; 57 opportunities from 31/22; and 12 opportunities th 08/04/22.				
	Attempted telephone 08/05/22 at 2:56pm w	interview with Staff D on as unsuccessful.				
	Coordinator (RCC) or revealed: -Staff D worked at the	with the Resident Care in 08/05/22 at 1:23pm e facility as a MA and as a ine month, maybe a month				

Division of Health Service Regulation

STATE FORM 6899 63ET13 If continuation sheet 16 of 105

NAME OF PROVIDER OR SUPPLIER SALEM TERRACE A. BUILDING: R B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127	AND FLAN OF CO	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD 8 WING 2609 OLD SALISBURY ROAD				A. BOILDING			
SALEM TERRACE 2609 OLD SALISBURY ROAD			HAL034098	B. WING		1	
SALEM TERRACE	NAME OF PROVID	VIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON SALEM. NC 27127	SALEM TERRA	RACE	2609 OLD	SALISBURY R	OAD		
	WINSTON			SALEM, NC 2	7127		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE
D 161 Continued From page 16 D 161	D 161 Co	Continued From pag	e 16	D 161			
and a half. -The facility often. -When a MA was hired, the training she provided consisted of placing the MA on the medication cart to shadow another MA for one to two weeks; after that the MA worked on her own on the medication cart. -She was not aware of the training provided by the facility nurse. -She was not aware if Staff D had been checked-off for LHPS tasks and completed the competency validation. Telephone interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was not aware Staff D had not completed the LHPS competency validation since she was hired at the facility. -The facility nurse recently started and worked part-time providing trainings. -The nurse was responsible for ensuring LHPS competency validations were completed. -She had observed the nurse providing trainings, but not sure if the training included LHPS competency validations. -She had not reviewed Staff D's personnel record to ensure the required training and LHPS competency validation was completed. Refer to interview with the facility's nurse on 08/04/22 at 5:35pm. Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. 4. Review of Staff E's medication aide (MA) personnel record revealed:	and -Th fac -Wi cor car afte me -Sh the -Sh che cor Tele 08/ -Sh the hire -Th par -Th cor -Sh but cor -Sh to e cor	and a half. The facility had a nu acility often. When a MA was hire consisted of placing the place of the place of the facility nurse. She was not aware of the facility nurse. She was not aware in the facility nurse. She was not aware in the facility nurse. She was not aware in the facility nurse was not aware in the facility. The facility nurse recompetency validation of the facility nurse recompetency validation. The nurse was responsived at the facility. The facility nurse recompetency validation of the train the facility nurse was response to the facility of the train the facility of the facility of the facility nurse was response to the facility of the faci	rse, but she was not in the ed, the training she provided the MA on the medication er MA for one to two weeks; ked on her own on the of the training provided by if Staff D had been 6 tasks and completed the in. with the Administrator on evealed: Staff D had not completed by validation since she was cently started and worked ainings. onsible for ensuring LHPS ins were completed. he nurse providing trainings, ining included LHPS ins. ed Staff D's personnel record d training and LHPS in was completed. the he facility's nurse on terview with the corporate (22 at 3:00pm. s medication aide (MA)				

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-There was no (Licensed Health Professional

STATE FORM 6899 63ET13 If continuation sheet 17 of 105

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE	
SALEM TI	EDDACE	2609 OLD	SALISBURY R	OAD	
SALEM II	ENNACE	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 161	Continued From page	e 17	D 161		
	for review in Staff E's	etency validation available personnel record.			
	Review of three diahe	etic residents' electronic			
		ation records (eMARs)			
		imented she checked FSBS			
	and administered insu	ulin 21 opportunities from			
	06/01/22 through 06/30/22; 39 opportunities from 07/06/22 through 07/31/22; and 6 opportunities from 08/01/22 through 08/04/22.				
	Telephone interview v	with Staff E on 08/05/22 at			
	10:15am revealed:	J.a 5.1 55/55/ a.			
	-She started working	at the facility as a MA			
	through a staffing age	-			
		III-time position of Special			
		r (SCUC) on 07/26/22 and			
	started her role as SC				
		competency validation for I not remember when.			
		ave her LHPS competency			
	validation in her staff				
		with the Resident Care			
	Coordinator (RCC) or revealed:	1 08/05/22 at 1:23pm			
		ng at the facility on 08/01/22			
	as the SCUC.	ing at the lability on ocionize			
		E worked on the medication			
	cart checking FSBS a	and administering insulin.			
		aff E worked at the facility as			
	, ,	ninistered medications;			
	including checking FS				
	administration of diab				
		Staff E completed LHPS			
	competency validatio	n training. /as responsible for providing			
	the LHPS competence				
	une Lin o competend	y vandauon naming.			
	Telephone interview v	with the Administrator on			

Division of Health Service Regulation

STATE FORM 6899 63ET13 If continuation sheet 18 of 105

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
74101 2741	or dorate of the transfer of t	IDENTIFICATION NO.	A. BUILDING: _			
		HAL034098	B. WING		08/0	₹ 05/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	JE. ZIP CODE		
			SALISBURY R	,		
SALEM TERRACE WINSTON			I SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE
D 161	Continued From page	e 18	D 161			
	08/05/22 at 1:33pm re- She was not aware Sthe LHPS competence FSBS and insulin adrestaff E had been at it then on Monday, 08/0 as the SCUC. -The facility nurse was use LHPS competence completed. -She had not reviewed to ensure the required competency validation. Refer to interview with 08/04/22 at 5:35pm. Refer to telephone intraccountant on 08/05/2 Interview with the fact 5:35pm revealed: -She had worked at the over one month. -She was still new and trainings that were resumed that were resumed to severyone. -She was unable to severyone. -She had documentate completed the LHPS with. -She had documentate completed the LHPS with.	evealed: Staff E had not completed by validation prior to checking ministration. The facility as agency staff, D1/22 Staff E started working s responsible for making cy validations were d Staff E's personnel record d training and LHPS n was completed. The facility nurse on terview with the corporate 22 at 3:00pm. The facility part-time for a little d was not sure of the quired. LHPS competency				
	_	m and did not document the ed anywhere.				

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accountant on 08/05/22 at 3:00pm revealed:

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN (J. CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	_150
		HAI 024000	B. WING		R	
		HAL034098	B. WIINO		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
			SALEM, NC 2			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 161	Continued From page	: 19	D 161			
	-She had been at the	facility helping the business				
ı	out since July 2022.					
	 Two weeks ago she records. 	started to work on personnel				
		urse to provide the LHPS				
	competency validation training. -The nurse had been trained on how to complete					
	the forms and the trai	nings required. sure what to do or if she				
		ould have let her know.				
	,					
D 164	10A NCAC 13F .0505 Diabetic Resident	Training On Care Of	D 164			
		Training On Care Of				
	Diabetic Residents	hall assure that training on				
		with diabetes is provided to				
		to the administration of				
ı	insulin as follows:					
	 Training shall be nurse, registered pha 	provided by a registered				
	practitioner.	iniacist of prescribing				
,	(2) Training shall incl	ude at least the following:				
	` '	diabetes and care involved				
,	in the management of (b) insulin action;	r diabetes;				
	(c) insulin action, (c) insulin storage;					
	` '	g and injection techniques				
,	for insulin administrat	ion;				
i	` '	evention of hypoglycemia				
	and hyperglycemia, ir	icluding signs and				

symptoms;

precautions;

(g) universal precautions;

(f) blood glucose monitoring; universal

(h) appropriate administration times; and(i) sliding scale insulin administration.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R
		HAL034098	B. WING		08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	ERRACE		SALISBURY R		
WINSTON			I SALEM, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 164	Continued From page	20	D 164		
	facility failed to ensuraides (Staff A, Staff D training on the care of obtaining fingerstick is administering insulin. The findings are: 1. Review of Staff A's (PCA)/medication aid revealed: -Staff A was hired on -There was no document the care of diabetic results. Review of the June at medication administration in the care of diabetic results. There was document insulin on 22 occasion 06/30/22There was document insulin on 43 occasion 07/31/22. Attempted telephone 08/05/22 at 1:38pm which is the care of diabetic results. The care of diabetic results are the care of diabetic result	ews and interviews, the e 3 of 6 sampled medication and Staff E) had completed f diabetic residents prior to blood sugars and personal care aide e (MA) personnel record 04/20/22. nentation on the training of esidents for Staff A. Ind July 2022 electronic ation record (eMAR) for an ident revealed: tation Staff A administered has from 06/01/22 through tation Staff A administered has from 07/01/22 through interview with Staff A on vas unsuccessful. with the Resident Care h 08/05/22 at 1:23pm t the facility as a MA for over			
		most two months. I, she checked FSBS and			

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE	
			A. BUILDING: _			
		HAL034098	B. WING	B. WING)22
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TI	FRRACE	2609 OL	D SALISBURY RO	OAD		
WINSTON			N SALEM, NC 27	7127		
(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 CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	BE CO	(X5) OMPLETE DATE
D 164	Continued From page	21	D 164			
	administered insulin t	o diabetic residents.				
	08/05/22 at 1:33pm re-She was not aware Straining for the care of The Business Office responsible for makin completed by the nurse had worked and she observed here. She was not sure if the for diabetic residents. She had not reviewed to ensure the required were obtained. Refer to interview with 08/04/22 at 5:35pm.	Staff A did not complete If diabetic residents. Manager (BOM) was Ig sure trainings were Ise. In additional and the facility part-time If doing trainings. In the trainings included caring It documents and trainings In the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility's nurse on It is a surface of the facility of the facility's nurse on				
	accountant on 08/05/22 at 3:00pm. 2. Review of Staff D's personal care aide (PCA)/medication aide (MA) record revealed: -Staff D was hired on 06/14/22There was no documentation Staff D completed care of diabetic resident training prior to the administration of insulin. Observation of Staff D on 08/04/22 at 4:30pm revealed Staff D obtained a FSBS on a resident and administered insulin. Review of three diabetic residents' June and July 2022 electronic medication administration records (eMARs) revealed: -There was documentation Staff D administered insulin on 28 occasions from 06/01/22 through					

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06/30/22.

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL034098	B. WING		R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SALEM TE	ERRACE		SALISBURY RO SALEM, NC 27		
			1	PROVIDER'S PLAN OF CORRECTION	J 0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 164	Continued From page	22	D 164		
	insulin on 57 occasion 07/31/22. -There was documen	tation Staff D administered ns from 07/06/22 through tation Staff D administered ns from 08/01/22 through			
	Attempted telephone interview with Staff D on 08/05/22 at 2:56pm was unsuccessful.				
	Coordinator (RCC) or revealed: -Staff D had worked a June 2022When Staff D worked and checked FSBS d -The only training she administration of insu MA on the medication-The Business Office responsible for makin completed by the nurs-The nurse had worked month but was only when was not sure if the training to Staff D.	at the facility as a MA since d, she administered insulin iabetic residents. e provided to Staff D prior to lin was shadowing another o cart. Manager (BOM) was g sure trainings were se. ed at the for a little over one vorked part-time. he nurse provided diabetic			
	08/05/22 at 1:33pm re-She was not aware Sdiabetic training prior insulin. -The facility nurse wa training to staff but watraining had been pro-The business office value trainings were co-She had not reviewe	Staff D had not completed to the administration of supposed to provide as unaware if diabetic			

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		HAL034098	B. WING		R 08/05	/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	SALEM TERRACE 2609 OLD			OAD		
WINSTON			N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 164	Continued From page	23	D 164			
	were obtained.					
	Refer to interview with 08/04/22 at 5:35pm.	n the facility's nurse on				
	Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.					
	4. Review of Staff E's medication aide (MA), personnel record revealed: -Staff E was hired on 07/26/22There was no documentation Staff E had completed training on the care of diabetic residents available for review in her personnel record.					
	medication administrative revealed: -There was document insulin on 21 occasion 06/30/22There was document insulin on 39 occasion 07/31/22There was document was document was document insulin on 39 occasion 07/31/22.	etic residents' electronic ation records (eMARs) tation Staff E administered as from 06/01/22 through tation Staff E administered as from 07/06/22 through tation Staff E administered as from 08/01/22 through				
	10:15am revealed: -She started working through an agency in -She was offered a fu Care Unit Coordinato started her role as SO -She had completed t	June 2022. II-time position of Special r (SCUC) on 07/26/22 and				

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-The facility should have her training certificate on

STATE FORM 6899 63ET13 If continuation sheet 24 of 105

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL034098	B. WING		08/0	5/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE	2609 OLD	SALISBURY R	OAD		
0.7.		WINSTON	SALEM, NC 27	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 164	Continued From page	24	D 164			
	file.					
	08/04/22 at 5:35pm.	n the facility's nurse on				
	Refer to telephone intaccountant on 08/05/	terview with the corporate 22 at 3:00pm.				
	Interview with the facility's nurse on 08/04/22 at 5:35pm revealed: -She had worked at the facility part-time for a little over one monthShe was still new and was not sure of the trainings that were requiredShe had not provided diabetic training for the medication aides.					
	-She had been at the out since July 2022Two weeks ago she personnel records bu documents and trainingThe facility hired a nu-The nurse should ha trainingThe nurse had been the forms and the trailing.	22 at 3:00pm revealed: facility helping the business started working on t she had not identified ngs that were missing. urse to provide the trainings. ve provided diabetic care trained on how to complete				
{D 270}	10A NCAC 13F .0901 Supervision	(b) Personal Care and	{D 270}			
		Personal Care and e supervision of residents in				

Division of Health Service Regulation

STATE FORM 6899 63ET13 If continuation sheet 25 of 105

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			1 \ /		E SURVEY PLETED	
			A. BOILDING.			_
		HAL034098	B. WING		08	R 8/ 05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E. ZIP CODE	·	
			D SALISBURY RO			
SALEM TE	ERRACE		N SALEM, NC 271			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 25	{D 270}			
	care plan and current	symptoms				
	care plan and current	. symptoms.				
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION	,				
	Based on record revie	ews, observations, and				
		failed to provide supervision				
		ty's policy for 2 of 5 sampled				
	_	related to a resident who				
		eek with 1 fall resulting in a				
	blackened eye and a					
		istory of falls including a fall				
	resulting in pain and a (#4).	a decrease in ambulation				
	The findings are:					
	Review of the facility's	s Fall Intervention Protocol				
	dated January 2022 r	evealed:				
	_	e obtained and the resident				
		or injuries; if a resident hit				
		ling, or complained of pain,				
	the resident was to be					
	hospital emergency d evaluation.	iepariment for further				
	-The environment wa	s to be assessed for				
		removed; the physician was				
		lan of care completed with				
	appropriate documen	•				
		b be notified for a review of				
	medication and evalu	•				
		be referred to home health				
		evaluation for strengthening				
	•	if the resident had a fall				
	while ambulating.	fall from a whooleheir the				
		fall from a wheelchair, the ferred to home health for				
		uation for balance training				

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 08/05/2022
					00/03/2022
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STAT		
SALEM TE	ERRACE		SALISBURY RO SALEM, NC 27		
240.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	d (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 270}	Continued From page	≥ 26	{D 270}		
	needed to anticipate i ensure safety.	n the resident as often as needs and act proactively to te 15-minute checks for 72 per policy.			
	03/16/22 revealed: -Diagnoses included arthritis, metabolic en left lower extremity, a hematuria, and hyper				
	revealed:	5's care plan dated 03/16/22			
	-Resident #5 used a v -There was no docum of assistance Resider ambulation. -Staff assisted Reside	nentation regarding the level nt #5 needed with			
		nentation regarding Resident			
	07/23/22 at 9:59am a -Resident #5 was fou -Resident #5 stated the and leg was hurting b -She requested to go -She was transported services (EMS) to a log	nd on the floor of her room. hat she fell and that her back badly. to the hospital. I by emergency medical			
	_ ·	#5's Incident/Accident 2 at 9:45am revealed: rst shift.			

her back and leg hurt.

-She was found in her room and complained that

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL034098	B. WING		R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM TI	ERRACE	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 270}	Continued From page	e 27	{D 270}		
	(MA) who completed Incident/Accident Rep 08/04/22 at 10:54am	vith the medication aide the progress note and the port dated 07/23/22 on was unsuccessful. 5's Fall Checklist dated			
	documented)There was no bleedi	al pain (place of pain not			
	have been assessed discomfort, changes i rotation of the legs or drowsiness, and reluctions, 16 hours, and 07/23/22. -Resident #5 should to 07/23/22 at 5:45pm, con 07/24/22 at 9:45arThere was a space to	22 revealed: bt completed. tation Resident #5 should for complaints of pain and n walking ability, outward arms, increased ctance to get out of bed at 8 24 hours after her fall on have been assessed on on 07/24/22 at 1:45am, and m. o check off Resident #5 was 16 hours, and 24 hours /22, but there was no			
	dated 07/25/22 revea -There was documen for Resident #5 from 07/25/22. -There was no addition	5's 15-minute Check Sheet led: tation of 15 minute checks 7:00am to 11:00pm on onal documentation of a after Resident #5's fall on			

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Division	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					_
			B. WING		R
		HAL034098	B. WING		08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
			SALISBURY R		
SALEM TE	RRACE				
		WINSTON	SALEM, NC 2	/12/	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	THE COLUMN TOTAL	is in the international of the	TAG	DEFICIENCY)	
			+		
{D 270}	Continued From page	e 28	{D 270}		
	07/23/22.				
	01123122.				
	Interview with a perso	onal care aide (PCA) on			
	08/04/22 at 11:38am	` ,			
		PCAs who found Resident			
	#5 on the floor in her				
		have any injuries, but she			
		hospital for evaluation.			
		to the facility on the same			
	day that she fell.	to the facility of the same			
	-	do anything differently for			
	Resident #5 when she				
	** *	Resident #5 was placed on			
		er her fall on 07/23/22.			
	10 minute oncoks and	51 Her fall 611 67726722.			
	Telephone interview v	with Resident #5's primary			
	-	on 08/05/22 at 8:50am			
	revealed:	31. 30,30, == at 3.33a			
		otified Resident #5 had a fall			
		r she did become aware of			
	her fall when she visit				
		dent #5 on 07/25/22, she			
		5 had right side weakness			
		not move like she wanted it			
		ysical therapy (PT) for			
	Resident #5.	,			
	-PT was also ordered	l due to her recent fall.			
	Telephone interview v	with Resident #5's home			
	health provider on 08	/05/22 at 8:34am revealed:			
	-Resident #5 was cur	rently receiving OT and was			
	admitted on 07/08/22	with a diagnosis of			
	lymphedema.				
	-The provider had not	t received an order for PT			
	until 08/04/22.				
	Based on record review	ews and interviews, there			
	was no documentatio	n 15-minute checks were			

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implemented for Resident #5 after her fall on 07/23/22; the 15 minute checks were not

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R	!
		HAL034098	B. WING		1	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
WANE OF T	TOVIDER OR GOLT EIER		SALISBURY R	•		
SALEM TE	ERRACE		SALEM, NC 2			
240.15	CHMMADY CT	ATEMENT OF DEFICIENCIES	T		NI T	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 29	{D 270}			
	implemented until 48	hours from the fall.				
		h the Special Care Unit on 08/03/22 at 4:20pm.				
	Refer to interview with 08/04/22 at 2:08pm.	h the Administrator on				
	 b. Review of Resident #5's progress note dated 07/30/22 at 9:00am revealed: -Resident #5 had an unwitnessed fall in her room around 7:15am. -The medication aide (MA) assessed Resident #5 and noticed she had a blackened left eye and a small cut above her left eye with a small amount of bleeding. -There were no other apparent injuries. -Resident #5 was transported via emergency 					
	emergency room (ER -Resident #5 returned	d from the ER on 07/30/22 nd was placed on 15-minute				
	dated 07/30/22 at 7:1 -Resident #5's legs gain her roomHer fall impact was causing a blackened left eye.	5's Incident/Accident Report 5am revealed: ave out on her while walking on the side of her face eye and small cut above her asported to the local hospital				
	dated 07/30/22 revea	5's ER After Visit Summary led: he ER with a diagnosis of a				

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-Imaging tests were completed, but there was no

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DIVISION	or riealin Service Negu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1		_
			B. WING		R
		HAL034098	B. WING		08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
			SALISBURY R		
SALEM T	ERRACE				
	Г	WINSTON	SALEM, NC 2	1121	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
				52.10.2.10.7	
{D 270}	Continued From page	2 30	{D 270}		
	documentation of signature of s	nentation regarding bruising			
	completed the progre	d 07/30/22 on 08/04/22 at			
	Review of Resident # 07/30/22 revealed:	5's Fall Checklist dated			
		ead and complained of			
		f pain not documented).			
		and a skin tears (location			
	not documented).	and a skin tears (location			
		nsported to the local hospital			
	by EMS.	isported to the local hospital			
	Review of Resident # Checklist date 07/30/3				
	-Resident #5 was ass	essed for complaints of pain			
	and discomfort, chang	ges in walking ability,			
	outward rotation of th	e legs or arms, increased			
	drowsiness, and reluc	ctance to get out of bed at 8			
	hours, 16 hours, and	24 hours after her fall on			
	07/30/22.				
		tation Resident #5 was			
		2 at 3:15pm, on 07/30/22 at			
		31/22 at 7:15am; there had			
	been no changes in h	er condition.			
		5's 15 minute Check Sheets			
	revealed:				
		tation of 15 minute checks			
		7/30/22 from 12:00pm to			
	12:00am.	tation of 15 minute sheets			
		tation of 15 minute checks			
	for Resident #5 on 07	7/31/22 from 7:00am to			

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-There was documentation of 15 minute checks

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		HAL034098	B. WING		08/0	S 5/2022
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZID CODE	1 00/0	JIZUZZ
NAME OF P	ROVIDER OR SUPPLIER		SALISBURY R			
SALEM TI	ERRACE		I SALEM, NC 2			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 270}	2:00pm. -There was no docume checks on 07/31/22 from the control of Reside 9:41am revealed: -Resident #5 had a solaceration above her land the resident #5's left eye below her left eye was there was yellowish cheek. Interview with Reside 11:29am revealed: -She fell and hit her hout above her eyeShe could not rement when it happened, but the land hit her hout above her eyeShe could not rement when it happened, but the land the land hit her hout above her eyeShe could not rement when it happened, but the land t	entation of 15 minute from 12:15am to 12:15am to 6:45am. ent #5 on 08/03/22 at cabbed, 1 inch horizontal left eye. elid was purple and the skin is purple. skin discoloration on her left ead, had a black eye and a laber the details of the fall or it it was much better. ministrator on 08/04/22 at lecond fall on 07/30/22, she sident #5. It o complete 15 minute there were any other acce other than 15-minute after a fall. with Resident #5's primary on 08/05/22 at 8:50am been notified Resident #5	{D 270}	DEPICIENCY)		
	Telephone interview v care provider (PCP) or revealed she had not had a fall on 07/30/22	ofter a fall. with Resident #5's primary on 08/05/22 at 8:50am been notified Resident #5				

was no documentation 15-minute checks were implemented continuously for 72 hours for Resident #5 after her fall on 07/30/22.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		08/0	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	2609 OLD S	RESS, CITY, STA BALISBURY RO BALEM, NC 2'	OAD	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 270}	Continued From page	32	{D 270}			
	Coordinator (SCUC) of Refer to interview with 08/04/22 at 2:08pm. 2. Review of Residen 05/25/22 revealed: -Diagnoses included of hypoglycemia, vitamin schizophrenia, and in	t #4's current FL2 dated dementia with psychosis, n D deficiency,				
	revealed: -Resident #4 used a v	4's care plan dated 05/19/22				
	of assistance Resider ambulation or with tra	nt #4 needed with				
	05/18/22 revealed: -Resident #4 fell at th lost his balance and fedoor beside him. (The where Resident #4 we head on.) -Emergency medical a Resident #4 to the loc (ER). Attempted telephone	e start of second shift as he ell hitting his head on the ere was no documentation as or which door he hit his services (EMS) transported cal hospital emergency room interview with the MA who as note dated 05/18/22 on was unsuccessful.				
	Review of Resident # Reports, Falls Checkl	4's Incident/Accident ists, Post Falls Checklists				

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revealed there was none available for Resident

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 11 2012211101		R	
		HAL034098	B. WING		1	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		D SALISBURY R			
_		WINSTO	N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 33	{D 270}			
	#4's fall on 05/18/22.					
	Interview with Residee 08/04/22 at 11:08am -Resident #4 was rec due to falls prior to his making progress; phy working with Residen maintain his strengthPhysical therapists w Resident #4 to ensure from his wheelchair to -He did not know abo 05/18/22 and had not recommendations for prevention to the facil Interview with Reside (PCP) on 08/01/22 at -She saw Resident #4 2022She reviewed a note documenting there wa 05/25/22 due to fallsThe previous provided due to Resident #4 ha -She would have experience of the same resident #4 ha -She would have experienced at 11:08 making the previous provided to Resident #4 ha -She would have experienced at 11:08 making the previous provided the same resident #4 ha -She would have experienced at 11:08 making progress; physical provided the provious provided the previous	eiving physical therapy (PT) s fall on 08/04/22 and was vsical therapists were t #4 on ambulation to vere also working with he he was able to transfer to his bed by himself. ut Resident #4's fall on made any interventions for fall lity. Int #4's primary care provider 3:27pm revealed: 4 for the first time in July from the previous provider as a face to face visit on er ordered a rollator walker aving abnormal gait. ected the facility to contact a				
	once the order for the	rovider to order the rollator e rollator was written.				
	was no documentatio	ews and interviews there n 15-minute checks were dent #4 after his fall on				
		h the Special Care Unit on 08/03/22 at 4:20pm.				
	Refer to interview with	h the Administrator on				

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08/04/22 at 2:08pm.

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
			B. WING		F	
		HAL034098	B. W		08/0)5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM T	ERRACE		SALEM, NC 2			
	OUR MAR DV OT			1		1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
(D 270)	0	- 04	(D 270)			
{D 270}	Continued From page	e 34	{D 270}			
	b. Review of Residen	t #4's progress note dated				
	06/07/22 revealed:					
	-Resident #4 had an i	unwitnessed fall in the				
		CU) courtyard and was found				
		h his two wheeled walker				
	nearby.					
	_	e tripped over his feet.				
		t hip pain, but he denied				
	hitting his head.					
	-Resident #4 was ser	nt to the local hospital				
) via emergency medical				
	services (EMS).	, 3 ,				
	-He returned to the fa	cility on 06/07/22.				
	Attempted interview v	vith the staff who				
	-	ress note dated 06/07/22 on				
	08/04/22 at 10:37am					
	Review of Resident #	4's Incident/Accident Report				
	dated 06/07/22 revea					
	-Resident #4 had an i	unwitnessed fall in the SCU				
	courtyard.					
	-He was found laying	on his back.				
	-He stated he tripped					
	complained of left hip	pain.				
		•				
	Review of Resident #	4's Fall Checklists revealed				
	there was no Falls Ch	necklist for Resident #4				
	dated 06/07/22.					
	Review of Resident #	4's 24 Hour Post Fall				
	Checklist dated 06/07	7/22 revealed:				
	-Resident #4 was ass	sessed for complaints of pain				
	and discomfort, chang	·				
		e legs or arms, increased				
		ctance to get out of bed at 8				
		24 hours after her fall on				
	06/07/22.					

Division of Health Service Regulation

-There was documentation Resident #4 was

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		08/05/2022	
NAME OF D	ROVIDER OR SUPPLIER	STDEET AP	DRESS, CITY, STA	TE ZIR CODE		
NAME OF FI	NOVIDER OR SUFFLIER					
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	I SALEM, NC 2	/12/		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
{D 270}	Continued From page	e 35	{D 270}			
, ,						
	•	3:00am, and 11:00am, but				
	his condition.	ere had been no changes in				
	nis condition.					
	Review of Resident #	4's progress note dated				
	06/09/22 at 2:26pm re	· -				
	•	al therapist visited with him				
	on 06/09/22 and repo	rted to the medication aide				
	(MA) that Resident #4 was complaining of left hip					
	pain and was unable to stand.					
		esident #4's PCP who gave				
		x-ray, left hip series, due to				
	pain in the left hip and	d inability to stand.				
	Review of Resident #	4's progress note dated				
		evealed Resident #4 had				
	•	ay complaining of leg pain.				
		, , , , , , , , , , , , , , , , , , , ,				
		4's progress note dated				
	06/09/22 at 4:32pm re					
		ned of left hip pain and the				
		P's office to request an				
	order for pain medica	tion. d that the PCP was waiting				
		the x-ray completed during				
	the local hospital ER	, .				
	Review of Resident #	4's progress notes dated				
	06/10/22 revealed:	-				
		as documentation a standing				
		nen (a medication used to				
		istered to Resident #4 due				
	to pain in his left hip.	notified Booldant #41- DCB				
		notified Resident #4's PCP				
		of left hip pain from his fall r was received to start				
	Resident #4 on ibupro					
	. tooldont // - on ibupit					
	Review of Resident #	4's progress note dated				

Division of Health Service Regulation

06/11/22 at 8:11pm revealed he continued to

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		HAL034098	B. WING		08/05/2022	
		HAL034090			00/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CALEME	-DDAGE	2609 OL	D SALISBURY R	OAD		
SALEM TE	ERRAGE	WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLET	Œ
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE DATE	
	70) 0 1: 15			,		-
{D 270}	Continued From page 36		{D 270}			
	complain of pain in his left hip.					
	Review of Resident #	4's progress notes dated				
		4 s progress notes dated				
	06/14/22 revealed: -At 1:55pm, Resident #4 complained of pain in his					
	• •	n standing and of not being				
	able to stand.	rr starraing and or not boing				
	-At 3:10pm, Resident	#4 was given				
	acetaminophen for leg pain.					
	•	5 1				
	Review of Resident #4's progress note dated					
	07/09/22 revealed:	· -				
	-Resident #4 asked if	his PCP could write an				
	order for him to have	a wheelchair.				
	-Resident #4 stated h	is legs did not work like they				
	used to, and he really	needed a wheelchair.				
		ility's contracted registered				
	` ,	22 at 4:35pm revealed:				
	courtyard on 06/07/22	ent #4 after he fell in the				
	•	t he hurt his hip and he was				
	sent out to the local h					
		walking after his fall on				
	06/07/22 and began t					
	_	s in place for Resident #4,				
		what other interventions				
	were in place.					
	'					
	Interview with Resident #4's physical therapist on 08/04/22 at 11:08am revealed:					
	-Resident #4 was pro	gressing with his physical				
	therapy and was work					
	maintain his strength.					
	-Physical therapists w					
		e he was able to transfer				
	from his wheelchair to					
	-He did not know abo	ut Resident #4's fall on				

06/07/22 and had not made any recommendations for interventions to the facility.

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Division of Health Service Regulation						
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					F	2
		HAL034098	B. WING		1	5/2022
					1	0/2022
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
17.0	_	,	17.0	DEFICIENCY)	-	
(D 070)	Continued From page 27		(D 070)			
{D 270}	Continued From page	∍ 37	{D 270}			
		ent #4's primary care provider				
	(PCP) on 08/02/22 at					
		4 for the first time in July			ļ	
	2022.				ļ	
	-Resident #4 had an x				ļ	
	06/10/22 due to comp	plaints of pain after he fell on				
	-The x-ray resulted in	the absence of any			ļ	
	fractures.	Tille absence of any			ļ	
		from the previous provider			ļ	
		as a face to face visit with			ļ	
	Resident #4 on 06/15					
	-On the 06/15/22 visit	t, Resident #4 continued to			ļ	
	complain of hip pain a	and the previous provider			ļ	
	ordered Resident #4				ļ	
	_	the previous provider			ļ	
		and did not fit the chair he			ļ	
	was using that did no	t belong to him.			ļ	
	Based on record revie	ews and interviews, there				
		on 15-minute checks were				
		ident #4 after his fall on				
	06/07/22.					
	Refer to interview with	h the SCUC on 08/03/22 at				
	4:20pm.					
		h the Administrator on				
	08/04/22 at 2:08pm.					
	c Review of Residen	it #4's progress note dated				
	08/01/22 at 8:50pm re					
		t #4 in his room with his				
	wheelchair tipped over					
		ne was trying to get in his				
	bed.	, , ,				
ļ	I		1			

Review of Resident #4's Incident/Accident Report dated 08/01/22 at 7:30pm revealed:

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Division of	Division of Health Service Regulation				1 Oraw	AITROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL034098	B. WING		R 08/0	R 5/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	-RRACE	2609 OLD	SALISBURY R	OAD		
OALLIN 11		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 270}	O} Continued From page 38		{D 270}			
	wheelchair tipped ove -Resident #4 complair right elbow hurt. -Resident #4 was sen (ER).	ned his ankles, left hip, and				
	courtyardHe had a bandage wright handResident #4 was prowheelchairThe wheelchair had another resident's nar-The back of Residenteet away from the froseat and his legs were level to the floor. Interview with Resider revealed:	revealed: Inted in a wheelchair in the Interapped loosely around his Interped loosely				
	-He was trying to tran- his bed when he fell. -He was sent out to th but he did not have ar -He had had previous remember when. Interview with the med documented Resident					

in the wheelchair.

-Resident #4 was found in his room with his wheelchair tipped over on its side and he was still

-Resident #4 stated his feet felt swollen and that

STATE FORM 6899 63ET13 If continuation sheet 39 of 105

MALO34098 D. WING D.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
CALID CONTINUED TO PRECIDENCE COMPLETE AND PROVIDER'S PLAN OF CORRECTION CALID PREFIX CALID PROVIDER'S PLAN OF CORRECTION PREFIX CALID PROVIDER'S PLAN OF CORRECTION CALID PREFIX CALID PROVIDER'S PLAN OF CORRECTION CALID PREFIX PREFIX CALID			HAL034098	B. WING			
(MA) D SUMMARY STATEMENT OF DEFICIENCIES CRACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE D CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
### (GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### (D 270) ### (SALEM TERRACE						
his elbow and his hip hurtResident #4 was sent to the hospital emergency room for further evaluationResident #4 was placed on 15-minute checks when he returned from the hospitalResident #4 was not on 15-minute checks prior to his fall on 08/01/22She usually checked on residents every 30-minutes or every hourShe did not know of any interventions put in place for Resident #4 except for physical therapy. Review of Resident #4's Fall Checklist dated 08/01/22 revealed: -Resident #4 did not hit his head, but he complained of unusual pain (place of pain not documented)There was no bleeding and no skin tearsResident #4 was transported to the local hospital by EMS. Review of Resident #4's 24 Hour Post Fall Checklist dated 08/01/22 revealed: -Resident #4 was assessed for complaints of pain and discomfort, changes in walking ability, outward rotation of the legs or arms, increased drowsiness, and reluctance to get out of bed at 8 hours, 16 hours, and 24 hours after his fall on 08/01/22There was documentation Resident #5 was assessed on 08/02/22 at 3:30am, on 08/02/22 at 11:30am, and on 08/02/22 at 7:30am and there	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMI	PLETE
-There was a space to check off Resident #4 was assessed at 8 hours, 16 hours, or 24 hours after his fall on 08/01/22, but there was no documentation he had been assessed.	{D 270}	his elbow and his hip Resident #4 was sen room for further evalu Resident #4 was plac when he returned fror Resident #4 was not to his fall on 08/01/22 She usually checked 30-minutes or every h She did not know of place for Resident #4 Review of Resident #4 Review of Resident #4 Gesident #4 did not h complained of unusual documented). There was no bleedin Resident #4 was tran by EMS. Review of Resident # Checklist dated 08/01 Resident #4 was ass and discomfort, chan outward rotation of the drowsiness, and reluct hours, 16 hours, and 08/01/22. There was document assessed on 08/02/22 11:30am, and on 08/0 had been no changes There was a space to assessed at 8 hours, his fall on 08/01/22, b	hurt. It to the hospital emergency ation. Deed on 15-minute checks in the hospital. It to the hospital emergency ation. Deed on 15-minute checks in the hospital. It to no 15-minute checks prior It to no residents every four. It any interventions put in except for physical therapy. It is Fall Checklist dated In this head, but he is pain (place of pain not in any interventions put in except for complaints of pain pain (place of pain not in any interventions in a pain (place of pain not in a pain in a pain (place of pain not in a pain in	{D 270}			

Division of Health Service Regulation

revealed:

Review of Resident #4's 15-minute Check Sheets

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Division of Health Service Regulation						
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		08/05/2022	
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	,		
SALEM TE	ERRACE		SALISBURY RO			
		WINSTON	N SALEM, NC 27	<u>'127 </u>		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	,	(X5) MPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		ATE
				DEFICIENCY)		
{D 270}	Continued From page		{D 270}			
ر ۱۵ کر در	Continued From Page	continued From page 40				
	-There was documentation of 15-minute checks					
		7:00am to 3:00pm and from				
	4:15pm to 4:30pm on					
		tation of 15-minute checks				
	for Resident #4 from 08/03/22.	7:00am to 11:45am				
		onal documentation of				
		n after Resident #5's fall on				
	08/01/22.	Tattor resident not a lan en				
	Interview with the Spe	ecial Care Unit Coordinator				
	, ,	at 12:23pm revealed:				
		08/01/22 and was sent out to				
	the ER.					
		e facility on the same day				
		umenting his vitals and any				
	changes each shift fo	or 24 nours. o started on 15-minute				
	checks for 72 hours.	o started on 15-minute				
	CHECKS IOI 12 HOURS.					
	Interview with Reside	ent #4's physical therapist on				
	08/04/22 at 11:08am					
	-Resident #4 was pro	ogressing with his physical				
	therapy and was work	<u> </u>				
	maintain his strength.					
		vere also working with				
		e he was able to transfer				
	from his wheelchair to	•				
	08/01/22 and had not	out Resident #4's fall on				
		r interventions to the facility.				
	1000mmonaatione is:	interventions to the racinty.				
	Interview with Reside	ent #4's primary care provider				
	(PCP) on 08/03/22 at					
		4 for the first time in July				
	2022.					
		st visit with Resident #4, staff				
		nt #4 had a history of falls.				
ļ	-Staff also informed h	ner Resident #4 liked to be				

independent and refused help.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL034098	B. WING		I	₹ 05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	-	
		2609 OLI	SALISBURY RO	AD		
SALEM T	ERRACE		N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{D 270}	Continued From page	e 41	{D 270}			
	08/01/22. -If she had been notif	of Resident 4's fall on ied of Resident #4's fall on nave requested a urinalysis dication.				
		•				
	Refer to interview with the SCUC on 08/03/22 at 4:20pm.					
	Refer to interview with 08/04/22 at 2:08pm.	h the Administrator on				
	revealed: -If a resident had an use was visible bleeding, emergency roomOnce the resident repaperwork would be fany new orders would and it would be docur progress notesOnce the resident reresident was placed of days and assessed for 24 hoursShe did not know of place for residents pr SCUC on 08/01/22, b continued to fall, the inhave the resident's less the sident's less that the	UC on 08/03/22 at 4:20pm unwitnessed fall and there the resident was sent to the turned to the facility, any forwarded to the SCUC and do be faxed to the pharmacy mented in the resident's turned to the facility, the on 15 minute checks for 3 or changes once each shift any interventions put in iter to starting her role as out in the future, if a resident intervention would be to vel of care reassessed.				
	2:08pm revealed:	ministrator on 08/04/22 at they were placed on 15				

Division of Health Service Regulation

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STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
AND FLAN C	A. BUILDING:		COMPL	=160		
		1141 00 4000	B WING		F	
		HAL034098	J		1 08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
			SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 270}	Continued From page	; 42	{D 270}			
	provider (PCP) was n condition, and skin che shift for 24 hours. If a resident had repewith the resident's fan medication review, ar modifications. Any interventions in should have been door record and increased checks) should have 15-minute check sheet-Residents who were routinely on 15 minute MAs were supposed checks and the SCUC to ensure the 15 minute completed and docum-She did occasional p	place after a resident's fall cumented in the resident's supervision (15-minute been documented on the et. high fall risks were not e checks. to document the 15 minute C was supposed to follow-up ute checks were being				
	for 2 of 5 sampled res Resident #4 who had pain in his left hip, rigidecrease in ambulation had 2 falls within a well- blackened eye and a This failure was detrirand welfare of the res Type B Violation. The facility provided a accordance with G. S CORRECTION DATE	laceration above her eye. mental the health, safety, sidents and constitutes a a plan of protection in 131D-34 on 08/04/22.				

Division of Health Service Regulation

19, 2022.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2609 OLD 9	SALISBURY R	OAD		
SALEM TI	ERRACE		SALEM, NC 2			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{D 273}	10A NCAC 13F .0902	2(b) Health Care	{D 273}			
	. ,	P. Health Care Assure referral and follow-up And acute health care needs				
	This Rule is not met FOLLOW-UP TO CO VIOLATION	•				
	Based on these findir Type B Violation has	ngs, the previously Unabated not been abated.				
	Based on observations, record reviews and interviews, the facility failed to ensure health care referral and follow up were completed for 3 of 5 sampled residents (#1, #4, and #5) who had orders for urinalyses and physical therapy (#1); orders for a rollator walker and a wheelchair, and a recommendation to obtain a referral to see a neurologist (#4); and an order for physical therapy (#5).					
	The findings are:					
	08/26/21 revealed: -Diagnoses included moderate intellectual diabetes.	of bladder and bowel.				
	06/06/22 revealed: -There was an order t	t #1's physician order dated for a urinalysis (UA), a urine test for the presence of a				

Division of Health Service Regulation

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Division of Health Service Regulation					
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		08/05/2022
		HAE034096			00/03/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		2609 OLI	SALISBURY R	OAD	
SALEM TI	ERRACE	WINSTO	N SALEM, NC 2	7127	
()(4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
{D 273}	Continued From page 44		{D 273}		
(2 2.0)			(2 2.0)		
	-There was a handwritten note on the bottom of the order form that the UA had been collected on				
	06/07/22.				
		1's record revealed there			
	was no UA result from the specimen collected on				
	06/07/22.				
		1's Emergency Medical			
	\	fer report dated 06/17/22			
	revealed she had bee				
		ent (ED) due to altered			
	mental status (AMS)	with weakness.			
	Daview of Davidant #	Ala ED Affan Viait Comana an e			
	dated 06/17/22 revea	1's ED After Visit Summary			
		with a urinary tract infection			
	(UTI).	with a dililary tract infection			
	-She had been presci	ribed Bactrim DS			
		otic used to treat various			
	- '	ablet two times daily for 7			
	days.	ablet two times daily for T			
	days.				
	Review of Resident #	1's Progress Notes			
	revealed:				
		ility's previous Special Care			
		UC) documented that			
	· ·	been collected and the lab			
	was called to pick it u				
	-On 06/09/22, a medi	•			
		ident #1 had been upset all			
		staff to help her with her			
	care and that she was	•			
	-On 06/11/22, the fac				
		ident #1 had been hollering			
		the start of the shift; she			
	_	om her room because her			
	roommates were una	ble to sleep with her yelling.			
		m Resident #1 was refusing			

Division of Health Service Regulation

assistance from staff and hitting, cursing and

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DIVISION	or riealin Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			B WING		R	
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM T	ERRACE		SALEM, NC 2			
			JALLIN, NC 2			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
iAO		,	I AG	DEFICIENCY)		
			+			
{D 273}	Continued From page	e 45	{D 273}			
	screaming at staff to	go away and threatening to			ĺ	
	harm them.	go ama, ama ambatog to				
		vious SCUC documented			ļ	
		yelling in the hallways.				
		locumented that Resident #1				
	· ·	sive behaviors towards staff				
	and her roommates.	ive beliaviors towards stair				
		ocumented that Posident #1				
		ocumented that Resident #1				
		g shift change, was yelling				
		s able to be redirected.				
		am, a MA documented that				
		aming and acting out, hitting				
	_	her wheelchair and not				
		her; she was sent to the				
		haviors and to protect her				
	along with the other re					
	· · · · · · · · · · · · · · · · · · ·	om, a MA documented that				
	she received a call fro	om a nurse at the hospital				
	who reported Resider	nt #1 would be discharged				
	that day and that she	was being treated for a				
	"raging UTI." She had	l received fluids and an				
	antibiotic through an i	ntravenous catheter (IV).			ĺ	
					ĺ	
	_	UC on 08/04/22 at 10:00am			l	
	revealed:					
		nployed at the facility on				
	06/06/22, but started	working as a medication				
	aide (MA) at the facili	ty through an agency shortly				
	thereafter.					
	-She knew that Resid	ent #1 was a difficult				
	resident to collect uring	ne specimens from due to				
	her dementia and her	behaviors.				
	-When the PCP order	ed UAs for residents, the				
	order first went to the	SCUC, then the SCUC was				
		ng the MA that a UA needed			ľ	
	to be collected.	-				
	-Urine specimens we	re collected by placing a			ľ	
	collection device into					
		e specimens were placed in				

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the designated refrigerator until the laboratory

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			, 50.25		
	HAL034098 B. WING		R 08/05/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CALEMIT	SALEM TERRACE 2609 OLD			OAD	
SALEWI II	RRACE	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 273}	Continued From page	2 46	{D 273}		
{D 273}	staff came to pick the -If the previous SCUC specimen was collect from the laboratory st there was no result for Telephone interview was the facility's contracted 12:50pm revealed the collect a UA specimen 2022, and they did not Resident #1. Telephone interview was second laboratory on revealed they had not UA specimen for Res they did not have any Interview with the Adr 3:00pm revealed: -She was not aware t UA obtained when it was -When the primary ca order to collect a UA, for telling the MA on obly placing a collection toiletOnce the UA was co would label the specifi designated refrigerate come and pick up the -The SCUC was resp	chad documented that the ed and awaiting pick-up aff, she did not know why or the UA. with a representative from a diaboratory on 08/04/22 at ey had not received a call to a for Resident #1 in June of thave any UA results for with a representative from a 08/04/22 at 1:00pm to received a call to collect a ident #1 in June 2022, and a UA results for Resident #1. ministrator on 08/04/22 at that Resident #1 never had a was ordered in June 2022. Interprovider (PCP) wrote an the SCUC was responsible duty to obtain the specimen in hat into the resident's lilected, the MA or SCUC men, place it in the or, and call the laboratory to	{D 273}		
	received by the labora -Once a UA result wa records staff would pr copy in the PCP's fold	atory. s available, the medical int the result and place a			

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STATE FORM 6899 63ET13 If continuation sheet 47 of 105

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			
		HAL034098	B. WING		R 08/05/202	22
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TI	ERRACE		SALISBURY R			
	CLIMMADY CT		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
{D 273}	June 2022 so she had they test her for a UT -She never received a result; the next comm from the facility was to #1 had went to the EUUTI. Telephone interview v 08/05/22 at 9:00am re-On 06/06/22, there we between Resident #1' facility's staff. -The facility staff were was having an increase week, her urine had a requesting an order for The previous PCP or but there was no result that order. -It was the PCP's expund was given, the facility so that trease indicated. Based on observation review, it was determinated interviewable. b. Review of Residen 07/25/22 revealed the urine and send for urine was to the trease of the result to the lab for the result so that trease indicated.	m revealed: having behaviors in early d suggested to the staff that I. a phone call about the UA hunication she had received to let her know that Resident D and was diagnosed with a with Resident #1's PCP on evealed: was a telephone encounter 's previous PCP and the e reporting that Resident #1 se in behaviors for the past a strong odor, and they were for a UA. Indered a UA for Resident #1, wilt available to review from exectation that if an order for a cility collect the UA, send the for testing, and follow up on transity to the started if as, interviews, and record ined that Resident #1 was t #1's physician order dated ere was an order to obtain nalysis (UA) to rule out (UTI) secondary to delirium	{D 273}			
		sult from the order written on				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	,
			B. WING		R	
		HAL034098	B. WING		08/0	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE					
		WINSTON	SALEM, NC 2	/12/		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	NEGOLATORT OR I	EGC IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL]
				,		
{D 273}	Continued From page	e 48	{D 273}			
	07/05/00					
	07/25/22.					
		nentation regarding the UA			ļ	
	order written 07/25/22	2.				
	Interview with the Spe	ecial Care Unit Coordinator				
	(SCUC) on 08/04/22	at 10:00am revealed:				
	-She had not been the	e SCUC on 07/25/22 when				
	Resident #1's UA ord	er was written.				
	-She knew that Resid	lent #1 was a difficult				
		ne specimens from due to				
	her dementia and her	•				
		le to collect a UA from				
		e supposed to document				
		Notes and notify the primary				
	care provider (PCP).	votes and notify the primary				
	. , ,	red UAs for residents, the				
		•				
		SCUC, then the SCUC was				
		ng the MA that a UA needed				
	to be collected.					
	•	re collected by placing a				
	collection device into					
		e specimens were placed in				
		erator until the laboratory				
	staff came to pick the	m up.				
		with a representative at the				
	•	boratory on 08/04/22 at				
		ey had not received a call to				
	collect a UA specime	n for Resident #1 in July				
	2022, and they did no	ot have any UA results for				
	Resident #1.					
	Telephone interview v	with a second laboratory on				
	08/04/22 at 1:00pm re					
		ect a UA specimen for				
		022, and they did not have				
	any UA results for Re					
	any Unicoults for Re	SIGGIL # 1.				
			1			

Division of Health Service Regulation

3:00pm revealed:

Interview with the Administrator on 08/04/22 at

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_B	
		HAL034098	B. WING		R	
		HALU34090			08/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
041 514 5		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5	 5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPL	LETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DAT	E
				52.10.2.10.7		
{D 273}	Continued From page	e 49	{D 273}			
	Cha was not swam t	hat Daaidant #4 navenhad a				
		hat Resident #1 never had a				
		was ordered on 07/25/22.				
		e an order to collect a UA,				
	duty to obtain the spe	nsible for telling the MA on				
	collection hat into the					
		llected, the MA or SCUC				
	would label the specia					
		or, and call the laboratory to				
	come and pick up the	•				
		onsible for following up on				
		ng they were collected and				
	received by the labora	-				
		s available, the medical				
		rint the result and place a				
	copy in the PCP's fold	· · · · · · · · · · · · · · · · · · ·				
	-If an MA was not abl					
	Resident #1, they we					
		ormation in the Progress				
	Notes and notifying th					
	, 0					
	Interview with a MA o	n 08/04/22 at 4:00pm				
	revealed:	·				
	-She remembered Re	esident #1 having an order				
	for a UA at the end of	July 2022, but thought it				
	had been collected or	n the day shift prior to her				
	coming in, so she did	not collect another one.				
	-She did not rememb	er Resident #1 having any				
	increase in symptoms	s or behaviors at the time				
	the UA was ordered of	on 07/25/22, because				
	Resident #1 often had	d behaviors due to her				
	dementia.					
		on her shift or needed to be				
	•	the SCUC would tell her.				
		le for collecting a UA for				
		uld put the collection hat into				
	her toilet and place th	ne specimen into a specimen				
	cup labeled for Resid	ent #1				

-She did not know what she would do with the specimen once collected, because she had never

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Division	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	_
			D WING		F	
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TW WILL OF T	NOVIBER OR GOLF EIER		, ,	,		
SALEM TI	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	INEGOLATORI ORT	EGC IDENTIF TING IN ORMATION)	TAG	DEFICIENCY)	MAIL	5,112
			+			
{D 273}	Continued From page	e 50	{D 273}			
		anidout hafaun				
	collected a UA for a re	esident before.				
	Talambana intansiaww	with Decident #415 DCD on				
		with Resident #1's PCP on				
	08/05/22 at 9:00am re					
		UA for Resident #1 on				
	07/25/22 because she					
	increased agitation th					
		ved a result from the UA she				
	ordered for Resident					
		d an update from the facility				
		able to collect the UA for				
	Resident #1.					
		on that if an order for a UA				
		collect the UA, send the				
	-	or testing, and follow up on				
		tment could be started if				
	indicated.					
		ns, interviews, and record				
		ined that Resident #1 was				
	not interviewable.					
		t #1's physician order dated				
		ere was an order for physical				
		on and treatment secondary				
	to decline in mobility	and balance.				
		1's record revealed there				
	_	garding the evaluation and				
	treatment order from	06/07/22.				
	•	with the facility's contracted				
	physical therapist on					
	revealed he had not r					
		and had not been providing				
	PT treatment for Resi	ident #1.				
	Interview with the Spe	ecial Care Unit Coordinator				
	(SCUC) on 08/04/22					
	-She had just found tl	hat day, 08/04/22, the hard				

Division of Health Service Regulation

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		HAL034098	B. WING		1	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CALEMA	-DDAGE	2609 OLD	SALISBURY R	OAD		
SALEM TI	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 273}	Continued From page	e 51	{D 273}			
	copy of the PT order of 06/07/22 and saw that pharmacy rather than -Resident #1 was ablitransfer, but needed a -Some days, Resident transfer without difficult unsteady, and it took to stand and pivot to a -Resident #1 did not be falls; she did have a five with staff present. -The SCUC who had would have been respect to the PT office, then not receive a phone of previous SCUC would calling the PT office to order. -Once an order was firesponsible for waiting receipt, stapling it to the placing it in the 48-hould be a subject of the previous stapling it to the placing it in the 48-hould be resident #1 used to a lot of cues, and couransfers but preferred -Once the order for Puene given to the SC been responsible for the scale of the scale	for Resident #1 from It it had been faxed to the Ithe PT office. Ithe eto stand, pivot, and It is assistance. Ithe #1 was able to stand and Ity, but some days she was It a lot of coaching to get her It complete the transfer. It is a lot of coaching to get her It complete the transfer. It is a lot of coaching to get her It complete the transfer. It is a lot of coaching to get her It is a lot of coac				

Division of Health Service Regulation

Telephone interview with Resident #1's guardian

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B. WING		R	
		HAL034098	B. WING		08/0	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2609 OL	SALISBURY R	OAD		
SALEM TE	ERRACE		N SALEM, NC 2			
			N SALEWI, NO 2	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		DATE
		,	,,,,,	DEFICIENCY)		
{D 273}	Continued From page	e 52	{D 273}			
	on 08/04/22 at 5:30pr	m revealed:				
		er an order for PT being				
	written for Resident #					
		ecrease in her mobility but it				
		ataracts making her hesitant				
		she could not see well.				
		sident #1 just sitting in her				
		en she was physically				
	capable of walking.	errone was priyolodily				
		nave falls, but needed help				
	with strengthening an					
	•	lent #1 to have PT treatment				
	to assist with strength					
	to assist with strength	ierning and balance.				
	Telephone interview v	vith Resident #1's PCP on				
	08/05/22 at 9:00am re					
		us PCP had written the				
	order for PT evaluation					
		#1 was disoriented a lot due				
	to her dementia.	, i was alsomerica a fet aus				
		and and pivot but she was				
	not able to walk.	and and pivot but one was				
		nefit Resident #1 because it				
	•	n her muscles which would				
	make transferring eas					
	5					
	Based on observation	ns, interviews, and record				
		ined that Resident #1 was				
	not interviewable.					
	2. Review of Residen	t #4's FL2 dated 05/25/22				
	revealed:					
	-Diagnoses included	dementia with psychosis,				
	hypoglycemia, vitamii					
	schizophrenia, and in					
		ni-ambulatory and used a				
	walker.	,				

a. Review of Resident #4's physician's order dated 05/25/22 revealed an order for a rollator

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					l R	•
		HAL034098	B. WING		1	5/2022
		TIALUUTUUU			1 00/0	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEM IE	INNACE	WINSTON	SALEM, NC 2	7127		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DATE
					-	
{D 273}	Continued From page	e 53	{D 273}			
	walker.					
	wantor.					
	Observations of the S	Special Care Unit (SCU) on				
	08/03/22 between 11					
	revealed:	•				
	-Resident #4 was pro	pelling in the hallway in a				
	wheelchair.					
		vo wheeled walker in his				
	room, but there was r	no rollator walker.				
		1.114 00.100.100 1				
	Interview with Reside	ent #4 on 08/03/22 at				
	11:56pm revealed:	Over a la la de de la la compa				
	had a rollator walker.	n 2 wheels, but he had never				
		vo wheeled walker as much				
		when he ambulated to the				
		ne participated in physical				
	therapy.					
	.,					
	Interview with the fac	ility's contracted registered				
	nurse (RN) on 08/03/	22 at 4:35pm revealed:				
		all in the SCU courtyard on				
	06/07/22.					
		eled walker with him when he				
	fell.					
		have a rollator walker and				
	rollator for him.	e facility had ordered a				
	Toliator for fillit.					
	Interview with a medi	cation aide (MA) on				
	08/03/22 at 12:06pm					
		igh fall risk with his last fall				
	being on 08/01/22.	-				
		have an order for a rollator				
	walker to her knowled	•				
	-Staff currently assist					
	showers and with toil	eting.				

Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 12:23pm revealed:

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Division of Health Service Regulation					
	VIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN	TIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
				R	
H.	AL034098	B. WING		08/05/2022	
NAME OF PROVIDER OF CURRILIER	CTDEET AS	DDECC CITY CTA	TE 7/D 00DE	·	
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SALEM TERRACE		SALISBURY RO			
		N SALEM, NC 27			
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTI	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETI THE APPROPRIATE DATE	Έ
{D 273} Continued From page 54		{D 273}			
-She had worked in the role of	SCUC since				
08/01/22					
-The SCUC was responsible for ordering medical equipments	•				
-She was not aware of any ord					
walker for Resident #4.	iora ronato.				
Interview with Resident #4's p					
(PCP) on 08/01/22 at 3:27pm -She saw Resident #4 for the					
2022.	irst time in July				
-She reviewed a note from the	previous provider				
documenting there was a face					
05/25/22 due to falls.					
-The previous provider ordere					
due to Resident #4 having abr	•				
-She did not know the rollator ordered for Resident #4.	had not been				
-She would have expected the	facility to contact a				
durable medical equipment pro					
rollator once the order for the					
Interview with the Administrato	or on 08/04/22 at				
2:08pm revealed:					
-Rollators were not covered by					
-Resident #4's family should h					
to inform of the order for a roll	•				
to cover the cost of the rollator					
been contacted regarding the	-				
rollator.					
-The SCUC was responsible for	or contacting				
Resident #4's family.					
Attempted telephone interview	with Resident #4's				
responsible party on 08/04/22					
unsuccessful.				l l	

dated 06/15/22 revealed an order for a

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Division	of Health Service Regu	lation			
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL034098	B. WING		08/05/2022
					1 00/00/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE	
SALEM TERRACE 2609 OLI			D SALISBURY R		
· · · · · · · · · · · · · · · · · · ·		WINSTO	N SALEM, NC 2	7127	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
{D 273}	Continued From page	e 55	{D 273}		
	wheelchair appropriat	te for his weight			
	Wilcolonali appropriat	te for file weight.			
	Review of Resident # 07/09/22 revealed:	4's progress note dated			
		his PCP could write an			
	order for him to have				
		is legs did not work like they			
		needed a wheelchair.			
	,,				
	Observations of the S	Special Care Unit (SCU) on			
	08/03/22 between 11:	:35am and 12:00pm			
	revealed:				
	-Resident #4 was pro wheelchair.	pelling in the hallway in a			
		a label attached to it and			
	another resident's na				
		it #4's calves were 1.5 feet			
		dge of the wheelchair seat			
		phtly above a parallel level to			
	the floor.				
	-There was not anoth	er wheelchair in his room.			
	Intoniou with Pooldo	nt #4 on 09/03/33 at			
	Interview with Reside 11:56pm revealed:	iii #4 OII OO/OO/ZZ at			
	•	elchair of his own, but he			
	had been using a whe	eelchair provided by the			
	facility for about 3 mo				
	-He requested a whee	elchair about a month ago			
		sician did not approve for			
	him to get a wheelcha	air.			
	-He was 6 feet tall.				
	Interview with the feet	ility's contracted registered			
		22 at 4:35pm revealed:			
	, ,	a wheelchair conducive to			
	his height.	a moderna conducto			
	_	out 2 inches between the			
		and the back of the legs.			
		n 2 inches between the front			

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edge of the seat and the back of Resident #4's

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R 08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E
{D 273}	Continued From page	÷ 56	{D 273}			
	legs in the wheelchair -She did not know if the wheelchair for Reside Interview with Reside 08/04/22 at 11:08am are recommended Reside wheelchair with a custom Interview with a medic 08/03/22 at 12:06pm are recommended Reside wheelchair with a custom recommended Reside wheelchair with a custom recommended Reside wheelchair with a medic 08/03/22 at 12:06pm are resident #4 was a high being on 08/01/22. Resident #4 did not he wheelchair to her knong a wheelchair to her knong a wheelchair was family of a resident with a res	the was currently using. The facility had ordered a new ant #4. Int #4's physical therapist on revealed he definitely ent #4 have a new hion. Cation aide (MA) on revealed: The fall risk with his last fall enave an order for a wledge. 22, Resident #4 began with ambulation and started donated to the facility by the ho had passed away. Int Coordinator (SCUC) and the responsible for following dical equipment. UC on 08/04/22 at 12:23pm				
	08/01/22 -The SCUC was resp	onsible for reviewing orders cal equipment for residents. of any orders for a				

06/07/22.

2022.

Interview with Resident #4's primary care provider

(PCP) on 08/01/22 at 3:27pm revealed: -She saw Resident #4 for the first time in July

-Resident #4 had an x-ray of his left hip on 06/10/22 due to complaints of pain after he fell on

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Division of	of Health Service Regu	ılation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
SALEM TE	ERRACE		SALISBURY RO SALEM, NC 27		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 273}	Continued From page	= 57	{D 273}		
	documenting there we Resident #4 on 06/15 -On the 06/15/22 visit complain of hip pain a ordered Resident #4 know the facility had Resident #4Facility staff advised not fit the chair he was to himShe would have expedurable medical equiporder a wheelchair fo was written.	e from the previous provider as a face to face visit with 5/22. t, Resident #4 continued to and the previous provider a wheelchair; She did not not ordered the rollator for Resident #4 was tall and did as using that did not belong sected the facility to contact a pment (DME) provider to or Resident #4 once the order			
	2:08pm revealed: -The SCUC was resp DME provider to orde Resident #4.	a wheelchair had been			
	dated 05/05/22 revea -The physical therapis medication aide (MA) Coordinator (SCUC) to primary care provider neurologist to confirm disease.	st discussed with the) and the Special Care Unit to have Resident #4's r (PCP) to refer him to a n or rule out Parkinson's			
	Interview with the bus	siness office manager (BOM)			

on 08/03/22 at 4:50pm revealed:

-She was responsible for making appointments

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE S COMPLE		
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	•	
			SALISBURY R			
SALEM TI	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 273}	Continued From page	÷ 58	{D 273}			
	the facility's appointm -She had not seen a rese a neurologist and appointments for him Interview with the SC revealed: -The SCUC was resp therapist notes and for recommendationsShe had worked in the 108/01/22She did not know ab from the physical therefrom Resident #4's Perconfirm or rule out Patenthe 11 out Patenthe 12 out Patenthe 12 out Patenthe 13 out Patenthe 14 out P	tments were documented in ent book. referral for Resident #4 to did not have any scheduled to see a neurologist. UC on 08/04/22 at 12:23pm onsible for reviewing ellowing up with any orders are role of SCUC since the recommendation rapist to obtain a referral CP to see a neurologist to rkinson's disease. would have been ing up with Resident #4's				
	home health provider revealed: -He saw Resident #4 made the recommend staff to obtain a referr to see a neurologistAt that time, Resider could not transfer or v-Resident #4 was baccontinued to have Padescribe the collection found in Parkinson's and decreased gait.	ck at baseline now, but he rkinsonisms (a term used to n of signs and symptoms disease) including shuffling rologist would determine s symptoms were				

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DIVISION	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	IPLETED
						R
		HAL034098	B. WING		08	8/05/2022
NAME OF D	ROVIDER OR SUPPLIER	CTDEET A	DDDECC CITY CTA	TE 710 CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SALEM TI	ERRACE		D SALISBURY R			
	T		N SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 273}	Continued From page	÷ 59	{D 273}			
	3:27pm revealed: -She saw Resident #4 2022There was no docum communication syste facility contacted the referral for Resident #She did not see an oprovider for Resident -The previous provide numbness in Resider sensation wass still pShe expected the factor previous provider for see a neurologist since the physical therapist. Interview with the Adr 2:08pm revealed: -She did not know ab from Resident #4's phreferral from her PCPThe home health proferral for Resident #4's PCP are referral for Resident #4 to schedule the appoint of the schedule acute cystitis without hyperkalemia.	at #4's feet and the tingling resent in his feet. cility to reach out to the an order for Resident #4 to be it was recommended by the ministrator on 08/04/22 at mout the recommendation mysical therapist to get a provider a usually spoke to the esidents to give updates. CUC to follow up with and the BOM to obtain a mysical therapist to get a provider and the BOM to obtain a mysical therapist to give updates. CUC to follow up with and the BOM to obtain a mysical threat and the see a neurologist and the see a neurologist and the see and the se				

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07/25/22 revealed:

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Division (of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
						R
		HAL034098	B. WING		08	3/05/2022
		070557.45	I DESCRIPTION OF I	T. T.D. 0.0.D.		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
{D 273}	Continued From page	e 60	{D 273}			
	-There was an order of (PT)/occupational the ambulation/walker an extremity strengthThere was documen on 07/27/22 at 2:00pr documentation where Review of Resident # 2022 revealed there we PT/OT order dated 07 documentation the or health agency for evaluation the or health agency for evaluation the or health agency for evaluation the specific provided with the Specific CSCUC) on 08/03/22 and forwarded schedule services with lift there was an urger schedule services with lift there with the SC revealed: -The order for a PT/O was accidentally faxe 07/27/22.	for a physical therapy rapy (OT) evaluation with d to check her right lower tation the order was faxed m, but there was no the order was faxed to. 5's progress notes for July was no documentation of a 7/25/22 and no der was sent to a home alluation of services. Is home health notebook attation of PT services for the business office to the business office to the home health provider. In need, the SCUC would the home health provider. The evaluation dated 07/25/22 d to the pharmacy on anyone followed up to see if				
	home health provider revealed:	sentative form Resident #4's on 08/05/22 at 8:34am rently receiving occupational				

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therapy and received physical therapy from

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R		
		HAL034098	B. WING		08/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE	2609 OLD S	SALISBURY R	OAD		
		WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI	E
{D 273}	Continued From page	e 61	{D 273}			
	02/11/22 through 04/0	other orders received for PT				
	services for Resident					
	08/04/22.	#5 until yesterday,				
		on 08/04/22 was for PT/OT /22.				
		nt #5's primary care provider				
	(PCP) on 08/05/22 at					
		otified Resident #5 had a fall or she did become aware of				
	her fall when she visit					
		dent #5 on 07/25/22, she				
		5 had right side weakness				
		not move like she wanted it				
	to, so she ordered ph					
	occupational therapy					
	-She expected the fac	cility to follow up with the				
	referral for PT/OT as	soon as possible.				
	Interview with the Adr 2:08pm revealed:	ministrator on 08/04/22 at				
	•	onsible for following up with				
		erapy/occupational therapy.				
		should have been followed				
	up on once received.					
	The facility failed to e	 nsure health care referral				
	_	to a resident, who had				
	-	sis tests due to changes in				
		t obtained resulting in the				
	_	nergency room visit and a				
		tract infection, and an order				
		ue to a decline in mobility				
		ad not been referred to the				
		(#1); a resident who was a				
		ormal gait, and an order for				
		a wheelchair but did not wheelchair resulting in a fall				
		ecommendation from the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL034098	B. WING		08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	•
TVAIVIL OF T	TOVIDER OR OUT FEILER		SALISBURY R		
SALEM TE	RRACE		SALEM, NC 2		
(VA) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	l (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 273}	Continued From page	e 62	{D 273}		
	physical therapist to sor confirm Parkinson's resident's shuffling gahis risk for falls and the from his primary care resident, who had right restricted movement if for physical therapy the home health agency, to the health, safety, a which constitutes a coviolation.	see a neurologist to rule out is disease due to the sit pattern which increased the referral was not obtained provider (#4); and a side weakness and sin her left leg, and an order that was not referred to the This failure was detrimental and welfare of the residents ontinuing Unabated Type B			
D 310	D 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a magic cup was served as ordered for 1 of 1 sampled resident with orders for a nutritional supplement (Resident #5). The findings are:		D 310		

Division of Health Service Regulation

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		7 BOILBING.		R	
		HAL034098	B. WING		08/05/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE	
SALEM T	FRRACE	2609 OLI	SALISBURY R	OAD	
OALLINI	LINIAGE	WINSTO	N SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 63	D 310		
	O6/16/22 revealed: -Diagnoses included arthritis, metabolic en lower extremity, breal cellulitis of the left low-There was an order meal tray daily. Review of Resident # Administration Recorrevealed: -There was an entry f meal tray daily and so-There was documen provided for 30 of 31 Review of Resident # revealed: -There was an entry f meal tray daily and so-There was documen provided for 31 of 31 Review of Resident # revealed: -There was an entry f meal tray daily and so-There was documen provided for 29 of 31 Review of Resident # through 08/04/22 revealed: -There was an entry f meal tray daily and so-There was an entry f meal tray daily and so-There was an entry f meal tray daily and so-There was an entry f meal tray daily and so-There was documen	for a magic cup on the lunch 5's electronic Medication d (eMAR) for May 2022 for magic cup on the lunch cheduled for 12:00pm. tation a magic cup was opportunities in May 2022. 5's eMAR for June 2022 for magic cup on the lunch cheduled for 12:00pm. tation a magic cup was opportunities in June 2022. 5's eMAR for July 2022 for magic cup on the lunch cheduled for 12:00pm. tation a magic cup was opportunities in July 2022. 5's eMAR for 08/01/22 ealed: for magic cup on the lunch cheduled for 12:00pm. tation a magic cup was opportunities in July 2022. 5's eMAR for 08/01/22 ealed: for magic cup on the lunch cheduled for 12:00pm. tation a magic cup was oportunities in between			

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Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED					
	R					
HAL034098 B. WING	08/05/2022					
	00:00:2022					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SALEM TERRACE 2609 OLD SALISBURY ROAD						
WINSTON SALEM, NC 27127						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(- /					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD IN TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR						
DEFICIENCY)						
D 040						
D 310 Continued From page 64 D 310						
Observation of the lunch meal service in the						
Special Care Unit (SCU) on 08/04/22 between						
12:00pm and 12:34pm revealed:						
Interview with Resident #5 on 08/04/22 at						
12:34pm revealed:						
-She did not know if she was supposed to get a						
magic cup with her lunch meal daily.						
-She did not get a magic cup with her lunch meal						
today and had not been served a magic cup						
previously.						
Observation of the kitchen freezer on 08/04/22 at						
1:43pm revealed:						
-There was a box of 4-ounce magic cups in a box						
in the freezer.						
-There were 48 magic cups in the box and 20						
magic cups were remaining.						
Interview with a dietary aide on 08/04/22 at						
1:44pm revealed:						
-The dietary staff was responsible for ordering						
magic cups for residentsThe dietary staff placed magic cups on the lunch						
meal trays for residents who had orders for magic						
cups with their meals or on the cart for residents						
who were supposed to have magic cups between						
meals.						
-The medication aides (MA) and personal care						
aides (PCA) did get the magic cups from the						
freezer for residents.						
-There was only 1 resident in the SCU who had						
orders for magic cups, and she received a magic						
cup with her breakfast and supper meal tray.						
-She did not know Resident #5 had an order for						
magic cups with her lunch meal tray.						
-No one let the dietary staff know Resident #5 was supposed to receive magic cups and magic						
was supposed to receive magic cups and magic						

meal tray.

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DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	, I
			B. WING		F	
		HAL034098	D. W		08/0)5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	ATE, ZIP CODE		
		2609 OLD	SALISBURY R	COAD		
SALEM TE	ERRACE		SALEM, NC 2			
	OUR MAR DV OT		1			T
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
D 210	0	. 05	D 310			
D 310	Continued From page	9 65	0310			
	-The Special Care Ur	nit Coordinator (SCUC) was				
	supposed to let the di	etary staff know when a				
	resident was to be se	rved a magic cup.				
	Telephone interview v	vith a MA on 08/05/22 at				
	10:09am revealed:					
	-She thought Resider	nt #5's magic cup was on her				
	lunch meal tray daily.					
	-If she documented R	lesident #5's magic cup was				
	given and it wasn't on	her lunch meal tray, then				
		en to get a magic cup for				
	her.	3 3 1				
	Interview with the SC	UC on 08/05/22 at 10:22am				
	revealed:					
	-She knew Resident #	#5 had an order for a magic				
	cup with her lunch me					
		cility in a different capacity				
	prior to becoming SC	UC on 08/01/22, and she				
	had asked about mag	gic cups for Resident #5.				
	-She was told by dieta	ary staff that a nutritional				
	supplement was a su	fficient replacement for a				
	magic cup when Resi	ident #5 did not have a				
	magic cup on her tray	<i>1</i> .				
	-She should have got	ten clarification earlier, but				
	she got clarification fr	om the Administrator on				
	yesterday, 08/04/22 t	hat Resident #5 should have				
	received magic cups	instead of nutritional				
	supplements on the lu					
		assumed without checking				
		up was on the lunch meal				
		nented the magic cup was				
	given.					
	•	onsibility to make sure the				
		e lunch meal tray, document,				
		the kitchen if the magic cup				
	was not on the tray.					
	·					
	Telephone interview v	vith the facility contracted				

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pharmacy on 08/05/22 at 10:37am revealed:

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	of Health Service Regu				T	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL034098	B. WING		R 08/05/2022	
NAME OF B				5. 7/D 00D5	1 00/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI D SALISBURY RO			
SALEM TE	RRACE		N SALISBURT RO			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE	
				DEI IGIENCT)		
D 310	Continued From page	e 66	D 310			
		for a magic cup on the lunch				
	tray daily.					
	magic cups through t	onsible for ordering the				
		supply the facility with				
	magic cups for Resid					
	requested them to.					
	Tolonhono intonvious	with Resident #5's primary				
	•	on 08/05/22 at 8:50am				
	revealed:	3.1 33, 33, <u>22</u> 33 3333				
	-Resident #5 had an	order in place for 1 magic				
		ch meal tray prior to her				
	becoming her PCP in	-				
	for a magic cup daily.	ny Resident #5 had orders				
		o serve Resident #5 a magic				
	cup daily with her lun					
	Interview with the Adr	ministrator on 08/04/22 at				
	2:08pm revealed:	11111110110101 011 00/0 1/22 dt				
	•	esident #5 was not being				
	served a magic cup of ordered.	daily with her meal tray as				
	-She previously inforr	med MAs to inform the				
		dication or order on the MAR				
	was not in the facility.					
		ected the MAs to follow up				
		hy Resident #4 was not o on her lunch meal tray.				
{D 358}	10A NCAC 13F .1004	4(a) Medication	{D 358}			
- 1	Administration	· <i>,</i>				
	104 NCAC 13E 100/	1 Medication Administration				
{D 358}	Administration	4(a) Medication 4 Medication Administration	{D 358}			

(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments

by staff are in accordance with:

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SU	
,	5. GG.W.EG.WG.	ISENTING THOMSELL	A. BUILDING: _			
		HAL034098	B. WING		08/05	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	1 23.33	<u></u>
CALEME		2609 OLD	SALISBURY R	OAD		
SALEM TI	ERRACE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 67	{D 358}			
	which are maintained (2) rules in this Secti and procedures. This Rule is not met Based on observatior interviews, the facility medication as ordere residents (#1, #3 and anti-anxiety medication	ns, record reviews and rfailed to administer				
	The findings are:					
	06/29/22 revealed: -Diagnoses included weakness, hyperlipid -There was an order	t #6's current FL2 dated vascular dementia, muscle emia, and type 2 diabetes. for Cerovite Senior (a mineral supplement), 1 tablet				
	medication administrative revealed: -There was an entry that take 1 tablet once data-There was document	66's July 2022 electronic ation record (eMAR) for Cerovite Senior tablets at 9:00am. tation that Cerovite Senior ed daily from 07/01/22				
	08/03/22 revealed: -There was an entry f take 1 tablet once da -There was documen	6's August 2022 eMAR on for Cerovite Senior tablets fily scheduled at 9:00am. tation that Cerovite Senior ed daily from 08/01/22				

Division of Health Service Regulation

STATE FORM 6899 63ET13 If continuation sheet 68 of 105

DIVIDION (or riealth Service Negu	ialion				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						,
		HAI 024000	B. WING		R	
		HAL034098			08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLF	SALISBURY R	OAD		
SALEM T	ERRACE		SALEM, NC 2			
			TOALLIN, NO 2			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
{D 358}	Continued From page	e 68	{D 358}			
	Observation of the me	edication pass for Resident				
	#6 on 08/03/22 at 9:0	· · · · · · · · · · · · · · · · · · ·				
		(MA) prepared four oral				
		dent #6 and Cerovite Senior				
		the other oral medications.				
	-The MA documented					
	administered at 9:00a	am on 08/03/22.				
		ent #6's medications on				
		12:00pm revealed there was				
	a medication card for	Resident #6 dispensed on				
	08/03/22 with 29 of 30	0 tablets remaining of				
	Cerovite Senior table	ts.				
	Interview with a MA o	n 08/03/22 at 9:20am				
	revealed:					
	-She had clicked the	wrong button on the eMAR				
		ministered when she meant				
	to document it as not					
		ite Senior supplement was				
	on order from pharma					
		vas currently "offline" so she				
		when the medication refill				
	had been requested f					
		send another refill request				
	that day.	to the e				
		osed to reorder medications				
		ached the last row on the				
		ally when there were 8				
	tablets remaining.					
	-	est medication refills by				
	clicking a refill button	the eMAR.				
		with a representative from				
	the facility's contracte	ed pharmacy on 08/03/22 at				
	2:45pm revealed:					
		ite Senior tablets had last				
		6/20/22 for 30 tablets which				
	was a 30-day supply.					

Division of Health Service Regulation

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Division	ot Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034098	B. WING		08/05/2022	
		10.1200.1000	<u> </u>		1 OO/OO/ZOZZ	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CALEMIT	EDDACE	2609 OLI	SALISBURY R	DAD		
SALEM TERRACE WINSTON		N SALEM, NC 27	7127			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DEL IOIEIGET)		
{D 358}	Continued From page	e 69	{D 358}			
	The substitute of the state of	-				
		ot received another refill				
	request until earlier th	-				
		een administered daily				
	have run out on 07/20	the 30-day supply would				
	nave run out on 07/20	3/22.				
	Intonious with the Spe	ocial Caro Coordinator				
	-	ecial Care Coordinator				
	(SCUC) on 08/04/22					
		been on any extended stays				
	_	from June 2022 through July				
	The state of the s	not have been an extra				
	supply of Cerovite tab					
	-She did not know wh					
		ovite tablets as administered				
		ays since 06/20/22 when				
	they only had a 30-da	ly supply. IAs who had documented				
	•					
		nistered to Resident #6 from				
	07/21/22 through 08/0	the missed doses occurred				
	prior to 07/20/22.	the missed doses occurred				
	prior to 07/20/22.					
	Interview with the Adr	ninistrator on 08/04/22 at				
	3:00pm revealed:	711110trator 011 00/0 1/22 at				
	· •	ware that Resident #6 had				
		r Cerovite Senior tablets.				
	_	osed to send a refill request				
		the quantity of tablets				
		area on the medication card,				
	usually when it was d					
	•	ll was not available by the				
		as due to be administered.				
		ole for calling the pharmacy				
		soon as possible, and				
	letting the SCUC know					
	follow-up on the refill					
	-When Resident #6 w					
		ts the SCUC in charge was				

Division of Health Service Regulation

position of SCUC.

someone different from who currently held the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE S COMPLE	
		7 50.250.		R		
HAL034098		B. WING		1	5/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
(Y4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I SALEM, NC 2	PROVIDER'S PLAN OF CORRECTION	N I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
{D 358}	Continued From page	e 70	{D 358}			
	-She did not know if the notified of Resident # refilledIf a medication was remedication pass, the document the medication which would show up initials with a circle are Telephone interview was reprovider (PCP) or revealed: -She was not aware the doses of Cerovite Selenthe multivitamin had #6 by her previous Polindication for use documentia, to ensure the nutrients they needed. Telephone interview was 10:15am revealed: -She had documented.	the previous SCUC had been 6's Cerovite needing to be not available during a MAs were supposed to ation as not administered, on the eMAR as the MA's ound them. With Resident #6's primary on 08/05/22 at 9:00am That Resident #6 had missed hior supplement. I been ordered for Resident CP, but there was no specific umented. I been eral tablets were sometimes patients, especially with hey were getting the I. With a MA on 08/05/22 at de Resident #6's Cerovite as				
	administered on 07/3 -She did not remember	or Resident #6 being out of				
	Cerovite.	documented the medication				
		ad not been available.				
	11:00am with a MA w	interview on 08/04/22 at ho documented Resident inistered on 08/01/22 and essful.				
	Based on observation determined that Residenterviewable.	n and record review it was dent #6 was not				

Division of Health Service Regulation

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	i Health Service Regu		1		ı		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
					R	,	
		HAI 024008	B. WING		08/05/2022		
		HAL034098			₁ 08/0	5/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		2609 OLD	SALISBURY R	OAD			
SALEM TE	RRACE		SALEM, NC 2				
	OUR MAR DV OT		·		. 1		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE	
iAO		,	IAG	DEFICIENCY)			
			+				
{D 358}	Continued From page	e 71	{D 358}				
	2 Paviou of Posidon	t #1's current FL2 dated					
	08/26/21 revealed:	it #15 current FLZ dated					
		schizoaffective disorder and					
	moderate intellectual	•					
	-She was constantly of	disoriented.					
		1's physician order dated					
	12/08/22 revealed the						
	lorazepam (a controlle	ed drug used to treat					
	anxiety) 0.5mg, take	one half tablet (0.25mg total)					
	twice daily as needed	I (PRN) for anxiety.					
	Review of Resident #	1's physician order dated					
	06/08/22 revealed the	ere was an order to increase					
	the lorazepam PRN d	lose from 0.25mg twice daily					
	PRN, to 0.5mg twice						
	,	,					
	Review of Resident #	1's June 2022 electronic					
	Medication Administra						
	revealed:	audit reddia (divir ii t)					
		or lorazepam 0.5mg, take					
	one half tablet (0.25m						
	-There was documen						
		ministered 15 times from					
	0.25mg PRN was add 06/01/22 through 06/3						
	•						
		for lorazepam 0.5mg, take					
		g) twice daily PRN, with a					
		and a discontinue date of					
	06/08/22 and no docu	umented administrations.					
	Review of Resident #	1's June 2022 CSCS					
	revealed:						
	-The CSCS was for lo	orazepam 0.5mg, take two					
	half tablets (0.5mg) tv	vice daily, and one half					
	tablet (0.25mg) twice						
	-There was documen						
		ministered 19 times from					
	_	RN dose had increased to					
	0.5mg twice daily PR						
	oloning twice daily PR	14, 11110ugii 00/30/22.	1				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R 08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD	
SALEM II	ERRACE	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	: 72	{D 358}		
	one half tablet (0.25m-There was document PRN was administered through 07/31/22. -There was an entry fone tablet (0.5mg) two-There was document PRN was administered through 07/31/22. Review of Resident # revealed: -The CSCS was for locally daily PRN. -There was document PRN was administered through 07/31/22. Observation of medic #1 on 08/03/22 at 3:4. -There was one medic process of the	for lorazepam 0.5mg, take ng) twice daily PRN. tation lorazepam 0.25mg at 8 times from 07/01/22 for lorazepam 0.5mg, take ice daily PRN. tation lorazepam 0.5mg at three times from 07/01/22 for lorazepam 0.5mg, take two y, and one half tablet twice tation lorazepam 0.25mg at 12 times from 07/01/22 for lorazepam 0.7/01/22			
	needed.	e tablet twice daily as			
	-There was a dispens dispensed quantity of -There were 12 tablet remaining.				
	the facility's contracte 2:45pm revealed: -They received an ord PRN lorazepam from 0.5mg twice daily PRI	with a representative from ad pharmacy on 08/03/22 at the der to increase Resident #1's 0.25mg twice daily PRN to N on 06/08/22. The first section of the design of the de			

previous lorazepam order and from Resident #1's

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HAL034098 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE	AD	R 08/05/2022
11AE004030	AD	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE	AD	
2609 OLD SALISBURY ROA		
SALEM TERRACE WINSTON SALEM, NC 271	127	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{D 358} Continued From page 73 {D 358}		
scheduled doses of lorazepam 0.5mg that they were going to use up prior to getting a refill from the pharmacy for the increased PRN dose. -They last dispensed lorazepam 0.5mg for Resident #1 on 07/27/22 for the order to administer 0.5mg twice daily PRN; they dispensed 30 tablets. Telephone interview with Resident #1's psychiatric primary care provider (PCP) on 08/04/22 at 10:45am revealed: -Resident #1 had been having an increase in her behaviors, such as crying out and yelling, in early June 2022 so she had adjusted a couple of her medications including the PRN lorazepamOn 06/08/22 she increased Resident #1's lorazepam PRN dose from 0.25mg twice daily PRN to 0.5mg twice daily PRNShe expected when she wrote a new order for lorazepam for Resident #1, the facility would ensure the previous order was discontinued so that the medication aides (MA) understood what the current dose wasThere would be no adverse effects to Resident #1 for receiving 0.25mg of lorazepam PRN instead of 0.5mg of lorazepam PRN aside from her anxiety and agitation behaviors not being as well controlled under the smaller dose. Interview with the Special Care Unit Coordinator (SCUC) on 08/04/22 at 11:45am revealed: -The previous SCUC who was working at the time of Resident #1's lorazepam PRN dose change was responsible for ensuring the current lorazepam dose was entered on the eMAR and the previous dose was discontinuedThe pharmacy was able to add or remove		

Division of Health Service Regulation

happen.

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Division of	of Health Service Regu	ılation				
STATEMENT OF DEFICIENCIES (X1		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					-	,
		HAL 024000	B. WING		R	
		HAL034098			00/0	05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
241 FM TI		2609 OLD	SALISBURY RO	OAD		
SALEM TE	ERRACE	WINSTON	N SALEM, NC 27	7127		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATURY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIAIE	DATE
			_	<u> </u>		
{D 358}	Continued From page	e 74	{D 358}			
	The SCHC was resn	onsible for completing				
		vould include checking the				
		rders compared to the				
	physician orders in th	•				
		her role as SCUC within the				
	-	d not yet completed any				
	eMAR audits.	That you do in place 2 along				
		nen the previous SCUC had				
		dit of Resident #1's eMAR.				
	-The MAs were suppo					
		es before administering it				
		orted to her that there were				
	-	azepam on Resident #1's				
		uld remove the incorrect				
	entry.					
		22/04/00				
		ministrator on 08/04/22 at				
	3:00pm revealed:					
		that Resident #1 had two				
		for PRN lorazepam and that				
		Iministering the 0.25mg dose				
	_	dose in June and July 2022.				
		onsible for checking the				
		but the SCUC who would				
	worked there.	ast eMAR audit no longer				
	-Once the MA admini	stored lorazenam to				
		that there were two entries				
		ment under, the MA should				
		e SCUC so that the incorrect				
	dose entry could be re					
	d000 01111 00212 2 1	omoved.				
	Interview with a MA o	on 08/04/22 at 4:00pm				
	revealed:					
	-She had documented	d administration of				
	lorazepam 0.25mg Pl	RN to Resident #1 three				
	times in July 2022.					
	-There were no entrie	es on the eMAR to				

administer lorazepam 0.5mg PRN for Resident #1 so she administered the dose that was

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	
		HAL034098	B. WING		08/0	5/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	RRACE		SALISBURY R			
	CLIMMA DV CT		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	÷ 75	{D 358}			
	PRN at the end of Jul was added to the eM/	ering 0.5mg of lorazepam y 2022 once that order entry AR because she assumed ed due to Resident #1's				
	determined that Residenterviewable. 3. Review Resident # 03/09/22 revealed diamellitus type II, osteo.					
	senexon-S 50-8.6mg	3's medication orders n order dated 05/17/22 for Monday, Wednesday and ed to treat constipation).				
	medication administrative revealed:	• •				
	8:00pm.	/, Wednesday and Friday at				
	was administered eve	tation senexon-S 50-8.6mg ery Monday, Wednesday and n 07/01/22 through 07/31/22.				
	revealed: -There was an entry f	3's August 2022 eMAR or senexon-S 8.6mg y, Wednesday and Friday at				
	-There was documen was administered eve	tation senexon-S 50-8.6mg ery Monday, 08/01/22 at day, 08/03/22 at 8:00pm.				

Division of Health Service Regulation

Observation of Resident #3's medications on

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Division of	of Health Service Regu	lation			1 Ortivi	AITROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMPLE	ILD
		HAL034098	B. WING		08/0	5/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	-RRACE	2609 OLD	SALISBURY R	OAD		
JALLIN 1L	INNAUL	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	÷ 76	{D 358}			
	hand at the facility on revealed senexon-S & administration.	08/04/22 at 2:58pm 3.6mg was not available for				
	facility's contract phar 9:40am revealed: -There was an order f Monday, Wednesday -On 06/28/22, the phar of senexon-S 8.6mgBecause Senexon-S Monday, Wednesday senexon-S should har 07/25/22, with the las Monday 07/25/22Senexon-S was not a facility had to call and -As of today's, date (0	for senexon-S 8.6mg and Friday. armacy dispensed 12 tablets was to be administered on and Friday; the 12 tablets of we lasted the resident until t administration being on automatically refilled, the				
	did not tell anyone be	r medications. enexon-S was nauseated lately, but she cause it was not bad. nced constipation or difficulty				
	Interview with the Res (RCC) on 08/04/22 at	sident Care Coordinator 12:06pm revealed:				

refilled.

-The facility medications were not automatically

-The medication aide (MA) who administered Resident #3's last dose of senexon-S should have reordered the medication using the eMAR

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Division of	of Health Service Regu	lation	_			
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
			B. WING		R	
		HAL034098	B. WIIVO		08/0	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2609 OLD	SALISBURY R	OAD		
SALEM TE	ERRACE		SALEM, NC 2			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
(D. 050)	0 11 1 -		(5.050)			
{D 358}	Continued From page	277	{D 358}			
	-If the MA did not reo	rder the senexon-S, the MA				
		kt time senexon-S was due				
	should have reordere					
	-The MA's were supp					
	medication label with					
		cation to ensure the right				
		dose was administered.				
		s available the MA was				
	supposed to docume medication was admi					
		exon-S was not administered				
	the MA should not ha					
	medication as admini					
		contacted the pharmacy to				
	•	on was not in the building.				
		also let her know the				
	medication was not a					
		g weekly medication and				
		ntify medications were				
	available.					
	-The medication and	eMAR audits had not been				
	done within the past t	wo weeks because the				
	Administrator was in t	the process of updating the				
	forms.					
	Interview with the Adr	ministrator on 08/04/22 at				
	11:34am revealed:					
	-The MA that adminis	tered the last senexon-S				
	dose should have red	ordered the medication using				
	the eMAR system.					
	-If the system had we	nt down when reordering				
	the medication; when	the system was back up the				
		e a note and checked to see				
	if the medication orde					
	-The next time the me	•				
		A should not have checked				
		red the medication and it				
	was not available					

Division of Health Service Regulation

-The MA should have reported the medication was not available to the Administrator and RCC.

STATE FORM 6899 63ET13 If continuation sheet 78 of 105

Division of	of Health Service Regu	lation	_		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		08/05/2022
NAME OF D	DOVIDED OD SUDDIJED	etert A	DDDEES CITY STA	TE ZID CODE	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
SALEM TE	RRACE		D SALISBURY R		
			N SALEM, NC 27		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
{D 358}	Continued From page	2 78	{D 358}		
(=)	. •		(= 333)		
	-When the MA attemp				
		not available, the MA			
	should have reordere				
	#3's senexon-S was r	tional accuse why Resident			
		and the MA signed the			
		nistered the medication.			
		ations to be available and to			
	be administered as or				
	-The RCC was suppo	sed to complete weekly			
	medication cart audits				
	discovered senexon-	S was not available.			
	Interview with the MA	that documented she			
		nt #3's last three doses of			
	senexon-S on 08/04/2	22 at 10:15am revealed			
	-On 07/25/22, She ad	Iministered Resident #3's			
	last dose of senexon-	S.			
	-She thought that she				
	medication using the				
	•	wn but she did not check to			
	see if the order went	_			
		ontinually went down and			
	sometimes did not rec -The next administrat				
	documented that she				
		unable to explain why.			
	-She thought that she	·			
	regarding the medica				
	-She did not documer				
	pharmacy and she did				
	Administrator and RC	C the medication was not			
	available.				
		xplain why she did not			
		n for the third time but			
		ninistered the medication.			
	-She was aware the r	nedication was not in the			

facility, and she aware that she should not signed the eMAR as if she administered the medication.

STATE FORM 6899 63ET13 If continuation sheet 79 of 105

DIVISION	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					_	
			B. WING		R	
		HAL034098	B. WING		08/05/2022	_
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
			, ,	•		
SALEM TE	RRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		٤
TAG	REGULATORT OR E	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	IAIL	
				,		\dashv
{D 358}	Continued From page	2 79	{D 358}			
		interview with Resident #3's				
		er (PCP) on 08/04/22 at				
	12:26pm was unsucc	essful.				
D 367	10A NCAC 13F .1004	(j) Medication	D 367			
	Administration					
	10A NCAC 13F .1004	Medication Administration				
	(j) The resident's med	dication administration				
		e accurate and include the				
	following:					
	(1) resident's name;					
	• •	cation or treatment order;				
	` '	ge or quantity of medication				
	administered;	go or quarring or mountainers				
		ministering the medication				
	or treatment;	gg				
	•	tion for the administration of				
		ents as needed (PRN) and				
		Ilting effect on the resident;				
	(6) date and time of a	_				
	(7) documentation of					
		nents and the reason for the				
	omission, including re					
	,	the person administering				
	• •	atment. If initials are used, a				
		to those initials is to be				
	•	ntained with the medication				
	administration record					
	administration record	(MAR).				
	This Pule is not mot	as evidenced by:				
	This Rule is not met					
		ns, interviews and record				
		iled to accurately document				
		lications on the electronic				
		ation Record (eMAR) for 1 of				
		(#1) who had an order for a				
	scheduled anti-anxiet	y medication.				

Division of Health Service Regulation

The findings are:

STATE FORM 6899 63ET13 If continuation sheet 80 of 105

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		HAL034098	B. WING		08	R :/ 05/2022
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 33	
SALEM T	ERRACE		D SALISBURY ROAN SALEM, NC 2713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 80	D 367			
	08/26/21 revealed: -Diagnoses included moderate intellectual -She was constantly Review of Resident # 12/08/22 revealed the lorazepam 0.5mg, taltotal) twice daily. Review of Resident # revealed: -There was an entry two half tablets (0.5m 9:00am and 9:00pmThere was documen administered twice da 06/30/22 except for the service of the service included in the service of the serv	disoriented. t1's physician order dated				
	Substance Count She -The order was for local half tablets (0.5mg) to (0.25mg) twice daily a -There was documen administered twice da	station lorazepam 0.5mg was aily at 9:00am and 9:00pm h 06/30/22 except for the 4/22 and 06/17/22.				
	-There was an entry to two half tablets (0.5m 9:00am and 9:00pm. -There was a second	for lorazepam 0.5mg, take ng) twice daily scheduled at entry for lorazepam 0.5mg, .5mg) twice daily scheduled				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	SURVEY	
						R
		HAL034098	B. WING		l	/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	E, ZIP CODE		
SALEM T	FRRACE	2609 OLD	SALISBURY RO	AD		
OALLINIT	LINIAOL	WINSTON	SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 367	Continued From page	e 81	D 367			
		tation lorazepam 0.5mg was oth entries for the evening				
	half tablets (0.5mg) tw (0.25mg) twice daily a -There was documen lorazepam 0.5mg dos	razepam 0.5mg, take two vice daily and one half tablet as needed.				
	revealed: -There was an entry f two half tablets (0.5m 8:00am and 8:00pmThere was a second take one full tablet (0. at 8:00am and 8:00pr -There was documen	1's August 2022 eMAR for lorazepam 0.5mg, take g) twice daily scheduled at entry for lorazepam 0.5mg, 5mg) twice daily scheduled m. tation lorazepam 0.5mg was oth entries for the 8:00pm				
	revealed there was de lorazepam 0.5mg dos 8:00pm on 08/01/22. Observation of medic #1 on 08/03/22 at 3:4 -There was one medi 0.5mg tablets, take on needed.	1's August 2022 CSCS ocumentation only one se was administered at ation on hand for Resident 0pm revealed: cation card for lorazepam ne tablet twice daily as seed date of 07/27/22 and				

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL034098	B. WING		R 08/05/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SALEM TE	RRACE	2609 OLD	SALISBURY R	OAD	
OALLIN 12	INVACE	WINSTON	SALEM, NC 2	7127	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 367	Continued From page	82	D 367		
	dispensed quantity of -There were 12 tablet remaining.	s out of 30 tablets			
	·	vith a representative from d pharmacy on 08/03/22 at one-half tablets of			
	lorazepam 0.5mg for Resident #1 on 05/20/22 for an order to take two half tablets twice daily scheduled and one half tablet twice daily PRN.				
	-The MAs would have	be been using the same spense both the scheduled			
	doses and the PRN d	oses. der to increase Resident #1's			
	•	0.25mg twice daily PRN to			
	-The facility still had h	alf tablets available that			
	from the pharmacy fo	e up prior to getting a refill r the increased PRN dose.			
	-They last dispensed Resident #1 on 07/27	/22 for the order to			
	administer 0.5mg twic dispensed 30 tablets.	e daily PRN; they			
	-They had received a	new refill request that day, t #1's lorazepam 0.5mg			
	health provider (MHP revealed that she exp new order for lorazep facility would ensure t discontinued so that t understood what the	with Resident #1's mental) on 08/04/22 at 10:45am ected when she wrote a am for Resident #1, the the previous order was he medication aides (MA) current dose was and could ment under the previous			

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Interview with the Special Care Coordinator (SCUC) on 08/04/22 at 11:45am revealed:

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		.ETED	
					_	_
			D WING		F	
		HAL034098	B. WING		08/0)5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TO UNIC OT TH	TO VIDER OR OUT FIER					
SALEM TE	ERRACE		SALISBURY R			
		WINSTON	SALEM, NC 2	7127		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
				,		
D 367	Continued From page	e 83	D 367			
	The provious CCLIC	who was working at the time				
	-	who was working at the time				
		cond lorazepam entry was				
		was responsible for ensuring				
		n dose was entered on the				
		were no duplicate entries.				
	-The pharmacy was a					
		m the eMAR but the facility				
	needed to approve th	•				
		onsible for completing				
		ould include checking the				
	eMAR for accurate or	•				
	physician orders in th					
	-	her role as SCUC within the				
	last week, so she had eMAR audits.	I not yet completed any				
		en the previous SCUC had				
		dit of Resident #1's eMAR.				
	-The MAs were support					
		es before administering it				
		orted to her that there were				
		azepam on Resident #1's				
	eMAR so that she co					
	entries.	did remove one of the				
	entines.					
	Interview with the Adr	ministrator on 08/04/22 at				
	3:00pm revealed:	Timistrator on 00/04/22 at				
	•	hat Resident #1 had two				
		for scheduled lorazepam.				
		onsible for checking the				
		but the SCUC who would				
	•					
	worked there.	ast eMAR audit no longer				
	-Once the MA admini	stered lorazepam 0.5mg to				
		that there were two entries				
		ment under, the MA should				
		e SCUC so that the extra				
	entry could be remove					
	Chay Could be lellion	ou.				
	Second interview with	n the SCUC on 08/04/22 at				

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3:50pm revealed:

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STATEMENT	of Health Service Regul OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034098	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
		2609 OL	D SALISBURY ROA	AD	
SALEM TE	RRACE	WINSTO	N SALEM, NC 271	27	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	lorazepam 0.5mg to Fentries on the eMAR of She had not noticed documented she adm Resident #1 and since issues with their eMA documentation had not second entry and documentation had not second entry and documented doses to Resident #1 Interview with a MA or revealed: She had documented lorazepam 0.5mg to Fentries on the eMAR of 07/27/22, 07/28/22, argued She would have noticed a second dose errone have seen her documentation. She had not noticed entries on the eMAR of lorazepam.	d that she administered Resident #1 under both on 07/26/22 and 07/31/22. there were two entries, she inistered one dose to e the facility was having R system she thought her of saved so she clicked the umented it again. Her two separate 0.5mg on 07/26/22 or 07/31/22. In 08/04/22 at 4:00pm desident #1 under both for the 8:00pm dose on and 08/01/22. Her done dose of lorazepam desident #1 under both for the 8:00pm dose on and 08/01/22. Her done dose of lorazepam desident #1 under both for the 8:00pm dose on and 08/01/22. Her done dose of lorazepam desident #1 she was administering the sould be under the control of the CSCS. There were two separate for Resident #1's scheduled was and record review, it was	D 367		
D 477	10A NCAC 13F .1409 Orientation ANd Train		D 477		
	10A NCAC 13F .1409 Orientation And Traini	Special Care Unit Staff			

Division of Health Service Regulation

The facility shall assure that special care unit staff

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AND PLAN OF CORRECTION DRITTIFICATION NUMBER ABUILDING COMPILETED	Division of	Division of Health Service Regulation						
MANE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2699 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (CALIDEFICIENCY WISTER BE PRECEDED BY PILL PRETIX TAG TAG TAG TO Continued From page 85 receive at least the following orientation and training: (1) Phor to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 276, 07104(18), for each special care unit to be operated. The administrator shall have in place a plan to tain other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete sk hours of orientation on the nature and needs of the residents. (3) Within its months of employment, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule 0.501 of this Subchapter, direct care staff sassigned to the unit shall complete sk hours of orientation and training; specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the facility falled to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility had completed the six hours of orientation and training specific to the population served within the first week hire.				(X2) MULTIPLE	CONSTRUCTION			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 2809 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 CONTINUED FOR INSPERIOR OF PREFICIENT OF PREFICE ADDRESS, CITY, STATE, 2IP CODE SUBMANY STATEMENT OF PREFICIENTS SECULATORY OR IS CONTINUED BY THE PROVIDERS OF PROVIDERS O	AND PLAN ()F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 2809 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 CONTINUED FOR INSPERIOR OF PREFICIENT OF PREFICE ADDRESS, CITY, STATE, 2IP CODE SUBMANY STATEMENT OF PREFICIENTS SECULATORY OR IS CONTINUED BY THE PROVIDERS OF PROVIDERS O						-	,	
NAME OF PROVIDER OR SUPPLIER SALEM TERRACE 2689 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREPRIX TAG SUMMARY STATEMENT OF DEFICIENCES (EXCH DEFICIENCY MUST BE PRECEDED BY PLUL PREPRIX TAG D 177 Continued From page 85 receive at least the following orientation and training: (1) Prior to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NACA 27G 104(18), for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule 0.0501 of this Subchapter, direct care staff sassigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care uni			HVI 034008	B. WING		1		
SALEM TERRACE SUMMARY STATEMENT OF DEFICIENCIES PREFIX SUMMARY STATEMENT OF DEFICIENCIES Dischard Conference PREFIX TAG PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREFIX PREFX PREF			HALU34090			1 00/0	1512022	
CALLED TRANCE	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
WINSTON SALEM, NC. 27127 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	041 514 55		2609 OLF	SALISBURY R	OAD			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 477 Continued From page 85 receive at least the following orientation and training: (1) Prior to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 276. 0104(18), for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule .0501 of this Subchapter, direct care staff assigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility had completed the six hours of orientation and training specific to the population served within the first week hire.	SALEMIE	ERRACE	WINSTO	SALEM, NC 2	7127			
receive at least the following orientation and training: (1) Prior to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 27G .0104(18), for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule .0501 of this Subchapter, direct care staff assigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the facility falled to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility had completed the six hours of orientation and training specific to the population served within the first week hire.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETE	
training: (1) Prior to establishing a special care unit for residents with a mental health disability, the administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 27G. 0.104(18), for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule 0.9501 of this Subchapter, direct care staff assigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 4 of 6 sampled staff (Staff A, Staff B, Staff D, and Staff E) who worked in the special care unit facility had completed the six hours of orientation and training specific to the population served within the first week hire.	D 477	Continued From page	e 85	D 477				
		receive at least the fortraining: (1) Prior to establish residents with a ment administrator shall do 20 hours of training squalified mental healt 10A NCAC 27G .010 unit to be operated. In place a plan to train unit that identifies corevaluations and sche achievement. (2) Within the first wemployee assigned to special care unit shall orientation on the nat residents. (3) Within six months staff shall complete 2 to the population bein (4) In addition to the .0501 of this Subchapassigned to the unit shours of continuing easigned to assure 4 of 6 B, Staff D, and Staff E care unit facility had corientation and training served within the first	ollowing orientation and along a special care unit for tal health disability, the ocument receipt of at least pecific to the population by a th professional, as defined in 4(18), for each special care The administrator shall have n other staff assigned to the ntent, texts, sources, idules regarding training reek of employment, each operform duties in the I complete six hours of ture and needs of the s of employment, direct care to hours of training specific ng served. In training required in Rule oter, direct care staff shall complete at least 8 ducation annually that is of the residents. as evidenced by: as pecific to the population					

Division of Health Service Regulation

1. Review of Staff A's personal care aide

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	SI CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COIVII L	LILD
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SALEM T	ERRACE		SALISBURY ROSALEM, NC 2			
	CHMMADV CT.				NI .	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 477	Continued From page	e 86	D 477			
	(PCA)/medication aid revealed: -Staff A's date of hire	e (MA) personnel record				
	- There was no docur	nentation of special care in the first week of hire.				
	Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.					
	Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed: -Staff A worked the SCU as neededWhen Staff A was hired the business office manager (BOM) was still at the facility full-timeThe business office was responsible to ensure Staff A completed SCU trainingShe was not sure who specifically provided the					
	sure the training was					
	accountant on 08/05/2	terview with the corporate 22 at 3:00pm.				
	I -	terview with the previous ger (BOM) on 08/05/22 at				
	Refer to telephone int Administrator on 08/0					
	revealed: -Staff B's date of hire - There was no docur unit (SCU) orientation	was 06/14/22. mentation of special care in the first week of hire. with the Resident Care				

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DIVISION	n nealth Service Negu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					B
		1141 024000	B. WING		R
		HAL034098	B. W. C		08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		2609 ○1 □	SALISBURY R	OAD	
SALEM TE	ERRACE				
			N SALEM, NC 2		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG		,	170	DEFICIENCY)	
			+		
D 477	Continued From page	e 87	D 477		
	revealed:				
		training to work in the			
		training to work in the			
	assisted living and the				
		d the third shift but she also			
	assisted as needed w				
	dressing, ambulation	•			
		SCU training had been			
	provided for Staff B.				
		was responsible for ensuring			
	all trainings were com	npleted.			
	·	terview with the corporate			
	accountant on 08/05/2	22 at 3:00pm.			
		terview with the previous			
		ger (BOM) on 08/05/22 at			
	3:09pm.				
	Refer to telephone int				
	Administrator on 08/0	5/22 at 1:33pm.			
	Review of Staff D's	- ' - '			
		e (MA) personnel record			
	revealed:				
	-Staff D's date of hire				
		nentation of special care			
	unit (SCU) orientation	n in the first week of hire.			
		interview with Staff D on			
	08/05/22 at 2:56pm w	as unsuccessful.			
	Telephone interview with the Resident Care				
	Coordinator (RCC) or	n 08/05/22 at 1:23pm			
	revealed:				
	-Staff D was crossed	training to work in the			
	assisted living and the	e SCU.			
		only in the SCU since she			
	was hired at the facilit				
	-Staff D was responsi				

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administration, and assisted as needed with

STATE FORM 6899 63ET13 If continuation sheet 88 of 105

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			A. BOILDING		R	
		HAL034098	B. WING		1	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		SALISBURY R			
0/0.15	SHIMMADV ST		SALEM, NC 2			0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 477	Continued From page	2 88	D 477			
	feeding as needed.	bulation/transferring and				
	Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm. Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm.					
	Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm. 4. Telephone interview with Staff E on 08/05/22 at 10:15am revealed: -She started working at the facility as a MA through an agency in June 2022. -She was offered a full-time position of Special Care Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22. -She had completed SCU orientation prior to starting as SCUC on 08/01/22 but could not remember what day she had completed the training. -The facility should have her training record on file.					
	accountant on 08/05/2	·				
		erview with the previous ger (BOM) on 08/05/22 at				
	Refer to telephone int Administrator on 08/0					

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Telephone interview with the corporate

STATE FORM 6899 63ET13 If continuation sheet 89 of 105

DIVIDION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034098	B. WING		
		HAL034096			08/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		2609 OLD	SALISBURY R	OAD	
SALEM TE	ERRACE		SALEM, NC 2		
	OUR MAR DV OT		,		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 477	Cantinuad Francisco	- 00	D 477		
D 477	Continued From page	e 89	0477		
	accountant on 08/05/2	22 at 3:00pm revealed:			
	-She was aware Spec	cial Care Unit (SCU) training			
	was required within th	ne first week of hire.			
	-In July 2022, she car	me to the facility to help the			
	business office part-ti	me.			
	-Two weeks ago, she	started working on			
	personnel records.	•			
	-She was not aware s	some employees had not			
	received the required	6 hours of special care unit			
	training.				
		vith the previous business			
	office manager (BOM) on 08/05/22 at 3:09pm			
	revealed:				
		was responsible for making			
	sure all trainings were				
		s in May 2022 and she was			
		aff SCU training was not			
	completed.				
		e paperwork went through			
		metimes never made it to			
	the business office.				
	_	is usually provided within the			
		on and should be in the			
	personnel record.				
	Telephone interview	vith the Administrator on			
	08/05/22 at 1:33pm re				
		t orientation and training was			
		eleted during orientation,			
		_			
	which was done the first week of hireThe business office was responsible for making				
	sure all personnel red				
	•	vas responsible for making			
		ds included the required			
	trainings.	ao maidada mo required			
		eft sometime in June 2022,			
		siness office two to three			
	days per week.				

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-She was not sure if the previous BOM would

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PRINTED: 08/26/2022 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		HAL034098			08/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	•		
SALEM TE	RRACE		SALISBURY RO SALEM, NC 2'			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 477	Continued From page	90	D 477			
	orientation and trainin -The corporate accou business office out at early July 2022. -She thought the requ	een completed due to the				
{D912}	O912} G.S. 131D-21(2) Declaration of Residents' Rights		{D912}			
	G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.					
	This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to staff qualifications-North Carolina Health Care Personnel Registry and criminal background checks, personal care and supervision, health care and medication aide training and competency.					
	The findings are:					
	facility failed to ensure A, B, D and E) had no listed on the North Ca Personnel Registry (H	es and record reviews, the e 4 of 6 sampled staff (Staff o substantiated findings arolina Health Care HCPR) prior to hire. [Refer to 13F .0405(a)(5) Other Staff				

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	_
			B WING		F	
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			SALISBURY R			
SALEM T	ERRACE					
		WINSTOR	I SALEM, NC 2	1121		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGOLATORI ORT	100 IDENTIF TING IN CINIMATION)	TAG	DEFICIENCY)	WATE	
{D912}	Continued From page	91	{D912}			
	Ouglifications (Type F	Niclotion \1				
	Qualifications (Type E	o violation)j.				
	0 Daned on manada	eviews and interviews the				
	,	e 2 of 6 sampled staff (Staff				
		criminal background check				
		[Refer to Tag 139, 10A				
	, , ,	7) Other Staff Qualifications				
	(Type B Violation)].					
	0.0					
	3. Based on record reviews, observations, and					
		failed to provide supervision				
	•	sidents (#4 and #5) related				
		I 2 falls within a week with 1				
		s (#5) and a resident who				
	_	sustained 3 falls with 1 fall				
	resulting in pain and a	a decrease in ambulation				
	(#4). [Refer to Tag 27	0, 10A NCAC 13F .0901(b)				
	Personal Care and St	upervision(Type B				
	Violation)].					
	4. Based on observat	ions, record reviews and				
	interviews, the facility	failed to ensure health care				
	referral and follow up	were completed for 3 of 5				
	sampled residents (#	1, #4, and #5) who had				
		and physical therapy (#1);				
	•	alker and a wheelchair, and				
		obtain a referral to see a				
		an order for physical therapy				
		3, 10A NCAC 13F .0902(b)				
	Health Care (Type A2	. ,				
	ricaliii Garc (Type Az	violation)j.				
	5 Rased on observat	ions, interviews, and record				
		led to ensure 4 of 6 sampled				
		Staff D and Staff E) who				
		tions had completed the				
		ng, including the 5, 10, or 15				
	hour medication aide	_				
		ills checklist, employee				
		ation of successfully taking				
	and passing the medi	cation aide examination.	1			

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STATEMEN	OT HEAITN SERVICE REGU TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE	SURVEY LETED
			A. BUILDING:			5
		HAL034098	B. WING		l l	R 05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
CALEME		2609 OL	D SALISBURY ROA	AD.		
SALEM TI	ERRACE	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{D912}	Continued From page 92		{D912}			
	[Refer to Tag 935, G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)].					
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S.§ 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration.		D935			
	Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. (2) A clinical skills evon NCAC 13F .0503 and (3) Within 60 days from individual must have a. An additional 10-hodeveloped by the Dep	oring or testing in which e potential for bleeding aluation consistent with 10A I 10A NCAC 13G .0503. om the date of hire, the completed the following:				

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administration.

1. The key principles of medication

STATE FORM 6899 63ET13 If continuation sheet 93 of 105

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _		_	
		HAL034098	B. WING		08/0	5/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD		
JALEWI 11	ERRAGE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	Continued From page	93	D935			
	Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. b. An examination de by the Division of Heat accordance with substitute accordance with substitute is not met TYPE B VIOLATION Based on observation reviews the facility fair staff, who administered employee verification medication aide during (A, B, D and E); 1 of 6 medication clinical sk administering medical sampled staff comple	oring or testing in which e potential for bleeding veloped and administered alth Service Regulation in section (c) of this section. as evidenced by: as, interviews, and record led to ensure 4 of 6 sampled ed medications, had that they had worked as a g the previous 24 months 6 sampled staff completed a ills checklist prior to				
	The findings are:					
	1. Review of Staff A's personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff A was hired on 04/20/22There was documentation Staff A had completed the medication clinical skills checklist on 04/15/22There was no documentation Staff A completed the 5, 10, or 15-hour medication aide trainingThere was no documentation of an employee verificationThere was no documentation Staff A had taken or passed the medication aide examination.					

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL034098	B. WING		R 08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	re. ZIP CODE	•	
			D SALISBURY RO			
SALEM TE	ERRACE	WINSTO	N SALEM, NC 27	127		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D935	Continued From page	94	D935			
	Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.					
	Review of residents' June and July 2022 electronic medication administration records					
	(eMARs) revealed: -There was documentation Staff A administered medications on 6 occasions from 06/01/22 through 06/30/22.					
	-There was document medications on 7 occurrent through 07/31/22.	tation Staff A administered asions from 07/01/22				
	Refer to interview with 08/04/22 at 5:35pm.	n the facility's nurse on				
	•	terview with the Resident CC) on 08/05/22 at 1:23pm.				
	Refer to telephone int Administrator on 08/0					
	Refer to telephone int accountant on 08/05/2	terview with the corporate 22 at 3:00pm.				
		terview with the previous ger (BOM) on 08/05/22 at				
	revealed: -Staff B was hired on -There was document	(PCA/MA) personnel record 06/14/22. tation Staff B completed the				
	5, 10, or 15-hour med	lication aide training on				

06/28/22.

verification.

-There was no documentation Staff B completed

-There was no documentation of an employee

the medication clinical skill checklist.

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			D WING		R	
		HAL034098	B. WING		08/0	5/2022
NAME OF D	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STA	TE ZID CODE		
IVAIVIL OI II	NOVIDEN ON OUT FIEN					
SALEM T	ERRACE		D SALISBURY R			
		WINSTO	N SALEM, NC 2	7127		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				22.10.2.10.1		
D935	Continued From page	95	D935			
	-There was no docum	nentation Staff B had taken				
	or passed the medica	ition aide examination.				
	Review of residents'	July and August 2022				
	electronic medication	administration records				
	(eMARs) revealed:					
		tation Staff B administered				
	medications on 8 occ					
	through 07/31/22.	40.01.0 110111 0770 1722				
	_	tation Staff B administered				
	medications on 3 occ					
		asions 110111 06/01/22				
	through 08/04/22.					
		01				
		vith Staff B on 08/05/22 at				
	2:41pm revealed:					
		ne facility since June 2022				
	-	exact start date), but she				
		orking mid-June 2022.				
		he mostly worked on the				
	medication cart.					
	-She administered me	edications to the residents.				
	-She had her 15-hour	medication aide training,				
	but no other training h	nad been provided since she				
	began working at the	facility.				
	-The facility nurse ver	bally told her that she was				
	going to provide addit	tional training, but nothing				
	had been provided.					
		passed the medication aide				
		starting work at the facility.				
	Refer to interview with	h the facility's nurse on				
	08/04/22 at 5:35pm.	Trans rasinty s marss on				
	55/5-1/22 at 5.55pm.					
	Pofor to tolonhone int	terview with the Resident				
	Care Coordinator (RC	CC) on 08/05/22 at 1:23pm.				
	.					
	•	terview the Administrator on				
	08/05/22 at 1:33pm.					

Refer to telephone interview with the corporate

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL034098		B. WING		R 08/05/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	ERRACE		D SALISBURY RO N SALEM, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE COMF	(5) PLETE ATE
D935	Continued From page	96	D935			
	accountant on 08/05/	22 at 3:00pm.				
	Refer to telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm. 3. Review of Staff D's personal care aide/medication aide (PCA/MA) personnel record revealed: -Staff D was hired on 06/14/22There was documentation Staff D had completed the medication clinical skills checklist on 07/06/22There was no documentation of employment verification for Staff DThere was no documentation of 5, 10 or 15-hour medication aide training and competency validationThere was no documentation Staff D had taken and passed the medication aide examination.					
	revealed: -There was documen medications on 13 oc through 07/31/22.	tation Staff D administered casions from 07/01/22 tation Staff D administered asions from 08/01/22				
	08/05/22 at 2:56pm w	interview with Staff D on vas unsuccessful. h the facility's nurse on				
		terview with the Resident CC) on 08/05/22 at 1:23pm.				

Refer to telephone interview with the

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI F	CONSTRUCTION	(X3) DATE S	URVEY	
, ,		IDENTIFICATION NUMBER:	1 ' '		COMPLETED	
			7 20.2510.		_	
			R WING		F	
		HAL034098	B. WING		08/0	5/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
SALEM T	FRRACE	2609 OL	D SALISBURY RO	DAD		
OALLIN I	LITTAGE	WINSTO	ON SALEM, NC 27	127		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG	1,2002,1101,1101,11		IAG	DEFICIENCY)	RIATE	
D935	Continued From page	e 97	D935			
	Administrator on 08/05/22 at 1:33pm.					
	Refer to telephone interview with the corporate					
	accountant on 08/05/	•				
		·				
		terview with the previous				
		ager (BOM) on 08/05/22 at				
	3:09pm.					
	4. Review of Staff E's	s, medication aide (MA),				
	personnel record rev					
	-Staff E was hired on	07/26/22.				
	-Staff E completed th	ne Medication Administration				
		ion Checklist on 07/28/22.				
		mentation of completion of a				
		5, 10, or 15-hour MA training course or				
	medication aide examination.					
	-There was no documentation of employment verification for Staff E.					
	verification for Stall E					
	Review of a resident	's July and August 2022				
	1	Administration Records				
	(eMARs) revealed:					
	-From 07/01/22 throu	ιαh 07/31/22 Staff F				

-From 07/01/22 through 07/31/22 Staff E documented the administration of medications on 15 days.

-From 08/01/22 through 08/04/22 Staff E documented the administration of medications on 1 day.

Telephone interview with Staff E on 08/05/22 at 10:15am revealed:

- -She started working at the facility as a MA through an agency in June 2022.
- -She was offered a full-time position of Special Care Unit Coordinator (SCUC) on 07/26/22 and started her role as SCUC on 08/01/22.
- -She had completed MA training and testing because she needed that for the agency she worked for prior to starting employment at the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND I PAR OF CONNECTION		A. BUILDING: _	A. BUILDING:		COMPLETED	
		D 14/11/0		R		
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SALEM TE	EDDACE	2609 OLD	SALISBURY R	OAD		
SALEWI II	ERRAGE	WINSTON	SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	Continued From page	e 98	D935			
	facility, but she could not remember exactly when she had completed the training and her MA exam. -The facility should have her training record on file.					
	Refer to interview with 08/04/22 at 5:35pm.	th the facility's nurse on				
	Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm.					
	Refer to telephone in Administrator on 08/0					
	Refer to telephone interview with the corporate accountant on 08/05/22 at 3:00pm.					
		terview with the previous ager (BOM) on 08/05/22 at				
	5:35pm revealed: -She had worked at the over one month.	the facility part-time for a little and was not sure of the equired.				
	-She had completed s skills checklists but st the checklist forms.	some medication clinical topped when she ran out of				
	sure what staff had co -She had also provide MAs but not all the M	certificate for the 15-hour				
	-If the MA did not hav result, then she had r	ve a 15-hour training test not provided the training. ne was not responsible for				

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obtaining proof the MA had taken and passed the

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
HAL034098		B. WING		R 08/05/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			SALISBURY R			
SALEM TE	ERRACE		N SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
D935	Continued From page	99	D935			
	medication aide exam					
	modication and exam	middon.				
		vith the Resident Care				
	Coordinator (RCC) or revealed:	n 08/05/22 at 1:23pm				
		ed, the training provided				
		hem out on the first shift,				
	working with another					
	• •	osed to check the MA off aining on the medication				
	cart.	aning on the medication				
	-The MA was verbally	asked to submit any				
	previous medication a	aide training, including				
		and passing the medication				
	aide examination.	use reenensible for encuring				
		vas responsible for ensuring cation as a medication aide.				
		nad been without a full-time				
		ger (BOM) since late May				
	2022 or early June 20					
		o was responsible for				
	obtaining required do	cuments without a BOM.				
	Telephone interview v 08/05/22 at 1:33pm re	vith the Administrator on				
		was responsible for making				
	sure all personnel rec					
		as responsible for making				
	sure personnel record trainings.	ds included the required				
		eft sometime in June 2022,				
		siness office two to three				
	days per week.	ntant started halving the				
		ntant started helping the the end of June 2022 or				
	early July 2022.	and dried of derite 2022 of				

-The facility's nurse was supposed to provide training to the MAs, but she had only worked at

the facility for a little over one month.
-She thought the required trainings and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	1 ` ′		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
		HAL034098	B. WING		R 08/05/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
SALEM TE	:DDACE	2609 OLD	SALISBURY R	OAD			
JALLIN 11	INNAUL	WINSTON	I SALEM, NC 2	7127			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D935	Continued From page	÷ 100	D935				
	documents had not been completed due to the turnover in the business office. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -The previous BOM left in June 2022 but continued to help the facility out part-time to get paperwork completedShe started working at the facility in July 2022 trying to help with the paperworkTwo weeks ago, she started working on personnel records. Telephone interview with the previous BOM on 08/05/22 at 3:09pm revealed: -She left the facility as the BOM at the end of May 2022.						
	-The paperwork initially went to the corporate office, and then came to the business officeWhen she was the BOM she noticed the paperwork went through several different hands, and sometimes never made it to herObtaining the MA training was not her responsibility, but she had to make sure the						
	paperwork was availa						
	as MAs and administeresidents had completeraining and competer administering medica 15 hour medication ai E); the clinical skills cof prior employment was previous 24 months (apossible medication expression of the complex previous 24 months).	ted the medication aide ncy evaluation before tions including the 5, 10, or de training course (A, D and hecklist (B); and had proof rerification during the A, B, D and E) resulting in errors. The facility's failure the health, safety, and welfare					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	HAL034098	B. WING	R 08/05/2022			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			

ALEM TE	ERRACE	D SALISBURY ROANISALEM, NC 271		
(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) COMPLET DATE
D935	Continued From page 101 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/05/22 for this violation. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2022.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S.§ 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the	D992		
	examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
ANDILAN			A. BUILDING: _			
		HAL034098	B. WING		08/0	5/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/0	<u> </u>
NAME OF T	NOVIDER OR GOLF EIER		SALISBURY R			
SALEM T	ERRACE		SALEM, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D992	Continued From page	e 102	D992			
	and the condition for prescribed. If the rest employee's examinat the presence of a cor care home may requi	ribed dosage and frequency, which the substance is alt of an applicant's or ion and screening indicates at a second examination fy the results of the prior sening.				
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 2 of 6 sampled staff (Staff A and Staff E) prior to hire.					
	The findings are:					
	1. Review of Staff A's, personal care aide (PCA)/medication aide (MA) personnel record revealed: -Staff A was hired on 04/20/22There was no documentation Staff A completed a drug screening. Attempted telephone interview with Staff A on 08/05/22 at 1:38pm was unsuccessful.					
		terview with the Resident CC) on 08/05/22 at 1:23pm.				
	Refer to telephone in Administrator on 08/0					
	accountant on 08/05/	s, medication aide (MA), ealed:				

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Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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			B. WING		R	
		HAL034098	B. WING		08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			D SALISBURY R			
SALEM TE	ERRACE		N SALEM, NC 2			
			N SALEWI, NC 2			
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PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
		,		DEFICIENCY)		
D992	Continued From page	e 103	D992			
	-There was no drug s	creen completed upon hire				
		her personnel record.				
	available for review in	The personner record.				
	Telephone interview v	vith Staff E on 08/05/22 at				
	10:15am revealed:	Will Stall L OII 00/03/22 at				
	-She started working	at the facility as a MA				
	through an agency in					
		II-time position of Special				
	Care Coordinator (SC					
	started her role as SCUC on 08/01/22She remembered completing a pre-employment					
		her hire date of 07/26/22				
	•	08/01/22 but could not				
	remember the exact of					
		e result of her drug test in				
	-	ne did not know if it would				
	have been filed yet si					
	nave boon mod yet on	ned drie was so new.				
	Refer to telephone int	terview with the Resident				
		CC) on 08/05/22 at 1:23pm.				
		20, an da, da, == an mean				
	Refer to telephone int	terview with the				
	Administrator on 08/0					
	7 (41)	0,22 at 1.00p				
	Refer to telephone int	terview with the corporate				
	accountant on 08/05/2					
	Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm					
	revealed:	·				
	-When new hires cam	ne to the facility for an				
		onist gave them paperwork				
	to complete.					
		given a form to complete				
		to a lab to have the drug				
	screen completed.					
		me back by email to the				
	business office mana					

Telephone interview with the Administrator on

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MALE OF PROVIDER OR SUPPLIER STEETADDRESS, CITY, STATE, ZIP CODE 2809 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 PREPER TAGS SUMMAY STATEMENT OF SECRETORISE STRULL (SALISBURY STATEMENT OF SECRETORISE STRUCK (SALISBURY STATEMENT OF SECRETORISE (SALISBURY STATEMENT OF SECRETORISE (SALISBURY STATEMENT OF SECRETORISE (SALI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		lii i			DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD WINSTON SALEM, NO. 27127 (X4) ID PREFIX TAG CONFIDER OR SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CONFIDER OR SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CONFIDER CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D992 Continued From page 104 08/05/22 at 1:33pm revealed: -The business office was responsible for ensuring drug screens were completedIf an employee drug screen was not completed the BOM was responsible for checking to obtain the drug screenShe thought the drug screen was missed due the turnover in the business officeShe had not checked personnel records to identify missing paperwork. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She started helping the facility out in July 2022 but had not completed personnel recordsTwo weeks ago, she started working on personnel records but was unaware of employees	AND FLANC	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLE	ILED
SALEM TERRACE 2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DEFICIENCY) D992 D992 Continued From page 104 08/05/22 at 1:33pm revealed: -The business office was responsible for ensuring drug screens were completedIf an employee drug screen was not completed the BOM was responsible for checking to obtain the drug screenShe thought the drug screen was missed due the turnover in the business officeShe had not checked personnel records to identify missing paperwork. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She started helping the facility out in July 2022 but had not completed personnel recordsTwo weeks ago, she started working on personnel records but was unaware of employees			HAL034098	B. WING		1	
SALEM TERRACE WINSTON SALEM, NC 27127	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) D PREFIX TAG (SA) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D992 Continued From page 104 08/05/22 at 1:33pm revealed: -The business office was responsible for ensuring drug screens were completed the BOM was responsible for checking to obtain the drug screenShe thought the drug screen was missed due the turnover in the business officeShe had not checked personnel records to identify missing paperwork. Telephone interview with the corporate accountant on 08/05/22 at 3:00pm revealed: -She started helping the facility out in July 2022 but had not completed personnel recordsTwo weeks ago, she started working on personnel records but was unaware of employees	SALEM TO	EDDACE	2609 OLD \$	SALISBURY R	OAD		
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	D992	08/05/22 at 1:33pm re- The business office of drug screens were countries. The BOM was responsible the BOM was responsible the drug screen. -She thought the drug turnover in the busines. She had not checked identify missing pape. Telephone interview of accountant on 08/05/2. She started helping the but had not complete. Two weeks ago, she personnel records but helping the per	evealed: was responsible for ensuring ompleted. screen was not completed sible for checking to obtain g screen was missed due the less office. d personnel records to rwork. with the corporate 22 at 3:00pm revealed: the facility out in July 2022 d personnel records. In started working on t was unaware of employees	D992			

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