Received via electronic mail 09/15/22.

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	T OF DEFICIENCIES OF CORRECTION	(21) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE S COMPL	
	:	HAL034098	8. WING		R 08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE	1 00/0	
SALEM T	FRRACE		D SALISBURY			
	r		N SALEM, NC	27127		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMFLETE DATE
{D 000}	Initial Comments		{D 000}			
	follow-up survey on	nsure Section conducted a 08/03/22 to 08/05/22 with an telephone on 08/05/22.				
D 131	10A NCAC 13F .040	06(a) Test For Tuberculosis	D 131			
	10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for			D 131 10A NCAC 13F .0406A2:A3 Test for Tuberculosis	5+A2:A24(a)	9-21-2 ongon
	measures adopted a Services as specifie	a in compliance with control by the Commission for Health d in 10A NCAC 41A .0205 at amendments and editions.		All staff will have a two step T negative results recorded or a with no active TB noted in the	B test with chest x-ray	
×	Copies of the rule and contacting the Depa Services Tuberculos	e available at no charge by rtment of Health and Human is Control Program, 1902 Raleigh, NC 27699-1902.		file. Please see Attachment A. The Business Office Manager utilize the New Hire Checklist to enure that records	will	
	reviews, the facility f sampled staff (Staff	t as evidenced by: ons, interviews and record ailed to ensure 1 of 6 D) had a test for tuberculosis		compliance. Attachment A: TB Testing Po		
	(TB) upon hire.			Procedure Attachment B: New Hire Chu	ecklist	
	The findings are:			-		
	revealed: -Staff D's hire date w	de (MA), personnel record vas 06/28/22.				
	-There was no oocur skin test.	nentation of a completed TB				
	revealed:	4/22 from 3:00pm to 4:08pm on duty on second shift.				7
		d passing medications to				
	In Service Regulation IRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	: yum	me Riteries-en, ac	loneny	XEJOAKE +
TE FORM					/_	111-0-
TE FORM			6299	BAET 13 Catherine Prater	If continuation	111

Reviewed and acknowledged 09/15/22.

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034098	(X2) MULTIPLE O A. BUILDING: B. WING	ONSTRUCTION	COM	SURVEY PLETED R
		1742034056				/05/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
SALEM T	ERRACE		D SALISBURY RO			
	CUMANADY		N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 7 DEFICIENC	ion should be 'He appropriate	(X5) COMPLET DATE
D 131	Continued From page	ge 1	D 131			
	Attempted interview 2:56pm was unsucc	with Staff D on 08/05/22 at cessful.				
	08/05/22 at 1:33pm -Staff D worked at th	with the Administrator on revealed; ne facility as a MA and as a				
		the residents assisting with rs, transportation and with				
	-She was not aware TB skin test.	Staff D had not completed a ed, they were required to				
	have a TB skin test.	chance to review Staff D's				
	completed.	ensure TB skin test was				
		ess Office Manager (BOM) ted part-time sometime in				
i.		untant started to help at the aff records at the end of June				
	-She thought Staff D	's TB skin test was missed a staff in the business office.				
1		22 at 3:00pm revealed:				
	because the previous June 2022.	elping the facility out s BOM became part-time in				
	weeks ago.	get staff records together 2 Staff D did not have a TB skin				
		with the previous BOM on				
.		s the full-time BOM in May			· ·	

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If continuation sheet 2 of 105

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PRINTED: 08/26/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PPOVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: в. R HAL034098 B. WING 08/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREEIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 131 Continued From page 2 D 131 2022. -The paperwork initially went to the corporate office and then came to her at the business office. -When 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(a)(5) Other Staff D 137 Qualifications D 137 10ANCAC 13F .0407(a)(5) Other Staff Ż Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult-care home All potential new hires will be shall: (5) have no substantiated findings listed on the screened through the NC Healthcare North Carolina Health Care Personnel Registry Personnel Registry prior to attending according to G.S. 131E-256; orientation. Upon a job offer being made, the This Rule is not met as evidenced by: Business Office Manager will submit TYPE B VIOLATION the paperwork to the Healthcare Personnel Registry. Upon receipt of the Based on interviews and record reviews, the facility failed to ensure 4 of 6 sampled staff (Staff results showing no substantial findings. A, B, D and E) had no substantiated findings orientation will be scheduled for the new listed on the North Carolina Health Care employee. If there are substantial findings, Personnel Registry (HCPR) prior to hire. the paperwork will be given to the The findings are: Administrator to review. At that time the offer of employment may be recinded. 1. Review of Staff A's, personal care aide The Business Office Manager will (PCA)/medication aide (MA) personnel record utilize the New Hire revealed: -Staff A was hired on 04/20/22. Checklist to ensure that records are in -There was documentation that a HCPR was compliance. 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. Attachment B: New Hire Checklist Division of Health Service Regulation

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	<u>Di Healkin Service med</u> TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	DIASTRUCTION		E SURVEY PLETED
		HAL034098	B. WING		08	3/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TI	ERRACE		D SALISBURY ROA N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLE DATE
D 137	Attempted telephone 08/05/22 at 1:38pm Telephone interview Coordinator (RCC) of revealed: -Staff A had worked as a MA for over one months. -When Staff A was h Manager (BOM) was a HCPR status chec -She did not know w completing the HCP BOM. Telephone interview 08/05/22 at 1:33pm -She was not aware was completed 2 da -She was aware that to have a HCPR stat starting work. -Staff A's HCPR sho hire.	e interview with Staff A on was unsuccessful. with the Resident Care on 08/05/22 at 1:23pm at the facility as a PCA and e month, maybe almost two irred the Business Office s responsible for making sure is was completed. ho was responsible for R when there was no full-time with the Administrator on revealed: Staff A's HCPR status check ys ago and not prior to hire. t all employees were required tus check completed prior to uld have been checked upon	D 137	` r		
	Business Office Mar 3:09pm.	nterview with the previous nager (BOM) on 08/05/22 at nterview with the corporate				
	Refer to telephone in Administrator on 08/ 2. Review of Staff B ⁵	nterview with the 05/22 at 1:33pm. s personal care aide				
	(PCA)/medication air revealed: -Staff B was hired or	de (MA) personnel record				

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STATEMENT	of Health <u>Cervice Requ</u> FOF DEFICIENCIES OF CORRECTION	Iation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034098	(X2) MULTIPLE C A. BUILDING: B. WING		COM	survey Pleted R 1/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) Complete Date
D 137	Continued From page	34	D 137			
	-There was documen was completed on 08 findings noted, -There was no docum was done on or prior Telephone Interview v 2:41pm revealed: -She was a MA and s PCA. -She started working (unable to recall the e -When she started working thing she was asked training. -No one told or inform would be completed. -She was aware from HCPR check was rec	Atation that a HCPR check 3/03/22. There was no mentation that a HCPR check to the date of hire. with Staff B on 08/05/22 at sometimes she worked as a at the facility in June 2022 exact date). orking at the facility, the only to provide was previous MA med her that a HCPR check a previous employers that a juired, but she was not ty that they were going to				
	Coordinator (RCC on revealed: -Staff B had worked a a PCA for almost two	at the facility as a MA and as months. iness office was responsible				
	08/05/22 at 1:33pm r -She was not aware 3 not completed until 0 -She had not reviewe to ensure the require status checks were o -The business office	Staff B's HCPR check was 8/03/22. d Staff B's personnel record d documents and HCPR				

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	of Health Service riegu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMPI	
			A. BUILDING.	·····		R
		HAL034098	B. WING		08/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TE	ERRACE		D SALISBURY ROA N SALEM, NC 271			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETI
D 137	Continued From page	e 5	D 137			
	not completing an H0	CPR check for Staff B.				
		tervlew with the previous ager (BOM) on 08/05/22 at				
	Refer to telephone in accountant on 08/05/	terview with the corporate /22 at 3:00pm.				
	Refer to telephone in Administrator on 08/0					
	revealed: -Staff D was hired on -There was no docum	le (MA) personnel record				
	Attempted telephone 08/05/22 at 2:56pm v	interview with Staff D on vas unsuccessful.				
	Coordinator (RCC) or revealed:	with the Resident Care n 08/05/22 at 1:23pm				
	a PCA for a little over and a half.	at the facility as a MA and as rone month, maybe a month was responsible for ensuring				
	Staff D's HCPR chec	k was completed upon hire. had been without a full-time				
	-She was not aware	who would be responsible for ck because there was no				
	08/05/22 at 1:33pm r	with the Administrator on evealed: a HCPR status check had				
sion of Hea	alth Service Regulation					tion sheet 6 o

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	ĺ
		HAL034098	B, WING		R 08/05/2022	
			DRESS, CITY, STA			
NAME OF PI	ROVIDER OR SUPPLIER		SALISBURY RI			ļ
SALEM TE	RRACE		SALISBORT R			
				PROVIDER'S PLAN OF CORRECTIO	N (X5)	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 137	Continued From page	e 6	D 137			
	not been completed o	on Staff D since her date of				
	hire.					
		onsible for making sure a				
	HCPR check was con					
	-She had not reviewe	ed Staff D's personnel record d documents and status				
	checks were obtained				1	
	Refer to telephone in	terview with the previous	2			
	Business Office Man	ager (BOM) on 08/05/22 at				
	3:09pm.					
	D-E to totacheme in	terview with the corporate				
	accountant on 08/05/		1			
2	accountain on obioo					
	Refer to telephone in	terview with the				
	Administrator on 08/0)5/22 at 1:33pm.		÷		
		s medication aide (MA),				
	personnel record rev					
	-Staff E was hired on	R check completed upon hire				
	-Inere was no norr	n Staff E's personnel record.	1			
	Telephone interview	with Staff E on 08/05/22 at				
	10:15am revealed:					
	-She started working	at the facility as a MA				
	through a staffing ag	ency in June 2022.				
	-She was offered a fu	ull-time position of Special				
	started her role as S	or (SCUC) on 07/26/22 and				
	started her fole as S	the facility had completed a				
	HCPR check or who	would have been				
	responsible to keep	personnel records.				
	VICEN A VICEN			1		
1		with the SCUC on 08/05/22				
1	at 1:23pm revealed:					
	-Staff E was the SCL					
	-Staff E officially bec	ame the SCUC on 08/01/22,				
1	but had previously w	orked with the facility through		<u> </u>		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	():2) MULTIPLE C	DNSTRUCTION	(XS) DATE COMF	SURVEY PLETED	
		HAL034098	B. WING		200102	R 08/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
SALEM TE	ERRACE		D SALISBURY ROA				
			N SALEM, NC 271			-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 137	Continued From pag	je 7	D 137				
	an agency as a MA. -When Staff E was h						
	Refer to interview wi 08/05/22 at 1:33pm.	th the Administrator on					
	Refer to telephone in BOM on 08/05/22 at	nterview with the previous 3:09pm.					
	Refer to telephone in accountant on 08/05	nterview with the corporate //22 at 3:00pm.		5			
	08/05/22 at 1:33pm -She was aware that to have a HCPR che work. -She was not aware completed on Staff A -The Business Office	t all employees were required ock completed prior to starting that a HCPR check was not					
	hires. -The business office full-time BOM and sl	currently did not have a he thought that contributed to CPR check for Staff A, B, D,		×			
	08/05/22 at 3:09pm -She left the facility a 2022. -She continued to we	with the previous BOM on revealed: as the BOM at the end of May ork in the business office					
	completing HCPR cl	BOM she did not complete					
		oleting the paperwork.					

Division of Health Service Regulation STATE FORM

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	(X2) MULTIPLE C	DHSTRUCTION		L SURVEY PLETED
		HAL034098	B. WING		08	R 6/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET #	DDRESS, CITY, STATE	, ZIP CODE		
SALEM T	ERRACE		D SALISBURY ROADN SALEM, NC 271			
0(4)10	SUMMARY ST	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT GROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
D 137	Continued From page	e 8	D 137			
		emailed her completed				
		he printed them, and put then				
	in the personnel reco					
		ersonnel records went				
		ent "hands" and sometimes				
	never made it to her.	au ana iliaetha if tha UCDD				
		ay specifically, if the HCPR ed but if there was not				
		they were not completed.				
	Telephone interview					
		22 at 3:00pm revealed: tant for the corporate office.				1
		started helping in the				
	business office.					
		put together personnel				
		ork that was required by the				
		ompleted that process. ould be completed by the				
	business office.					
	-She had completed	HCPR checks on 08/03/22				
	for some employees	but not for all employees.				
	The facility failed to a	nsure 4 of 6 sampled staff				
	(Staff A, B, D, and E)					
	completed prior to hir	e. This failure resulted in the				
	facility not knowing if	staff had substantiated				
		R which was detrimental to				1
		d welfare of the residents				
	and constitutes a Typ					
	The facility provided a	a plan of protection in				
	accordance with G.S.	131D-34 on August 5, 2022				
	for this violation.					
	CORRECTION DATE	FOR THE TYPE B				1
		OT EXCEED SEPTEMBER	1			
	20, 2022.				8	
	neneseese ● 115-116 (1999)99 (1999)					
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
			10000		R
	163	HAL034098	B. WING		08/05/2022
		STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
NAME OF PR	IOVIDER OR SUPPLIER		SALISBURY R		
SALEM TE	RRACE		SALISBURT R		
			1	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 139	Conlinued From pag	e 9	D 139		
n 490	10A NCAC 13F .040		D 139		
D 139	Qualifications		-		
	Quantoutorio				
	10A NCAC 13F .040	7 Other Staff Qualifications			.
	(a) Each staff persor	n at an adult care home shall:		D 139 10A NCAC 13F .0407(a)(7) Oth	ier .
	(7) have a criminal b	ackground check in		Staff Qualifications	6-70-55
	accordance with G.S	5. 114-19.10 and 131D-40;		Stan Quanneactons	5-20-2 1449/10
	This Rule is not me	t as evidenced by:		All potential staff members will	
	TYPE B VIOLATION			All potential stall memoers win	learound
1				through the facility Criminal Bac	Kground
	Based on record rev	riews and Interviews the		provider prior to attending orient	tatation.
	facility failed to ensu	re 2 of 6 sampled staff (Staff		Upon a job offer being made, the	Business
		a criminal background check		Office Manager will submit the	paperwork
	completed upon hire	.		to the Criminal Background prov	vider.
	The findings are:		1	Upon receipt of the results, the	
	0 (<u>199</u> 8)			Business Office Manager will sh	now the
		's personal care aide (PCA)		Administrator the results and ob	tain
	personnel record re	vealed:		approval of the applicant for ori	
1	-Staff was hired on	04/20/22.		The results will be maintained e	lectronically
1	-There was docume	entation that a criminal was obtained on 08/04/22 with		The results will be maintained e	bo ken in
	no findings.			and proof of the submission wil	
	-There was no docu	imentation that a criminal		the employee file. The Business	s Onice
	background check v	was completed upon or before		Manager will utilize the New	
	hire.			Checklist to ensure that records	are in
				compliance.	
	Attempted telephon	e interview with Staff A on			
	08/05/22 at 1:38pm	was unsuccessful.		Attachment B: New Hire Chee	cklist
	Telephone interview	v with the Resident Care			1
1	Coordinator (RCC)	on 08/05/22 at 1:23pm	. b		
	revealed:				
1	-Staff A had worked	at the facility as a PCA and	4		
1		e month, maybe almost two			
	months.	me to the facility for an			
	-When new hires Ci	ame to the facility for an otionist gave them paperwork			
1	to complete.	Monat gave mont paper for			
Division of L	to complete. lealth Service Regulation				11 11
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) WULTIFLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		R
		HAL034098	B. WING		08/05/2022
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
ALEM TE	RRACE		D SALISBURY ROA		
		WINSTO	N SALEM, NC 271	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 37 MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO {EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
D 139	Continued From pag	e 10	D 139	4453.4 957.68 97.68 97.986 97.986 96 85 67	
	-The paperwork inclu	uded a form to sign for the			
		check to be completed.			
		Manager (BOM) was			
		ng sure criminal background			
	checks were complet	ted and in the personnel			
	record.				
[-The business office	had been without a full-time			
	BOM for almost three				
		ho was responsible for			
		background checks when			
3	there was no BOM.				
	Refer to telephone in	terview with the previous			
		ager (BOM) on 08/05/22 at			
	3:09pm.	ugui (_ •, • •			
		terview with the corporate			
	accountant on 08/05/	/22 at 3:00pm.			
	Refer to telephone in	terview with the			
	Administrator on 08/0				
[s medication aide (MA)			18
	personnel record rev				
	-Staff D was hired on				
	••••••	nentation that a criminal			
		as completed upon hire,			
	before hire or thereaf	iter.			
1	Attempted telephone	interview with Staff D on			
	08/05/22 at 2:56pm v				
	Telephone interviews	with the RCC on 08/05/22 at			
	1:23pm revealed:				
		at the facility as a MA and as			
		one month, maybe a month			
	and a half.	10 ¹⁰ -			
	-When Staff D came				
1	receptionist should have	ave given her paperwork to			
		at a tarantar an Eastern and and an all	1		
	Ith Service Regulation	ed signing for a criminal		· · · · · · · · · · · · · · · · · · ·	

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PRINTED: 08/26/2022 FORM APPROVED

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STATEMENT	f <u>Health Service Requ</u> of deficiencies if correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 08/05/2022
		HAL034098			·
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STAT		
SALEM TE			SALISBURY RO		
SALENIIC		WINSTON	SALEM, NC 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 139	Continued From page	e 11	D 139		
	background check to -The BOM was respo background checks h	be completed. onsible for ensuring criminal had been completed. had been without a full-time			
	Business Office Man 3:09pm.	terview with the previous ager (BOM) on 08/05/22 at			
	Refer to telephone in accountant on 08/05.	terview with the corporate /22 at 3:00pm.			
	Refer to telephone in Administrator on 08/0	iterview with the 05/22 at 1:33pm.			
	08/05/22 at 3:09pm i -She left the facility a	with the previous BOM on revealed: as the BOM at the end of May			
	part-time.	ork in the business office			
	completing criminal I	she was not responsible for background checks. BOM she did not complete			
	criminal background	checks. was responsible for			
	-The corporate office	red paperwork for new hires. e sometimes emailed her the			
1	-The paperwork for J	criminal background checks. personnel records went prent "hands" and sometimes	а		
	hrough several difference in the several difference in the sever made it to her				
	-She was unable to	say specifically why the	1		1
	criminal background	checks were not completed.			1
	-She was the accou	with the corporate 5/22 at 3:00pm revealed: ntant for the corporate office. e started working at the			
Division of H	ealth Service Regulation				if continuation sheet 12 of 1

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If continuation sheet 12 of 105

PRINTER: 66/20/2022 FORM ASEROVED

STATEMENT	i <u>Health Service Fieou</u> of deficiencies f correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 08/05/2022
		HAL034098	DRESS, CITY, STATI		••••••••••••••••••••••••••••••••••••••
NAME OF PF	OVIDER OR SUPPLIER		SALISBURY RO		
SALEM TE	RRACE	WINSTON	ISALEM, NC 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 139	checks for all employ which employees did background check. Telephone interview 1 08/05/22 at 1:33pm r -She was aware all e criminal background -She did not why Sta check was completed hire. -The business office completing criminal th hires. -The business office full-time BOM and st not completing a crim Staff A. -She was responsibl was completed, but a A's personnel record documents and crim obtained.	s office to help out. ted 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 d yesterday and not upon was responsible for background checks on new currently did not have a he thought that contributed to hinal background check on e for making sure paperwork she had not reviewed Staff to ensure the required inal background checks were	D 139		
	(Staff A and Staff D) check completed up in the facility not kno history which was de health, and welfare of constitutes a Type B	Violation.			
	accordance with G.S. for this violation.	a plan of protection in 5, 131D-34 on August 5, 2022 E FOR THE TYPE B NOT EXCEED SEPTEMBER			

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If continuation sheet 13 of 105

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	OF DEFICIENCIES F CORRECTION	Call PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		1141 024000	B. WING			੨ 05/2022
		HAL034098			1 001	0012022
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ITE, ZIP CODE		
SALEM TE	PRACE	2609 OL	D SALISBURY R	OAD		
21-12-2141 1 6		WINSTO	ON SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	uld be	(X5) COMPLETE DATE
D 139	Continued From pag	e 13	D 139			
	20, 2022.		1			
D 161	10A NCAC 13F .050 For LHPS Tasks	4(a) Competency Validation	D 161			
	Licensed Health Proi (a) An adult care ho non-licensed person not practicing in their governed by their pra- licensing laws are co- demonstration for an specified in Subpara Rule .0903 of this Su- performing the task a competency is assur oversight and super- This Rule is not met Based on observation reviews, the facility f sampled staff (Staff competency validate Professional Suppor demonstration include blood sugar checks	nel and licensed personnel licensed capacity as actice act and occupational ompetency validated by return y personal care task graph (a)(1) through (28) of ubchapter prior to staff and that their ongoing red through facility staff <i>v</i> ision.		D 161 10A NCAC 13F .0504(a) Competency Validation for LHPS All Resident Care Staff will b an RN using the LHPS prior t with Residents. The LHPS w completed as part of the empl orientation. All Med Tech's w using the LHP for Medication tasks and will demonstrate ab blood sugar checks and insuli prior to performing these task residents. The Business Offi- will utilize the New Hire Che to ensure that records are in c	e screened o working ill be oyee's will be scree a Administr ility to perf a injections to diabet ce Manager ocklist	ened ation form s ic
	The findings are:	s personal care alde		Attachment B: New Hire Cl Attachment C: LHPS Form		
	(PCA)/medication aid revealed: -Staff B was hired or	de (MA) personnel record				
	LHPS competency v					
	Review of a resident	ж.	1			

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: R B. WING 08/05/2022 HAL034098 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 161 D 161 Continued From page 14 administration record (eMAR) for August 2022 revealed Staff B documented obtaining fingerstick blood sugar checks for 3 opportunities in August 2022. Telephone interview with Staff B on 08/05/22 at 2:41pm revealed: -She was a MA and sometimes she worked as a PCA. -She was checked-off for LHPS tasks at her previous employment but not at this facility. -The facility nurse had verbally told her that she was going to provide LHPS training but had not completed the training. -She worked third shift and she usually checked FSBS at 6:00am in the morning, but she did not administer insulin. -Since her employment at the facility, she had not received training related to LHPS tasks. Telephone interview with the Resident Care Coordinator (RCC) on 08/05/22 at 1:23pm revealed: -Staff B worked at the facility as a MA and as a PCA for a little over one month, maybe a month and a half. -There was a nurse who worked at the facility was part-time. -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 competency validation. -When a MA was hired, the only training she provided was for the MA to shadow another MA for one to two weeks before being on the medication cart by herself. Telephone Interview with the Administrator on 08/05/22 at 1:33pm revealed: -She was not aware Staff B had not completed

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FRINTED: 08/26/2022 FORM ADDITIONS

STATEMENT	f Health Service Requ of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED R
		HAL034098	B. WING		08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
			SALISBURY RO		
SALEM TE			SALEM, NC 27	PROVIDER'S PLAN OF CORREC	TION (X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 161	Continued From pag	e 15	D 161		
U 161	the LHPS competence -The facility nurse was LHPS competency v -She had not reviewa to ensure the required including LHPS com Refer to interview wi 08/04/22 at 5:35pm. Refer to telephone in accountant on 08/05 2. Review of Staff D (PCA)/medication all -She was hired on 0 -There was no docu competency validati Staff D. Observation of Staff revealed Staff D obt and administered in Review of three dial medication administ revealed Staff D do	cy validation. as responsible for ensuring alidations were completed. ed Staff B's personnel record ad training was completed petency validations. th the facility's nurse on hterview with the corporate 5/22 at 3:00pm. 's personal care aide de (MA) record revealed: 6/14/22. mentation a LHPS on had been completed for 'D on 08/04/22 at 4:30pm tained a FSBS on a resident sulin. betic residents' electronic tration records (eMARs) cumented she checked FSBS			
	06/01/22 through 06	sulin 28 opportunities from 5/30/22; 57 opportunities from 7/31/22; and 12 opportunities 1gh 08/04/22.			
}	08/05/22 at 2:56pm	e Interview with Staff D on was unsuccessful.			
	Coordinator (RCC) revealed: -Staff D worked at	v with the Resident Care on 08/05/22 at 1:23pm the facility as a MA and as a r one month, maybe a month			
Division of H	lealth Service Regulation		6899	63ET13	If continuation sheet 16 of

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STATEMENT	# Health Service Finds OF DEFICENCIES OF CORRECTION	ation (X1) FROVIDER/SUPPLIER/CL14 IDENTIFICATION NUMBER: HAL034098	(X2) MULTERS	00H9TR/107H0N	(XII) DATE CURVE? COMPLETED R 08/05/2022
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
		2609 OL	D SALISBURY RO	DAD	
SALEM T	ERRACE	WINSTO	N SALEM, NC 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 161	and a half. -The facility had a nut facility often. -When a MA was hire consisted of placing is cart to shadow anoth after that the MA woon medication cart. -She was not aware the facility nurse. -She was not aware checked-off for LHPS competency validation -She was not aware the LHPS competen hired at the facility. -The facility nurse re- part-time providing to -She had observed to but not sure if the tra competency validation -She had not review to ensure the required competency validation -She had not review to ensure the required -She had not review to ensure the requi	rse, but she was not in the ed, the training she provided the MA on the medication her MA for one to two weeks; (ked on her own on the of the training provided by if Staff D had been S tasks and completed the on. with the Administrator on revealed: Staff D had not completed cy validation since she was cently started and worked rainings. bonsible for ensuring LHPS ons were completed. the nurse providing trainings, alining included LHPS ons. ed Staff D's personnel record ed training and LHPS on was completed. the the facility's nurse on interview with the corporate 5/22 at 3:00pm. 's medication aide (MA) vealed:	D 161		
Division of H	lealth Service Regulation		6899	63ET13	If continuation sheet 17 of 10

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Division of	f Hoalth Service Frequi OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	· · · · · · · · · · · · · · · · · · ·	R
		HAL034098	B. WING		08/05/2022
			DRESS, CITY, STATI	E, ZIP CODE	
NAME OF PF	ROVIDER OR SUPPLIER		SALISBURY RO		
SALEM TE	ERRACE		SALEM, NG 27	127	71011
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 161	for review in Staff E's Review of three diab medication administr revealed Staff E doc and administered ins 06/01/22 through 06 07/06/22 through 07 from 08/01/22 through Telephone interview 10:15am revealed: -She started working through a staffing ac -She was offered a Care Unit Coordinal started her role as S -She had completed LHPS tasks but cou- The facility should validation in her sta	betency validation available is personnel record. etic residents' electronic ration records (eMARs) umented she checked FSBS sulin 21 opportunities from /30/22; 39 opportunities from /31/22; and 6 opportunities gh 08/04/22. with Staff E on 08/05/22 at g at the facility as a MA gency in June 2022. full-time position of Special or (SCUC) on 07/26/22 and SCUC on 08/01/22. I competency validation for Id not remember when. have her LHPS competency ff record.	D 161		
	Coordinator (RCC) revealed: -Staff E started wor as the SCUC. -As the SCUC, Stat cart checking FSBS -Prior to 08/01/22 S agency staff and ac including checking administration of di -She was not sure competency valida -The facility's nurse the LHPS competen	abetic residents. if Staff E completed LHPS			
Division of I	Telephone Intervie Health Service Regulation		6899	63ET13	If continuation sheet 18 of 1

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Division o	f Health Servics Requ	Lation			(X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	COMPLETED
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·····	
					R
		HAL034098	B. WING		08/05/2022
		11/2004030			
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	re, zip code	
		2609 OLI	SALISBURY RO	DAD	
SALEM TE	ERRACE	WINSTO	V SALEM, NC 27	7127	
	OT IN ALL AND Y CO	ATEMENT OF DEFICIENCIES	- ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY	NATE DATE
				DEFICIENCI	
	O	- 18	D 161		
D 161	Continued From pag	6 10	10.01		
	08/05/22 at 1:33pm r	evealed;			
	-She was not aware	Staff E had not completed			
	the LHPS competend	cy validation prior to checking			
	FSBS and insulin ad	ministration.			
	-Staff E had been at	the facility as agency staff,			
	then on Monday, 08/	01/22 Staff E started working	1		
	as the SCUC.				
	-The facility nurse wa	as responsible for making			
	sure LHPS competer	ncy validations were			
	completed.				
	-She had not review	ed Staff E's personnel record			
	to ensure the require	ed training and LHPS			
	competency validation	on was completed.			
	Refer to interview wi	th the facility nurse on	1		
	08/04/22 at 5:35pm.				
	Refer to telephone in	terview with the corporate			
	accountant on 08/05	/22 at 3:00pm.			
	Interview with the fac	cility's nurse on 08/04/22 at			
	5:35pm revealed:				
	-She had worked at	the facility part-time for a little			
	over one month.				
		nd was not sure of the	1		
ľ	trainings that were re	equired.			
	-She had completed	LHPS competency		1	
	validations with som	e employees but not			
	everyone.				
	-She was unable to	say which employees she			
		s competency validations			
	with.	and the states		1	
1	-She had document	ation for some staff who had			
	completed the LHPS	S competency validations.			
	-Some trainings wer	e not documented because			
}	she ran out of the fo	rm and did not document the			
1	training was comple	ted anywhere.			
		11. 41			
	Telephone interview	with the corporate			
		5/22 at 3:00pm revealed:			
Division of He	ealth Service Regulation				If continuation sheet 19 of 10

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	OF DEFICIENCIES OF CORRECTION	(C) PROVIDER/SUPPLIEF/CLIM IDENTIFICATION NUMBER:		CONSTRUCTION	COMP	SURVEY LETED
		HAL034098	B. WING	····		05/2022
IAME OF PR	ROVIDER OR SUPPLIER	2609 OLI	DDRESS, CITY, STA D SALISBURY R N SALEM, NC 2	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ould be	(X5) COMPLETE DATE
D 161	out since July 2022. -Two weeks ago shu records. -The facility hired a competency validati -The nurse had bee the forms and the tr -If the nurse was no needed forms, she 10A NCAC 13F .056	e facility helping the business e started to work on personnel nurse to provide the LHPS ion training. n trained on how to complete	D 161 D 164			
	Diabetic Residents An adult care home the care of resident insulin as follows: (1) Training shall b nurse, registered pl practitioner. (2) Training shall ir (a) basic facts abo in the management (b) insulin action; (c) insulin storage; (d) mixing, measur for insulin administ (e) treatment and and hyperglycemia symptoms; (f) blood glucose n precautions; (g) universal preca (h) appropriate ad	ring and injection techniques ration; prevention of hypoglycemia , including signs and nonitoring; universal		D164 10ANCAC 13F .0505 Train On Care of Diabetic Resident All Resident Care Staff will on diabetic care utilizing the manual at time of orientation will be overseen by RN who information, review testing a the training. The Business C will utilize the New Hire Ch training is complete and reco compliance. Attachment B: New Hire C Attachment M: Orientation Acknowledgement	be trained State of NC n. Training will review and sign off Office Manap lecklist to en ords are in Checklist	on ger

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PEUNTED- 06/26/2022 PORMARPECMED

Division of	Health Service Rogul	alion	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT AND PLAN O	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		R
		HAL034098	B. WING		08/05/2022
	OVIDER OR SUPPLIER		DRESS, CITY, STATE,		
			SALISBURY ROA		_
SALEM TE	50 80		N SALEM, NC 2712	DROVIDER'S PLAN OF CORRECT	10N (X5)
(X4) ID PREFIX TAG	CAOU DEDICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE OUMFLETE
D 164	Continued From pag	e 20	D 164		
					-
	facility failed to ensu	iews and interviews, the re 3 of 6 sampled medication D and Staff E) had completed of diabetic residents prior to blood sugars and			
	The findings are:				
	(PCA)/medication a revealed: -Staff A was hired o	's personal care aide ide (MA) personnel record n 04/20/22. Imentation on the training of residents for Staff A.			
	medication adminis insulin dependent r -There was docum insulin on 22 occas 06/30/22.	and July 2022 electronic tration record (eMAR) for an esident revealed: entation Staff A administered sions from 06/01/22 through entation Staff A administered sions from 07/01/22 through			
	Attempted telepho 08/05/22 at 1:38pr	ne interview with Staff A on n was unsuccessful.			
	Coordinator (RCC revealed: -Staff A had worke	w with the Resident Care) on 08/05/22 at 1:23pm of at the facility as a MA for over a almost two months. ked, she checked FSBS and			K and Vision sheet 21 (

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If continuation sheet 21 of 105

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Division of	Health Service Regu	ielion	·····		(X3) DATE SURVEY
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		COMPLETED
AND PLAN OF	CORRECTION		A. BUILDING.		R
		HAL034098	B. WING		08/05/2022
	<u> </u>		DRESS, CITY, STAT		
NAME OF PR	OVIDER OR SUPPLIER		SALISBURY RO		
SALEM TE	RRACE		SALEM, NC 27		
	DUMINADV CT	ATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECT	ON (X5) D BE COMPLETE
(X4) ID PREFIX	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		DEFICIENCY	
	Continued From pag		D 164		
D 164					
	administered insulin	to diabetic residents.	2		
	Telephone interview	with the Administrator on			
	08/05/22 at 1:33pm	revealed:			1
1	-She was not aware	Staff A did not complete of diabetic residents.			
]]	The Business Office	e Manager (BOM) was			
	responsible for maki	ng sure trainings were			2
	completed by the nu	irse.			
	-The nurse had work and she observed h	ked at the facility part-time			
	-She was not sure if	the trainings included caring			
	for diabetic resident	s.			
	-She had not review	ed Staff A's personnel record ed documents and trainings	1		
1	were obtained.	ed ubcuments and trainings	8		
			ł		
		ith the facility's nurse on			
	08/04/22 at 5:35pm				
	Refer to telephone	interview with the corporate			9 84
Ì	accountant on 08/0	5/22 at 3:00pm.			
1	D. D. Januar F. Stoff F)'s personal care aide			
	2. Review of Stan L	ide (MA) record revealed:			
	Staff D was hired 0	on 06/14/22.			
	-There was no doci	umentation Staff D completed			
	administration of in	ident training prior to the sulin.			
1					
	Observation of Stat	ff D on 08/04/22 at 4:30pm			
1	revealed Staff D of and administered in	stained a FSBS on a resident			
1					4
	Review of three dia	abetic residents' June and July	{		
	2022 electronic me	edication administration records			
	(eMARs) revealed:	entation Staff D administered			
1	insulin on 28 occas	sions from 06/01/22 through			
	06/30/22.				Heantinuation sheet 22 of

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STATEMENT	THEARTH CERVICE FERRE	ALIOFI (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()(2) (30) (TIPLE C		(YA) DATE SURVEY COMPLETED
AND PLAN C	F CORRECTION	IDEN IFICATION NOMBER:	A. BUILDING:		R
			B. WING		08/05/2022
. <u> </u>		HAL034098	<u></u>		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STAT		
	12		SALISBURY RO		
SALEM TE	ERRACE	WINSTON	SALEM, NC 27	127	ION (X5)
(X4) ID PREFIX TAG	IEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ID BE COMPLETE
D 164	Continued From pag	e 22	D 164		
	insulin on 57 occasid 07/31/22. -There was documen insulin on 12 occasid 08/04/22. Attempted telephone 08/05/22 at 2:56pm Telephone interview Coordinator (RCC) of revealed: -Staff D had worked June 2022. -When Staff D work and checked FSBS -The only training st administration of ins MA on the medicatif -The Business Offic responsible for mak completed by the mi	with the Resident Care on 08/05/22 at 1:23pm at the facility as a MA since ed, she administered insulin diabetic residents. he provided to Staff D prior to sulin was shadowing another on cart. e Manager (BOM) was ing sure trainings were urse. ked at the for a little over one			
	month but was only -She was not sure i training to Staff D.	worked part-time. f the nurse provided diabetic			
	Telephone interview 08/05/22 at 1:33pm -She was not award diabetic training pri-	e Staff D had not completed or to the administration of			
	-The facility nurse to training to staff but training had been f -The business offic sure trainings were She had not revie	e was responsible for making completed by the nurse. wed Staff D's personnel record			
Division of I	to ensure the requirements to ensure the requirements of the service Regulation	red documents and trainings	6899	63ET13	If continuation sheet 23 of

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Division of	i Health Service Kegu	lation			(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	OWRINGTION	COMPLETED
AND PLAN O	FCORRECTION	IDEN INIGATION NUMBER:	A. BUILDING:		
					R
		HAL034098	B. WING		08/05/2022
		STREETA	DDRESS, CITY, STATE	, ZIP CODE	
NAME OF PF	ROVIDER OR SUPPLIER		D SALISBURY RO.		
SALEM TE	RRACE		N SALEM, NC 271		
				PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PREFIX	(FACH CORRECTIVE ACTION SHOULD	BE COMPLETE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
1/10					
D 164	Continued From pag	e 23	D 164		[
	8. W				
	were obtained.				
	D. Franka internetovet wi	th the facility's nurse on			
	08/04/22 at 5:35pm.	an the raoling of the of the			
{	Refer to telephone in	nterview with the corporate			
1	accountant on 08/05	5/22 at 3:00pm.			
1					
ļ	4. Review of Staff E	's medication aide (MA),			
Į	personnel record rev -Staff E was hired of	- 07/26/22			
1 I	-Staff E was nired of	mentation Staff E had			
	completed training (on the care of diabetic			
	residents available f	for review in her personnel			
1	record.				
	Review of three dial	betic residents' electronic	}		
	medication adminis	tration records (eMARs)			
	revealed:	entation Staff E administered			8
	inculin on 21 occas	ions from 06/01/22 through	ļ		r
	06/30/22				
1	-There was docume	entation Staff E administered			
	insulin on 39 occas	ions from 07/06/22 through			
1	07/31/22.	t the Diaff IT administored			
1	-There was docume	entation Staff E administered			1
	insulin on 6 occasio	ons from 08/01/22 through			
	08/04/22.				
	Telephone interview	w with Staff E on 08/05/22 at		1	
1	10.15am revealed:				
ł	-She started workin	ng at the facility as a MA			
1	through an adenCV	in June 2022.		1	
	Charupa offered a	full-time position of Special			
	Care Unit Coordina	ator (SCUC) on 07/26/22 and SCUC on 08/01/22.		1	
{	She had complete	ad training on the care of			
	-Sne nau complete	but could not remember the			
	evect date.				
	-The facility should	have her training certificate on			
1	-The facility should	I have her training contribute of			26 - 2291

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STATEMENT	THEALTH SERVICE MEET	IIDÎIOD (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) (0:2) HOLTIPLE (0		(/3) DATE SURVEY COMPLETED	69 N
AND PLAN C	F CORRECTION		A. BUILDING:		R 08/05/2022	
		HAL034098	B. Wilds		1 08/05/2022	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
SALEM TE	RRACE		SALISBURY RO			
			N SALEM, NC 271	PROVIDER'S PLAN OF CORF	ECTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLI	ETE
D 164	Continued From pag	e 24	D 164			
	file.					
	Refer to interview wi 08/04/22 at 5:35pm.	th the facility's nurse on				
	Refer to telephone in accountant on 08/05	nterview with the corporate /22 at 3:00pm.				
	5:35pm revealed: -She had worked at over one month. -She was still new a trainings that were n	cility's nurse on 08/04/22 at the facility part-time for a little nd was not sure of the equired. ed diabetic training for the				
	Telephone interview accountant on 08/08 -She had been at th out since July 2022. -Two weeks ago she personnel records b documents and train -The facility hired a -The nurse should h training. -The nurse had bee the forms and the tr -If the nurse was no	5/22 at 3:00pm revealed: e facility helping the business e started working on ut she had not identified nings that were missing. nurse to provide the trainings. ave provided diabetic care in trained on how to complete				
{D 270]	10A NCAC 13F .090 Supervision)1(b) Personal Care and	{D 270}			
	Supervision (b) Staff shall provi accordance with ea	01 Personal Care and de supervision of residents in ch resident's assessed needs,				
Division of He	alth Service Regulation		6199 6	3ET13	If continuation sheet 2	5 of 10

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NAME OF PR	ROVIDER OR SUPPLIER		B. WING		R 08/05/2022
			DRESS, CITY, STAT	TE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·
SALCINIT			SALISBURY RO		
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES CY 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 COMPL
{D 270}	Continued From pag care plan and current This Rule is not me TYPE B VIOLATION Based on record re- interviews, the facilit according to the fac residents (#4 and # had 2 falls within a blackened eye and resident who had a resulting in pain an (#4). The findings are: Review of the facil dated January 202 -Vital signs were to was to be observe their head, was blu the resident was to hospital emergence evaluation. -The environment hazards and haza to be notified and	ge 25 ht symptoms. It as evidenced by: Views, observations, and ity failed to provide supervision on the supervision ility's policy for 2 of 5 sampled 5) related to a resident who week with 1 fall resulting in a a laceration (#5) and a history of falls including a fall d a decrease in ambulation ity's Fall Intervention Protocol 2 revealed: b be obtained and the resident id for injuries; if a resident hit eeding, or complained of pain, b be sent out to the local cy department for further was to be assessed for irds removed; the physician was a plan of care completed with mentation.	{D 270}	D 270 10A NCAC 13F.0901(b) Per Care and Supervision All Med Techs and Supervisor retrained in the use of the Res Protocol. Staff will be trained how to d each fall, any reslting injury for follow up action and doc In addition, a paperwork flow established wherein the Resi Coordinator/Special Care Co review all paperwork related complete the investigation a through on the protocol to e are completed and that steps taken to prevent future falls <i>Attachment D: Fall Prevent</i>	ors will be sident Fall locument on and the need umentation. w has been ident Care bordinator will I to falls, and follow nsure all steps s have been
	medication and e -The resident was for physical thera and balance train while ambulating -If the resident has resident was to b	as to be notified for a review of valuation for repeat falls. s to be referred to home health py evaluation for strengthening ing if the resident had a fall ad a fall from a wheelchair, the be referred to home health for evaluation for balance training		Attachment E: Signature Fall Prevention Protocol 1	Fraining.

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Division of	Healin Service Regu	6100			(X3) DATE SUR	VEY
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COMPLET	ED
AND PLAN OF	CORRECTION				R	
		HAL034098	B. WING			2022
			I CITY CTAT			
NAME OF PR	OVIDER OR SUPPLIER		DRESS, CITY, STAT			
SALEM TE	RRACE		SALEM, NC 27			
	10	ATEMENT OF DEFICIENCIES	10	BROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETE
(X4) ID PREFIX	JEACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	ROPRIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ING.	DEFICIENCY)		
			{D 270}			
{D 270}	Continued From pag	e 20				
	and positioning.	the regident as often as				
.	-Staff was to check of	on the resident as often as needs and act proactively to		-		
	ensure safety.					
	-Staff was to complete 15-minute checks for 72					
	hours following a fall per policy.					
	1. Review of Resident #5's current FL2 dated					
	03/16/22 revealed:					
4	-Diagnoses included	I major depressive disorder,				
e.	arthritis, metabolic encephalopathy, cellulitis of left lower extremity, acute cystilis without					
	hometuria and hyperkalemia.					
	-Resident #5 was semi-ambulatory with a walker.					
	Boview of Resident	#5's care plan dated 03/16/22				
1	revealed:					
1	-Resident #5 used a	a walker to ambulate.				C.
	-There was no docu	imentation regarding the level ent #5 needed with				
	ambulation.					
	-Staff assisted Res	ident #5 with transfers.				
	-There was no documentation regarding Resident					
	#5's orientation.					
	a. Review of Resid	ent #5's progress notes dated				e.
	07/23/22 at 9:59an	and 2:47pm revealed:				
	-Resident #5 was f	ound on the floor of her room. I that she fell and that her back				
	and led was hurting	g badly.				
1	She requested to	go to the hospital.	}			1
	She was transported by emergency medical					6
1	services (EMS) to	a local nospital. the hospital on 07/23/22.				
	Review of Reside	nt #5's Incident/Accident				
ļ	Report dated 07/2 -Resident #5 fell o	3/22 at 9:45am revealed:				
	-Kesident #5 lell o	her room and complained that				
	her back and leg h)urt				<u> </u>
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STATEMENT	of Health Corvice Reau of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
ND PLAN C	IF CORRECTION		A. BUILDING:			
		HAL034098			08	R 1/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET 4	DDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY ROA	AD'		
SALEM TE		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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From page	e 27	{D 270}		·····	1
10 21 01	Continued From page	5 21				
	(MA) who completed incident/Accident Re	Attempted interview with the medication aide (MA) who completed the progress note and the Incident/Accident Report dated 07/23/22 on				
	08/04/22 at 10:54am was unsuccessful. Review of Resident #5's Fall Checklist dated					
	07/23/22 revealed: -Resident #5 did not hit her head, but she					
	complained of unusual pain (place of pain not documented).					
	-There was no bleeding and no skin tears. -Resident #5 was transported to the local hospital by EMS.			-		
1	Review of Resident #5's 24 Hour Post Fall Checklist date 07/23/22 revealed:					
	-The checklist was no					
		tation Resident #5 should				
		for complaints of pain and				
	discomfort, changes rotation of the legs or	in walking ability, outward				
	drowsiness, and relu- hours, 16 hours, and	clance to get out of bed at 8 24 hours after her fall on				
	07/23/22. -Resident #5 should	have been assessed on				
	07/23/22 at 5:45pm, on 07/24/22 at 9:45a	on 07/24/22 at 1:45am, and				Ì
		io check off Resident #5 was				
	assessed at 8 hours,	16 hours, and 24 hours				
	after her fall on 07/23	3/22, but there was no		-		
	documentation she h	ad been assessed.				
	Review of Resident # dated 07/25/22 revea	f5's 15-minute Check Sheet				
		itation of 15 minute checks				
	for Resident #5 from 07/25/22.	7:00am to 11:00pm on				
	-There was no addition	onal documentation of				
	Increased supervision	n after Resident #5's fall on				-

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STATEMEN	DT health Service Rect TOF DEFICIENCIES DF CORRECTION	(21) PROVIDER/SUPP_IER/CLi4 IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:		(22) DATE SURVE / COMPLETED	
		HAL034098 B. WING			company of the second se	२)5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	E. ZIP CODE		
-			D SALISBURY RO			
SALEM T	ERRACE		N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From page	28	{D 270}		· · · · · · · · · · · · · · · · · · ·	
	07/23/22.					
	08/04/22 at 11:38am i -She was one of the F #5 on the floor In her -Resident #5 did not F was sent to the local f -Resident #5 returned day that she fell. -She was not told to d Resident #5 when she -She was not sure if R 15 minute checks afte Telephone interview w care provider (PCP) o revealed: -She had not been not on 07/23/22; however her fall when she visite -When she saw Resid observed Resident #5	PCAs who found Resident room on 07/23/22. have any injuries, but she hospital for evaluation. It to the facility on the same o anything differently for e returned. Resident #5 was placed on r her fall on 07/23/22. With Resident #5's primary n 08/05/22 at 8:50am Resident #5 had a fall she did become aware of ed her on 07/25/22, she had right side weakness of move like she wanted it risical therapy (PT) for		-		
	health provider on 08/0	ith Resident #5's home 05/22 at 8:34am revealed: ently receiving OT and was with a diagnosis of				
	lymphedema.	received an order for PT				
	was no documentation	ws and interviews, there 15-minute checks were ent #5 after her fall on e checks were not				

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TATEMENT	f Health Service Reg of deficiencies f correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		HAL034098			08	R /05/2022
	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	, ZIP CODE		
			D SALISBURY ROA			
SALEM TE	RRACE	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAW OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From page	ge 29	{D 270}			
	implemented until 4	8 hours from the fall.				
	Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/03/22 at 4:20pm.					
	Refer to interview w 08/04/22 at 2:08pm	ith the Administrator on		-		
	07/30/22 at 9:00am -Resident #5 had an around 7:15am. -The medication aic and noticed she had small cut above her of bleeding. -There were no oth -Resident #5 was tr medical services (E emergency room (E -Resident #5 return	n unwitnessed fall in her room le (MA) assessed Resident #5 d a blackened left eye and a left eye with a small amount er apparent injuries. ansported via emergency MS) to the local hospital ER). ed from the ER on 07/30/22 and was placed on 15-minute				
	dated 07/30/22 at 7 -Resident #5's legs in her room. -Her fall impact was causing a blackene left eye.	#5's Incident/Accident Report 15am revealed: gave out on her while walking s on the side of her face d eye and small cut above her ransported to the local hospital				
	dated 07/30/22 rev	d the ER with a diagnosis of a				

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TATEMENT	I Health Service Reg of Deficiencies F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
1010110			A. BUILDING:			D
		HAL034098	B. WING			R /05/2022
AME OF PR	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
0.1 1504 1515	DDAGE	2609 OL	D SALISBURY RO	AD		
ALEM TE	RITAUE	WINSTO	ON SALEM, NC 271	27		
(X4) ID		TATEMENT OF DEFICIENCIES	di	PROVIDER'S PLAN C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLET DATE
{D 270}	Continued From pag	je 30	{D 270}			
	documentation of sig	nificant findinos.		-		1
		mentation regarding bruising				
	and cut above left ey					1
		- 2000				
	Attempted telephone	a interview with the MA who				
		ess note and Incident				
	Accident Report dated 07/30/22 on 08/04/22 at					
	10:57am was unsuc	cessful.				
	Review of Resident	#5's Fall Checklist dated				
	07/30/22 revealed:					
		head and complained of				
		of pain not documented).				
	-There was bleeding	and a skin tears (location			8	
	not documented).					
	-Resident #5 was transported to the local hospital					
	by EMS.					
	Review of Resident #	#5's 24 Hour Post Fall				
	Checklist date 07/30					
		sessed for complaints of pain				
		nges in walking ability,				
		ne legs or arms, increased				
		ctance to get out of bed at 8	1			
	07/30/22.	24 hours after her fall on				
		ntation Resident #5 was				
		22 at 3:15pm, on 07/30/22 at				
		31/22 at 7:15am; there had				
	been no changes in l	ner condition.				
	Review of Resident #	#5's 15 minute Check Sheets				
	revealed:					
		ntation of 15 minute checks				
	an East of the first of the second	7/30/22 from 12:00pm to				1
	12:00am.	detion of dE minute checks				1
		ntation of 15 minute checks				
		7/31/22 from 7:00am to				1
	12:00am.	ntation of 15 minute checks				

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	OF DEFICIENCIES OF CORRECTION			(22) HULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED R
		HAL034098	B. WING	····	08	/05/2022
VAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
SALEM T	ERRACE		D SALISBURY RO			
Dini		 	N SALEM, NC 271	127		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC - CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
{D 270}	Continued From pag	je 31	{D 270}			
	for Resident #5 on 08/01/22 from 12:15am to 2:00pm. -There was no documentation of 15 minute checks on 07/31/22 from 12:15am to 6:45am.					
	Observation of Resident #5 on 08/03/22 at 9:41am revealed: -Resident #5 had a scabbed, 1 Inch horizontal laceration above her left eye. -Resident #5's left eyelid was purple and the skin					
	below her left eye wa -There was yellowish cheek.	as purple. I skin discoloration on her left				
	11:29am revealed: -She fell and hit her t cut above her eye.	ent #5 on 08/04/22 at nead, had a black eye and a				
		nber the details of the fall or ut it was much better.				
	2:08pm revealed:	ministrator on 08/04/22 at				
	went to check on Res	second fall on 07/30/22, she sident #5. I to complete 15 minute				
	-She did not know if t	ace other than 15-minute		-		
	care provider (PCP) o	vith Resident #5's primary on 08/05/22 at 8:50am been notified Resident #5 2.				

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING 08/05/2022 HAL034098 STREET ADDRESS, CITY, STATE, ZIP-CODE NAME OF PROVIDER OR SUPPLIER 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES 'n (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {D 270} {D 270} Continued From page 32 Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/03/22 at 4:20pm. Refer to interview with the Administrator on 08/04/22 at 2:08pm. 2. Review of Resident #4's current FL2 dated 05/25/22 revealed: -Diagnoses included dementia with psychosis, hypoglycemia, vitamin D deficiency, schizophrenia, and insomnia. -Resident #4 was semi-ambulatory with a walker. -Resident #4 was intermittently disoriented. Review of Resident #4's care plan dated 05/19/22 revealed: -Resident #4 used a walker to ambulate. -There was no documentation regarding the level of assistance Resident #4 needed with ambulation or with transfers. a. Review of Resident #4's progress notes dated 05/18/22 revealed: -Resident #4 fell at the start of second shift as he lost his balance and fell hitting his head on the door beside him. (There was no documentation where Resident #4 was or which door he hit his head on.) -Emergency medical services (EMS) transported Resident #4 to the local hospital emergency room (ER). Attempted telephone Interview with the MA who completed the progress note dated 05/18/22 on 08/04/22 at 10:57am was unsuccessful. Review of Resident #4's Incident/Accident Reports, Falls Checklists, Post Falls Checklists revealed there was none available for Resident

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	of deficiencies	(21) PROVIDEN/SUPPLIER/CU/. IDENTIFICATION NUMBER:	(12) MULTIPLE C A. BUILDING:	ONSTRUCTION	(KS) DATE SUI COMPLET		
		HAL034098 B. WING			R 08/05/	R 05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	ODRESS, CITY, STATE	, ZIP CODE	1 00/00/2022		
		2609 OL	D SALISBURY RO	AD			
SALEM TE	ERRACE		N SALEM, NG 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 APPR DEFICIENCY)	ULD BE	(X5) COMPLE DATE	
{D 270}	Continued From page	33	{D 270}				
1	#4's fall on 05/18/22,						
	08/04/22 at 11:08am -Resident #4 was rec due to falls prior to his making progress; phy working with Residen maintain his strength. -Physical therapists w Resident #4 to ensure from his wheelchair to -He did not know abou 05/18/22 and had not recommendations for prevention to the facili Interview with Residen (PCP) on 08/01/22 at -She saw Resident #4 2022. -She reviewed a note documenting there wa 05/25/22 due to falls. -The previous provide due to Resident #4 ha -She would have exper medical equipment pro once the order for the Based on record revie	eiving physical therapy (PT) s fall on 08/04/22 and was sical therapists were t #4 on ambulation to the was able to transfer his bed by himself. ut Resident #4's fall on made any interventions for fall ity. Int #4's primary care provider 3:27pm revealed: for the first time in July from the previous provider as a face to face visit on r ordered a rollator walker ving abnormal gait. acted the facility to contact a povider to order the rollator				, k	
	implemented for Resid 05/18/22.	ient #4 after his fall on					
		the Special Care Unit n 08/03/22 at 4:20pm.					
	Refer to interview with 08/04/22 at 2:08pm.	the Administrator on		·			

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PEINTED: 09/20/2022 FORM APPROVED

TATEMENT	<u>if Health Service Regu</u> OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
				A. BUILDING:		
		HAL034098	B. WING	08	R /05/2022	
IAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY RO	4D		
ALEM TE		WINSTO	N SALEM, NC 271	27		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID DDCCIV	PROVIDER'S PLAN O (EACH CORRECTIVE AC		(X5) COMPLET
PREFIX TAG		LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
{D 270}	Continued From pag	e 34	{D 270}			
	h. Review of Resider	nt #4's progress note dated				
	06/07/22 revealed:					
		unwitnessed fall in the				
	Special Care Unit (SCU) courtyard and was found					
	laying on his back with his two wheeled walker					
	nearby. -Resident #4 stated he tripped over his feet.		1			
		ft hip pain, but he denied				
	hitting his head.					E.
	-Resident #4 was sent to the local hospital					
8		I) via emergency medical				52
	services (EMS).	111 00107100		-1		
	-He returned to the fa	acility on 06/07/22.				
	Attempted interview with the staff who			20		
	documented the progress note dated 06/07/22 on					
	08/04/22 at 10:37am	was unsuccessful.				
	Review of Resident #	4's Incident/Accident Report				
	dated 06/07/22 revea					
		unwitnessed fall in the SCU				
	courtyard. -He was found laying	on his hack				
	-He stated he tripped					
	complained of left hip					
	Review of Resident #	4's Fall Checklists revealed				
		necklist for Resident #4				
	dated 06/07/22.					21
	Review of Resident #	'4's 24 Hour Post Fall		2		
	Checklist dated 06/07	7/22 revealed:				
		sessed for complaints of pain				
	and discomfort, chan					1
		e legs or arms, increased clance to get out of bed at 8				1
	Contract in the second s	24 hours after her fall on				
	06/07/22.					
1	-There was documen	tation Resident #4 was				1

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STATEMEN	<u>nt Health Service Freq</u> FOF DEFICIENCIES DF CORRECTION	(CT) PROVIDER/SUPSLIER/CLM IDENTIFICATION NUMBER;	1	CONSTRUCTION		E SURVEY PLETED
				A. BUILDING:		
		HAL034098	B. WING		R 08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
CALENT		2609 O	LD SALISBURY RO	AD		
SALEM T	EKKAGE		ON SALEM, NC 27			
(X4) (D PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 270}	Continued From pag	e 35	{D 270}			
	assessed at 7:00pm	, 3:00am, and 11:00am, but			÷.	
	there was no date: th	here had been no changes in				
	his condition.	iere naa been ne changes in				
		#4's progress note dated				10
	06/09/22 at 2:26pm r					2
		cal therapist visited with him				
		orted to the medication aide				
	pain and was unable	4 was complaining of left hip		ŝ		
		lesident #4's PCP who gave				
	a verbal order for an x-ray, left hip series, due to					
	pain in the left hip and inability to stand.			-		
	Review of Resident #	4's progress note dated				
		evealed Resident #4 had		,		
	been in his room all day complaining of leg pain.					
	Review of Resident # 06/09/22 at 4:32pm re	4's progress note dated evealed:				
		ned of left hip pain and the				
		P's office to request an				
	order for pain medica					
2		d that the PCP was waiting the x-ray completed during				
ĺ	the local hospital ER					
	···- ·····		· · · ·			
	Review of Resident #4	4's progress notes dated	-			
	06/10/22 revealed:					
		as documentation a standing				
		ten (a medication used to				
	treat pain) was adminitor to pain in his left hip.	istered to Resident #4 due	1			
		notified Resident #4's PCP				
		f left hip pain from his fall				
	on 06/07/22; an order					
	Resident #4 on ibupro	ıfen.				
	Review of Resident #4	i's progress note dated				
		vealed he continued to				
	th Service Regulation	· · · · · · · · · · · · · · · · · · ·	<u> </u>			
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TATEMENT	f Health Service Real of Deficiencies F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING: B. WING		COM	E SURVEY IPLETED R 8/05/2022
		HAL034098	B. WING			5/05/2022
IAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
6 E		2609 OL	D SALISBURY ROA	/D		
SALEM TE	RRACE	WINSTO	N SALEM, NG 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From pag	e 36	{D 270}			
i	complain of pain in h	is left hip.				
,	06/14/22 revealed: -At 1:55pm, Residen			-		
	07/09/22 revealed: -Resident #4 asked order for him to have -Resident #4 stated	#4's progress note dated if his PCP could write an e a wheelchair. his legs did not work like they y needed a wheelchair.			·	
	nurse (RN) on 08/03 -She assessed Resi courtyard on 06/07/2 -Resident #4 said th sent out to the local -Resident #4 stoppe 06/07/22 and began -Physical therapy wa	at he hurt his hip and he was hospital. d walking after his fall on				
	08/04/22 at 11:08an -Resident #4 was pr therapy and was wo maintain his strengt -Physical therapists Resident #4 to ensu from his wheelchair -He did not know ab 06/07/22 and had no	ogressing with his physical rking on ambulation to n. were also working with re he was able to transfer to his bed by himself. out Resident #4's fall on		_		

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NO PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL034098	B. WING			R 3/05/2022
AME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
ALEM T	ERRAGE		SALISBURY RO			
(X4) ID	SLIMMARY	TATEMENT OF DEFICIENCIES	N SALEM, NC 271	27		
PREFIX	EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From pag	e 37	{D 270}			
	(PCP) on 08/02/22 a She saw Resident # 2022. Resident #4 had an 06/10/22 due to comp 06/07/22. The x-ray resulted in fractures. She reviewed a note documenting there with Resident #4 on 06/15 On the 06/15/22 visit complain of hip pain a ordered Resident #4 is Facility staff advised Resident #4 was tall a was using that did not Based on record revie was no documentation implemented for Resid 06/07/22. Refer to interview with 4:20pm. Refer to interview with 08/04/22 at 2:08pm.	4 for the first time in July x-ray of his left hip on plaints of pain after he fell on the absence of any from the previous provider as a face to face visit with //22. t, Resident #4 continued to and the previous provider a wheelchair. the previous provider and did not fit the chair he t belong to him. wws and interviews, there on 15-minute checks were dent #4 after his fall on the SCUC on 08/03/22 at the Administrator on				
C - V -	08/01/22 at 8:50pm rev Staff found Resident # vheelchair tipped over	#4 in his room with his				
	Review of Resident #4 ated 08/01/22 at 7:30	's Incident/Accident Report				

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			n negare as ass	1 (JAMA A) (1997) 	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		HAL034098	B. WING		R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATI	E, ZIP CODE	
SALEM TH	FRRACE		D SALISBURY RO		
		WINSTO	N 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP
(D 270)	Continued From page	38	{D 270}		
	wheelchair tipped ove -Resident #4 complain right elbow hurt.	nd in his room with his er. ned his ankles, left hip, and t to the emergency room			
	courtyard. -He had a bandage wiright hand. -Resident #4 was prop wheelchair. -The wheelchair had a another resident's nam -The back of Resident feet away from the from	revealed: ted in a wheelchair in the rapped loosely around his pelling in the hallway in a label attached to it and			
	revealed: -He had a fall a few da -He was trying to trans his bed when he fell.			r	
	n the wheelchair.	#4's incident/accident on 08/03/22 at 4:07pm			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/ IDENTIFICATION NUMBER:	- 14 - 1940	CONSTRUCTION		E SURVEY IPLETED
·		HAL034098	B. WING		0	R 8/05/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E. ZIP CODE	8 900 - De	
SALEM T	EDBACE		D SALISBURY RO			
			ON SALEM, NC 27			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	0/6)
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) Comple Date
{D 270}	Continued From page	e 39	{D 270}			
	his elbow and his hip	burt				
	-Resident #4 was ser	nt to the hospital emergency				
	room for further evalu	tation.				
		ced on 15-minute checks				
	when he returned from	m the hospital				
82	-Resident #4 was not	on 15-minute checks prior				- 12 - 10
	to his fall on 08/01/22					
	-She usually checked	on residents every	1 1			
	30-minutes or every h	IOUF.				
	-She did not know of	any interventions put in				
l l	place for Resident #4	except for physical therapy.				
	Review of Resident #	4's Fall Checklist dated				
1	08/01/22 revealed:	For an oneckist dated				
	-Resident #4 did not h	it his head, but he				
	complained of unusua	I pain (place of pain not				
	documented).	• • • • • •				
	-There was no bleedir	ig and no skin tears.				
	-Resident #4 was tran	sported to the local hospital				1
	by EMS.					
	Review of Resident #4					
	Checklist dated 08/01/					
	-Resident #4 was asse	essed for complaints of pain				
	and discomfort, chang	es in walking ability,				
	outward rotation of the	legs or arms, increased				
		ance to get out of bed at 8				
	1001S, 16 nours, and 2 08/01/22.	4 hours after his fall on				
ļ.	There was documenta	ation Resident #5 was				
		at 3:30am, on 08/02/22 at				
I.	11:30am, and on 08/02	2/22 at 7:30am and there				
	had been no changes i	in his condition.				
	There was a space to	check off Resident #4 was	1			
1	assessed at 8 hours, 1	6 hours, or 24 hours after				
	nis fall on 08/01/22, bu					
0	documentation he had	been assessed.				
1	Review of Resident #4	s 15-minute Check Sheets				
	evealed:		1 1			

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: B. WING		CON	TE SURVEY APLETED R
	~	HAL034098	D. WING		0	8/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TI	ERRACE		D SALISBURY ROA			
		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 270}	Continued From page	e 40	{D 270}			
	for Resident #4 from 4:15pm to 4:30pm on -There was documen for Resident #4 from 08/03/22. -There was no addition increased supervision 08/01/22.	tation of 15-minute checks 7:00am to 11:45am onal documentation of a after Resident #5's fall on ecial Care Unit Coordinator				
	the ER. -He came back to the and staff started docu changes each shift for	8/01/22 and was sent out to facility on the same day menting his vitals and any				
	08/04/22 at 11:08am i -Resident #4 was pro- therapy and was work maintain his strength. -Physical therapists w Resident #4 to ensure from his wheelchair to -He did not know abou 08/01/22 and had not recommendations for	gressing with his physical ing on ambulation to ere also working with he was able to transfer his bed by himself. ut Resident #4's fall on		-		
	(PCP) on 08/03/22 at -She saw Resident #4 2022. -At the time of her first informed her Resident	3:27pm revealed: for the first time in July t visit with Resident #4, staff t #4 had a history of falls. er Resident #4 liked to be		-	<u>.</u>	

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1070 74	CONSTRUCTION		LETED
1. <u>19</u>		HAL034098	B. WING		2	R /05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
SALEM TE	RRACE	2609 OL	D SALISBURY RO	AD		
		WINSTO	ON SALEM, NG 271	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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
{D 270}	Continued From page	e 41	{D 270}			
	-She was not notified	of Resident 4's fall on				
	08/01/22.	OF Resident 4 5 1dil Off		22.2		
		ied of Resident #4's fall on				
	08/01/22, she would have requested a urinalysis and reviewed his medication.					
	Based on record reviews and interviews, there					
		n 15-minute checks were			3 <u>0</u>	
	implemented continue					
F	Resident #4 after his t					
	Refer to interview with 4:20pm.	the SCUC on 08/03/22 at				
	Refer to interview with the Administrator on 08/04/22 at 2:08pm.					
	Interview with the SCU revealed:	JC on 08/03/22 at 4:20pm				
	-If a resident had an u	nwitnessed fall and there				-
	was visible bleeding, t	he resident was sent to the				
	emergency room.					
		urned to the facility, any				
		prwarded to the SCUC and	1			
		be faxed to the pharmacy ented in the resident's				
	progress notes.	lemed in me residents				
		urned to the facility, the				
		n 15 minute checks for 3				
		changes once each shift				
	for 24 hours.	LIGHUGS UNDE GACH SHILL				
	She did not know of a	ny interventions put in				
		r to starting her role as				
		t in the future, if a resident			800	
		tervention would be to				
	have the resident's leve					
	interview with the Adm	inistrator on 08/04/22 at				
	2:08pm revealed:					
		ney were placed on 15				
	h Service Regulation		<u></u>			

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	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/C-14 IDENTIFICATION NUMBER:		CONSTRUCTOR.		E SURVEY PLETED
		HAL034098	B. WING		08	R 3/05/2022
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	ERRACE	2609 OL	D SALISBURY RI	DAD		
MALCIN N		WINSTO	N SALEM, NC 27	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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
{D 270}	Continued From page	e 42	{D 270}			
	provider (PCP) was r condition, and skin cf shift for 24 hours. -If a resident had rep with the resident's far medication review, ar modifications. -Any interventions in should have been do record and increased checks) should have 15-minute check she -Residents who were routinely on 15 minut -MAs were supposed checks and the SCU to ensure the 15 minut completed and docur -She did occasional p	high fall risks were not e checks. I to document the 15 minute C was supposed to follow-up ute checks were being				
	for 2 of 5 sampled rea Resident #4 who had pain in his left hip, rig decrease in ambulati had 2 falls within a w blackened eye and a This failure was detri- and welfare of the rea 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 5. 131D-34 on 08/04/22.				

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the provide Health Service Requiration

TATEMENT	Health Service Fiel OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
					R	
		HAL034098	B. WING		08/05/2022	
VAME OF PR	OVIDER OR SUPPLIER	STREET	ODRESS, CITY, ST	ATE, ZIP CODE		
	90 A OF	2609 OL	D SALISBURY R	CAD		
SALEM TE		WINSTO	N SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
(D 273)	10A NCAC 13F .09	902(b) Health Care	{D 273}		-	
	10A NCAC 13F .09			D273 10A NCAC 13F .0902 Hea	13 C	
	(b) The facility sha	all assure referral and follow-up			a -21-22	
		and acute health care needs		All listed issues on the POC	can ()	
	of residents.			completed. Facility is still v	vaiting for 'ON'	
				equipment to be delivered.		
	This Rule is not m	et as evidenced by:		All orders for referral and for	llow up will	
	FOLLOW-UP TO C	CONTINUING TYPE B		be given to the SCU Coordin	nator/Al	
	VIOLATION			Coordinator depending on th	ne level of	
	Deced on these fin	dings, the previously Unabated		care of the resident. A copy		
i		as not been abated.		to Medical Records at the sa		
	Type & Violadon II			Each Coordinator is		
		tions, record reviews and		responsible for completing t	he referral and	
		lity failed to ensure health care		turning in a completed recor		
		up were completed for 3 of 5 (#1, #4, and #5) who had		Records in a timely manner.		
	orders for unnalvs	es and physical therapy (#1);	1	The completed record will in	a aluda tha	
	orders for a rollato	r walker and a wheelchair, and		-		
	a recommendation	to obtain a referral to see a		following:		
		nd an order for physical therapy		The Order	an an antaran antaran .	
	(#5).			The date that the follow up		
	The findings are:			The results of the follow u		
	andra - analan ang -			The date of the Face to Fa		
		lent #1's current FL2 dated		The delivery date of any e		
	08/26/21 revealed:			The date that the lab picke		
	-Diagnoses include	ed schizoaffective disorder, Jal disability, and type 2		The date PT or OT started		
	diabetes.	The monomity are the w		Any issues that caused a d	elay in follow up	
	-She was incontine	ent of bladder and bowel.				
	-She was constant	tly disoriented.		Medical Records will check	on the follow up	
	A Raview of Resin	ient #1's physician order dated		to ensure that referral is bein	ng addressed in	
	06/06/22 revealed:			atimely manner. Medical Re		
	-There was an ord	er for a urinalysis (UA), a urine		the order when completed.		
		d to test for the presence of a		· ·		

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Division_0	f Health Service Regu	iation			(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	COMPLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
			1		R
		HAL034098	B. WING		08/05/2022
			·		
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
		2609 OLD	SALISBURY RO	DAD	
SALEM TE	RRACE	WINSTON	SALEM, NC 27	127	
			ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID		TATEMENT OF DEFICIENCIES	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
					<u> </u>
			{D 273}	27.24	
{D 273}	Continued From pag	e 44	[0 2.0]		
	-There was a handw	ritten note on the bottom of			
}	the order form that ft	ne UA had been collected on		~	
	06/07/22.			-	
	00/01/22.				
Ì	 Review of Resident :	#1's record revealed there			
ļ	Neview Of Result fro	m the specimen collected on			2
	06/07/22.	in ing specificit concernent			
	00/01/22.				
	D C. Dasidant	#1's Emergency Medical			
	Review of Resident	after manet dated 06/17/22			
	Services (EMS) tran	sfer report dated 06/17/22	74		1
	revealed she had be	en transferred to the			
}	Emergency Departm	nent (ED) due to altered			
	mental status (AMS)) with weakness.			
		141 CD Attan Viet Cummant			
	Review of Resident	#1's ED After Visit Summary			
	dated 06/17/22 reve	aled:			
1		s with a urinary tract infection			
4	(UTI).		1		
	-She had been pres	cribed Bactrim DS			
1	800-160mg (an anti	biotic used to treat various			0
	infections) take one	tablet two times daily for 7			62
e e e e e e e e e e e e e e e e e e e	days.		ļ		
		Prevente data			2
	Review of Resident	#1's Progress Notes			
	revealed:	8 % (c)	ļ		
1	-On 06/07/22, the fa	cility's previous Special Care			
	Unit Coordinator (S	CUC) documented that			ſ
	Resident #1's UA h	ad been collected and the lab			
1	was called to pick it	up from the facility.			
ļ	_On 06/09/22, a me	dication aide (MA)			
	documented that Re	esident #1 had been upset all			
	day and not allowin	g staff to help her with her			
1	care and that she w	as velling out.			
1	-On 06/11/22, the fa	acility's Administrator			
	documented that R	esident #1 had been hollering		~	
	and screaming sinc	e the start of the shift; she			
	had to be removed	from her room because her	n 58		
	roommates were ur	hable to sleep with her yelling.			
1	Once in a private ro	oom Resident #1 was refusing		1	
	assistance from sta	off and hitting, cursing and	. <u> </u>		
	lealth Service Regulation			5/ - 12	If continuation sheet 45 o
Division of H	Raint Service Meditoriou		6699	63FT13	Il continuation stiller 45 0

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If continuation sheet 45 of 105

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Division o	f Health Service Regu	lation			(X3) DATE SURVEY
and the second se	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	COMPLETED
AND PLAN C	IF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		
		}			R
		LIAL 024009	B, WING		08/05/2022
		HAL034098		-10	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE	
		2609 OLI	SALISBURY RO	DAD	
SALEM TO	ERRACE		SALEM, NC 27		
				PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) 1D	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
IAG			_	DEFICIENCY)	
		······································	{D 273}		
{D 273}	Continued From pag	e 45	{[] 213}		
	screaming at staff to	go away and threatening to			
	harm them.	go anay and an and and			
	-On 06/13/22 the ne	evious SCUC documented			
1	that Decident #1 was	s yelling in the hallways.	1 1		
1		documented that Resident #1			
	-On 06/14/22, a MA	sive behaviors towards staff			
1	and her roommates.	SIYO DEHAVIOLS LOWALDS STAN			
	and her roominates.	documented that Resident #1			
	-On Up/15/22, a WA	ng shift change, was yelling	1 3		
	Was aggravated duri	as able to be redirected.			
		am, a MA documented that			
	-On 00/1/122 at 9.5/	eaming and acting out, hitting			
1	Resident #1 was sci	her wheelchair and not			
{	ner legs and arms of	her she was cont to the			
1	allowing start to help	her; she was sent to the			
	hospital due to her b	ehaviors and to protect her			
ļ	along with the other	residents.			
]	-On 06/17/22 at 6:42	Spm, a MA documented that			
1	she received a call f	rom a nurse at the hospital			
	who reported Reside	ent #1 would be discharged			
	that day and that she	e was being treated for a			
1	"raging UTI." She ha	d received fluids and an	1		·
	antibiotic through an	intravenous catheter (IV).			
		CUC on 08/04/22 at 10:00am			
1	revealed:				
	-She had not been a	employed at the facility on	1		
4	06/06/22, but started	working as a medication			1
		ility through an agency shortly			,
	thereafter.	1 I II a sure a stiffer sult			
	-She knew that Res	ident #1 was a difficult			
1	resident to collect ut	ine specimens from due to			
1	her dementia and he	er behaviors.			
	-When the PCP ord	ered UAs for residents, the			1
	order first went to th	e SCUC, then the SCUC was	1		
		ying the MA that a UA needed			
1	to be collected.		ļ		
20	-Urine specimens w	ere collected by placing a	2		
	collection device int	o the toilet.			1
1	-Once collected, uri	ne specimens were placed in			
	the designated refri	gerator until the laboratory			<u>_</u>
Division of H	ealth Service Regulation				If continuation sheet 46 of 10

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If continuation sheet 46 of 105

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STATEMENT	f Health Service Reg OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	SURVE? PLETED
AND PLAN C	IF CORRECTION	DERTH TOATION NONDER	A. BUILDING:	<u> </u>		D
		HAL034098	B. WING		08	R /05/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY ROA	4D		
SALEM TE	RRACE	WINSTO	N SALEM, NC 271			the state
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN		(X5) COMPLETE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	DATE
{D 273}	Continued From pag	ge 46	{D 273}			
10	staff came to pick th	IC had documented that the				
8	-in the previous SCO	cted and awaiting pick-up	1 1			
		staff, she did not know why				
10	there was no result t					
	uicie was no iesuit					
	Telephone interview with a representative from					
	the facility's contracted laboratory on 08/04/22 at					
	12:50pm revealed they had not received a call to			1		10 10
	collect a LIA specim	en for Resident #1 in June				
	2022 and they did r	not have any UA results for		-		
	Resident #1.					
	ICESILICITE #14					
3	Telephone Interview with a representative from a					
	second laboratory o	n 08/04/22 at 1:00pm				9
	revealed they had n	ot received a call to collect a				
	LIA specimen for Re	sident #1 in June 2022, and				
	they did not have an	ny UA results for Resident #1.				
	Interview with the A	dministrator on 08/04/22 at				
	3:00pm revealed:					·
	-She was not aware	that Resident #1 never had a				
	UA obtained when it	t was ordered in June 2022.				
	-When the primary of	care provider (PCP) wrote an				
	order to collect a UA	A, the SCUC was responsible				
	for telling the MA on	duty to obtain the specimen				
	by placing a collecti	on hat into the resident's				
	toilet.					í.
	-Once the UA was c	collected, the MA or SCUC				
	would label the spe	cimen, place it in the				
	designated refrigera	tor, and call the laboratory to				
	come and pick up th	ne specimen.				1
	-The SCUC was res	sponsible for following up on				
	UA orders and ensu	iring they were collected and				
	received by the labo	pratory.				
	-Once a UA result w	vas available, the medical				
	records staff would	print the result and place a				
	copy in the PCP's fo	Diger for review.				
	Telephone interview	with Resident #1's guardian				
lelon of Wa	alth Service Regulation		t			20 y 200 100
ATE FORM			⁶⁸⁹⁹ 6	3ET13	if continu	ation sheet 47

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING 08/05/2022 HAL034098 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {D 273} {D 273} Continued From page 47 on 08/04/22 at 5:30pm revealed: -Resident #1 started having behaviors in early June 2022 so she had suggested to the staff that they test her for a UTI. -She never received a phone call about the UA result; the next communication she had received from the facility was to let her know that Resident #1 had went to the ED and was diagnosed with a UTI. Telephone interview with Resident #1's PCP on 08/05/22 at 9:00am revealed: -On 06/06/22, there was a telephone encounter between Resident #1's previous PCP and the facility's staff. -The facility staff were reporting that Resident #1 was having an increase in behaviors for the past week, her urine had a strong odor, and they were requesting an order for a UA. -The previous PCP ordered a UA for Resident #1, but there was no result available to review from that order. -It was the PCP's expectation that if an order for a UA was given, the facility collect the UA, send the specimen to the lab for testing, and follow up on the result so that treatment could be started if indicated. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable. b. Review of Resident #1's physician order dated 07/25/22 revealed there was an order to obtain urine and send for urinalysis (UA) to rule out urinary tract infection (UTI) secondary to delirium and agitation. Review of Resident #1's record revealed: -There was no UA result from the order written on Division of Health Service Regulation

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Division d	f Health Servics Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	OF CORRECTION	IDEN INICATION NOMBER:	A. BUILDING:		
c			B. WING		R 08/05/2022
		HAL034098	. wite		00/00/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	TE, ZIP CODE	
~			D SALISBURY RC		
SALEM TE	ERRACE	WINSTO	N SALEM, NC 27		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{D 273}	Continued From pag	e 48	{D 273}		
	07/25/22.				
	-There was no docur order written 07/25/2	nentation regarding the UA 2.			
	Interview with the Sp	ecial Care Unit Coordinator			
	(SCUC) on 08/04/22	at 10:00am revealed: ne SCUC on 07/25/22 when			
	Resident #1's UA or	der was written.			
	-She knew that Resi	dent #1 was a difficult			
	resident to collect ur	ine specimens from due to	ļ		
	her dementia and he	ble to collect a UA from			
	Resident #1 they we	re supposed to document			
	that in the Progress	Notes and notify the primary			
	care provider (PCP).	ered UAs for residents, the			
	order first went to the	e SCUC, then the SCUC was			
	responsible for notify	ving the MA that a UA needed			
ł	to be collected.	and collected by placing a			
	-Urine specimens we collection device into	ere collected by placing a			
	-Once collected, utir	te specimens were placed in			
	the designated refrig	perator until the laboratory			
ļ	staff came to pick th	em up.		-	
	Telephone interview	with a representative at the			
	facility's contracted	aboratory on 08/04/22 at			
	12:50pm revealed th	ney had not received a call to en for Resident #1 in July			1
	collect a UA specim	not have any UA results for		-	
	Resident #1.				
		with a second inheritory on			
	Telephone interview	with a second laboratory on revealed they had not		-	
	received a call to co	llect a UA specimen for			
1	Resident #1 in July	2022, and they did not have			
	any UA results for F	Resident #1.		4	
ł	Interview with the A	dministrator on 08/04/22 at			
	3:00pm revealed:				
Division of H	lealth Service Regulation		6653	63ET13	If continuation sheet 49 of 10

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PUNTED: 08/26/2022 FORM APPROVED

STATEMENT	i <u>Health Service Reau</u> of Deficiencies F Correction	ation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034098			(X3) DATE SURV COMPLETE R 08/05/2	D
	ROVIDER OR SUPPLIER	, STREET AD	DRESS, CITY, STAT	re, ZIP CODE		
		2609 OLD	SALISBURY RO	DAD		
SALEM TE	RRACE	WINSTON	SALEM, NC 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 273}	Continued From page		{D 273}			
	UA obtained when it w -When the PCP wrote the SCUC was respo- duty to obtain the spe- collection hat into the -Once the UA was co- would label the speci- designated refrigerate come and pick up the -The SCUC was resp UA orders and ensur- received by the labor -Once a UA result was records staff would p copy in the PCP's fol -If an MA was not ab Resident #1, they we documenting that infi- Notes and notifying to Interview with a MA or revealed: -She remembered R for a UA at the end of had been collected of coming in, so she did -She did not remembered Resident #1 often had dementia. -If a UA was ordered Resident #1 often had dementia. -If a UA was ordered Resident #1, she wo her toilet and place for cup labeled for Resi -She did not know w	a resident's toilet. Illected, the MA or SCUC men, place it in the or, and call the laboratory to a specimen. bonsible for following up on ling they were collected and atory. as available, the medical rint the result and place a der for review. le to collect a UA on are responsible for formation in the Progress the PCP. on 08/04/22 at 4:00pm esident #1 having an order of July 2022, but thought it on the day shift prior to her d not collect another one. or Resident #1 having any s or behaviors at the time on 07/25/22, because ad behaviors due to her I on her shift or needed to be t, the SCUC would tell her. ble for collecting a UA for huld put the collection hat into the specimen into a specimen dent #1. what she would do with the				
	specimen once colle	ected, because she had never				

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Division of	í Fiealth Service Regu	lation	· · · · · · · · · · · · · · · · · · ·		(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		COMPLETED
AND PLAN O	FCORRECTION	MENTICIONION NOMBER	A. BUILDING:		R
		HAL034098	B. WING		08/05/2022
	<u> </u>				
NAME OF PF	ROVIDER OR SUPPLIER		DRESS, CITY, STATE		
SALEM TE	RRACE		SALISBURT NO		
		ATEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF CORRE	CTION (X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ing i	DEFICIENCY)	
		- E0	{D 273}		
{D 273}	Continued From pag				
Į	collected a UA for a	resident before.			
	Telephone interview	with Resident #1's PCP on			
	08/05/22 at 9:00am 1	revealed:			
	-She had ordered the 07/25/22 because sh	e UA for Resident #1 on be bad been baying			
ŀ	increased aditation t	hat day.			
Ì	-She had never rece	ived a resull from the UA she	1 1		
	ordered for Residen	t #1. ed an update from the facility			
	stating they were no	t able to collect the UA for			
Ì	Resident #1.				
	-it was her expectation	ion that if an order for a UA iy collect the UA, send the			
	specimen to the lab	for testing, and follow up on			
	the result so that tre	atment could be started if			
	indicated.				
	Based on observation	ons, interviews, and record	а. — — — — — — — — — — — — — — — — — — —		
	review, it was deter	mined that Resident #1 was			
	not interviewable.				
	c Review of Reside	ent #1's physician order dated			
	06/07/22 revealed t	here was an order for physical			
	therapy (PT) evaluate to decline in mobilit	ation and treatment secondary			
1					
	Review of Resident	#1's record revealed there			
	were no PT notes r	egarding the evaluation and			
	treatment order from				
1	Telephone interview	w with the facility's contracted			
1	obvisical therapist C	on 08/04/22 at 11:15am ot received a referral to			
ļ	revealed ne nad no	#1 and had not been providing			
	PT treatment for R	esident #1.			
ł	an parks http://www.analysis.com				
}	(SCUC) on 08/04/2	Special Care Unit Coordinator 22 at 12:30pm revealed:			
	-She had just foun	d that day, 08/04/22, the hard			
Division of t	lealth Service Regulation		66599	63ET13	If continuation sheet 51 of 1

If continuation sheet 51 of 105

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STATEMENT	f Health Service Keg of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 08/05/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, STATE		
SALEM TE	RRACE) Salisbury Ro. N Salem, NC 271		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
(D 273}	Continued From pag	je 51	{D 273}	······································	
	copy of the PT orde	for Resident #1 from			
1		at it had been faxed to the			
	pharmacy rather that	in the PT office.			
	-Resident #1 was at transfer, but needed	ble to stand, plvot, and			
	-Some days, Reside	ent #1 was able to stand and		<i>.</i> .	
	transfer without diffi	culty, but some days she was			
	unsteady, and it too	k a lot of coaching to get her			
	to stand and pivot to	complete the transfer.			
	-Resident #1 did not	have a history of frequent fall on 07/23/22 but it was			
	witnessed, and Res	dent #1 had sat on the floor			
3	with staff present.				
	-The SCUC who ha	d been employed on 06/07/22	82		
	would have been re	sponsible for faxing the order			
	to the PT office, the	n once faxed if the facility did call within 48-72 hours, the			
	not receive a phone	Id have been responsible for			
	calling the PT office	to ensure they received the			
	order.				
	-Once an order was	faxed, the SCUC was		-	
	responsible for walt	ing for the confirmation			
	placing it in the 48-h	the original order, and nour folder for follow-up.			
	Interview with the A	dministrator on 08/04/22 at			
	3:00pm revealed:				
		that Resident #1 had a PT			
	referral that had not	been followed-up on. o be able to walk but needed			
	a lot of cues, and co	ould benefit from PT.			
	-Resident #1 used a	a walker to assist in her			
	transfers but prefer	ed her wheelchair.			
	-Once the order for	PT was written, it would have			
	been given to the S	CUC; the SCUC would have r faxing the order to the PT			
	office then olacing a	a copy in the 48-hour folder to			
	ensure follow-up wa	as completed.			
		with Resident #1's guardian			
vision of He	alth Service Regulation		0359 6	3ET13	If continuation sheet 52 of 1

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STATE	on of Health Scivice Frequencies Ment of Deficiencies An of Correction	(21) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034098		CONSTRUCTION		
	OF PROVIDER OR SUPPLIER M TERRACE	2609 OI	ADDRESS, CITY, STAT LD SALISBURY RC DN SALEM, NC 27	DAD		
(X4) PREF TAC	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(XS) COMPLETE DATE
{D 2	on 08/04/22 at 5:30p. -She did not remembry written for Resident # -Resident #1 had a d seemed due to her can to stand up because -She did not want Reveal wheelchair all day wh capable of walking. -Resident #1 did not with strengthening ar -She would like Resident to assist with strengthen 08/05/22 at 9:00am r -Resident #1's previde order for PT evaluate -She knew Resident to her dementia. -Resident #1 could sinot able to walk. -Seeing PT would be would help strengthe make transferring ea Based on observation review, it was determ	m revealed: er an order for PT being 1 in June 2022. ecrease in her mobility but it ataracts making her hesitant she could not see well. sident #1 just sitting in her nen she was physically have falls, but needed help nd balance. dent #1 to have PT treatment hening and balance. with Resident #1's PCP on evealed: nus PCP had written the on and treatment. #1 was disoriented a lot due tand and pivot but she was nefit Resident #1 because it n her muscles which would	{D 273}			
	revealed: -Diagnoses included hypoglycemia, vitam schizophrenia, and ir	nt #4's FL2 dated 05/25/22 dementia with psychosis, in D deficiency, nsomnia. mi-ambulatory and used a		*		
	dated 05/25/22 revea of Health Service Regulation	nt #4's physician's order aled an order for a rollator	6339		if continuation	ion shaet 53 of 105
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TATEMENT	t Health Service Reg OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		HAL034098	B. WING		08	R 3/05/2022
IAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
		2609 OL	D SALISBURY RO	DAD		
ALEM TE	RRACE	WINSTO	N SALEM, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 273}	Continued From pag	je 53	{D 273}			
	walker.					
	08/03/22 between 1 revealed: -Resident #4 was pr wheelchair.	Special Care Unit (SCU) on 1:35am and 12:00pm opeiling in the hallway in a two wheeled walker in his no rollator walker.				
	11:56pm revealed: -He had a walker wi had a rollator walke -He did not use the now, but he did use	sident #4 on 08/03/22 at I: with 2 wheels, but he had never				
	nurse (RN) on 08/03 -Resident #4 had a 06/07/22. -He had his two who fell. -Resident #4 did no	icility's contracted registered 3/22 at 4:35pm revealed: fall in the SCU courtyard on eeled walker with him when he t have a rollator walker and the facility had ordered a				
	08/03/22 at 12:06pt -Resident #4 was a being on 08/01/22. -Resident #4 did no walker to her knowl	high fall risk with his last fall of have an order for a rollator ledge. isted Resident #4 with				
	Interview with the S (SCUC) on 08/04/2 ealth Service Regulation	Special Care Unit Coordinator 2 at 12:23pm revealed:		<u> </u>		nuation sheat 54

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
			A. BUILDING:		1	
		HAL034098	B. WING			R /05/2022
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TE	RRACE	2609 OL	D SALISBURY ROA	4D		
		WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
{D 273}	Continued From pa	ge 54	{D 273}			
	-She had worked in	the role of SCUC since				
	08/01/22					
l l		sponsible for reviewing orders				
		dical equipment for residents.				
		of any orders for a rollator				
1	walker for Resident	#4.				
(2 d	Interview with Resid	ient #4's primary care provider				
		at 3:27pm revealed:				
		#4 for the first time in July				
	2022.					
		te from the previous provider				
		was a face to face visit on				
	05/25/22 due to falls					
		der ordered a rollator walker				
		having abnormal gait. he rollator had not been				
	ordered for Residen					
		pected the facility to contact a				
		lipment provider to order the				3
		ler for the rollator was written.				
		dministrator on 08/04/22 at				
	2:08pm revealed:					
		covered by insurance. y should have been contacted				
		r for a rollator and requested				
	to cover the cost of t					
	-She did not know if	Resident #4's family had				
	been contacted rega	arding the order for the				1
	rollator.					1
		ponsible for contacting				1
	Resident #4's family					4
1	Attempted telephone	e interview with Resident #4's				
		08/04/22 at 9:40am was				
	unsuccessful.					
		nt #4's physician's order				
	dated 06/15/22 reve			•		
	th Service Regulation					

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TATEMENT	f Health Service Kegu of DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	
		HAL034098	B. WING		08	R /05/2022
	ROVIDER OR SUPPLIER		DORESS, CITY, STATE	ZIP CODE	, <u></u>	1.54
			D SALISBURY ROA			
GALEM TE	RRACE		N SALEM, NC 271			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5) COMPLET
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	DATE
{D 273}	Continued From page	3 55	{D 273}			
	wheelchair appropria	te for his weight.				
		4's progress note dated				
	07/09/22 revealed:					
	-Resident #4 asked II order for him to have	his PCP could write an				
-Resident # used to and Observation 08/03/22 be revealed: -Resident #		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				
		pelling in the hallway in a				
	wheelchair.	a label attached to it and				
	another resident's na					
	-The back of Resider	t #4's calves were 1.5 feet				
20	away from the front e	dge of the wheelchair seat				
8	and his legs were slig the floor.	htly above a parallel level to				
	-There was not anoth	er wheelchair in his room.				
	Interview with Reside	nt #4 on 08/03/22 at				
	11:56pm revealed:					
		elchair of his own, but he				
	facility for about 3 mo	eelchair provided by the				
	-He requested a whe	elchair about a month ago				
	and was told the phys	sician did not approve for				
	him to get a wheelch	air.				
i	-He was 6 feet tall.					
	Interview with the fac	llity's contracted registered				
1	nurse (RN) on 08/03/	22 at 4:35pm revealed: a wheelchair conducive to				
	-Resident #4 needed his height.	a wheelchail conducive to		22		
	-There should be abo	out 2 inches between the		10		
	front edge of the seal	t and the back of the legs.				8
	-There was more that	n 2 inches between the front				
	edge of the seat and	the back of Resident #4's				

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TAPISION	UI I	1:301111	VILLE.	REQUIZION

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL034098	B. WING		R 08/05/2022	
	ROVIDER OR SUPPLIER			200005		10312022
VAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
SALEM T	ERRACE) SALISBURY RO N SALEM, NC 271	50 C		
(NA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	· · · · · · · · · · · · · · · · · · ·	PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	A EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLET DATE
{D 273}	Continued From page	e 56	{D 273}			
2		r he was currently using. he facility had ordered a new ent #4.				
08/04/22		nt #4's physical therapist on revealed he definitely ent #4 have a new				2
	wheelchair with a cus	shion.				
	Interview with a medi 08/03/22 at 12:06pm					
	being on 08/01/22.	igh fall risk with his last fall				
	-Resident #4 did not i wheelchair to her kno	wiedge.				
		22, Resident #4 began with ambulation and started			-	
	-The wheelchair was	donated to the facility by the				
		ho had passed away. hit Coordinator (SCUC) and				
		e responsible for following				
	Interview with the SC revealed:	UC on 08/04/22 at 12:23pm				
		ne role of SCUC since				
		onsible for reviewing orders cal equipment for residents.				
	-She was not aware of wheelchair for Reside					
	(PCP) on 08/01/22 at	nt #4's primary care provider 3:27pm revealed:				
	2022.	t for the first time in July				
		k-ray of his left hip on plaints of pain after he fell on				
	06/07/22. Illh Service Regulation					

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ATEMENT	Health Service Requerts	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO			SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING;			'n
		HAL034098	8, WING		08	R 105/2022
			DRESS, CITY, STATE			
AME OF PR	OVIDER OR SUPPLIER		SALISBURY RO			
ALEM TE	RRACE		SALEM, NC 271	27		
T	SUMMARY S	TATEMENT OF DEFICIENCIES	tD	PROVIDER'S PLAN OF C	ORRECTION	(X5) COMPLETE
(X4) ID PREFIX TAG	IEACH DEFICIENT	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TI	HE APPROPRIATE	DATE
{D 273}	Continued From pag	ne 57	{D 273}			
{0 21 3}						
1	-The x-ray resulted in fractures.	n the absence of any	1 1			
	-She reviewed a not	e from the previous provider				
	documenting there v	was a face to face visit with				
1	Resident #4 on 06/1	5/22.				
	-On the 06/15/22 vis	sit, Resident #4 continued to				
l	complain of hip pain	and the previous provider				
	ordered Resident #4	a wheelchair; She did not not ordered the rollator for				
	know the facility had	The ordered the rollator for				
	Resident #4.	d Resident #4 was tall and did				
	pot fit the chair he w	vas using that did not belong				
	to him.					
	She would have ex	pected the facility to contact a				6
	durable medical equ	uioment (DME) provider to				
	order a wheelchair i was written.	for Resident #4 once the order				
	Interview with the A	dministrator on 08/04/22 at				
	2:08pm revealed:	11 L. F testing the				
	-The SCUC was rea	sponsible for contacting the				
		der the wheelchair for				
	Resident #4.	if a wheelchair had been				
	ordered for Resider					
	c. Review of Resid	ent #4's physical therapy notes				
	dated 05/05/22 rev	ealed: apist discussed with the				
	- I ne physical utera	IA) and the Special Care Unit				
	Coordinator (SCUC	C) to have Resident #4's				
	I primany care provid	der (PCP) to reter him to a				
	neurologist to confi	irm or rule out Parkinson's	ļ			1
	disease.					
	-Resident #4 prese	ented with a shuffling gait	Į			
	pattern increasing	nis usit of falls.				
	Interview with the	business office manager (BOM)				1
	00/02/22 at 4:5	Opm revealed: ible for making appointments				
	1					- 82

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
AND PLAN C	of Correction	IDENTIFICATION NUMBER:	A. BUILDING:			
		1			R	
		HAL034098	B. WING		08/05/20	22
				······		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
			SALISBURY RO			
SALEM TE	ERRACE		N SALEM, NC 27			
				PROVIDER'S PLAN OF CORRECTION	<u> </u>	(X5)
(X4) ID		ATEMENT OF DEFICIENCIES		(EACH CORRECTIVE ACTION SHOULD	BE CC	OMPLETE
PREFIX	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
TAG				DEFICIENCY)		
			(D.070)			
{D 273}	Continued From page	e 58	{D 273}		1	
	with outside provider	s and for scheduling				
1	transportation.					
	-All echeduled appoint	ntments were documented in			1	
	the facility's appointn		{			
	She had not eeen a	referral for Resident #4 to				
	-one nau nut seen a	d did not have any scheduled				
		to see a neurologist.				
	appointments to min	Lo ope a hoarologion				
	Intonview with the SC	CUC on 08/04/22 at 12:23pm	1 1			
	revealed:	100 off off the de tereophic			1	
		consible for reviewing				
1	therapist actos and f	ollowing up with any orders				
	or recommendations				ļ	
	She had worked in f	he role of SCUC since			1	
	08/01/22.	pout the recommendation				4
1	-She did not know at					
1	from the physical the	erapist to obtain a referral PCP to see a neurologist to				
1	trom Resident #4'S F				15	
	confirm or rule out P	ainiisuiis uisease.				
	-The previous SCUC	, would have been				
		ving up with Resident #4's				
1	PCP and the physici	ar merapisi.				
ļ		acontative from Resident #4's				
	Interview with a repr	esentative from Resident #4's				
}		r on 08/04/22 at 11:08am				
	revealed:	I for a huniant therease and				
	-He saw Resident #4	for physical therapy and				
	made the recommen	idation on 05/05/22 for facility				
		rral from Resident #4's PCP				
	to see a neurologist.	1 did was as wested to at he				
1	-At that time, Reside	ent #4 was so weak that he			ļ	
1	could not transfer or	Walk.	ļ	1 · · · ·		
1	-Resident #4 was ba	ack at baseline now, but he				
	continued to have P	arkinsonisms (a term used to				
1	describe the collection	on of signs and symptoms		1		
		disease) including shuffling		1		
1	and decreased gait.	t t				
	-A consult with a neu	urologist would determine			1	
	whether Resident #4	rs symptoms were		1		
1	medication related o	r neurological.	_!	l		<u> </u>
Division of He	ealth Service Regulation	55 55 <u>S. ann</u>			If continuation sh	eel 59 of 10

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
		HAL034098	8. WING		08	R /05/2022
	OVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
		2609 OL	D SALISBURY RO	AD		
ALEM TE	RRACE	WINSTO	N SALEM, NG 271			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES IGY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SI-1OULD BE HE APPROPRIATE	(X5) COMPLET DATE
(D 273)	Continued From pa	ge 59	{D 273}			
	3:27pm revealed: -She saw Resident 2022. -There was no doct communication sys facility contacted th referral for Residen -She did not see ar provider for Reside -The previous provi- numbness in Resid sensation wass still -She expected the previous provider for see a neurologist st the physical therap Interview with the A 2:08pm revealed: -She did not know from Resident #4's referral from her Pr -The home health SCUC after seeing -She expected the Resident #4's PCF referral for Resident to schedule the ap 3. Review of Resident depressive disorder encephalopathy, c acute cystitis withous hyperkalemia.	Administrator on 08/04/22 at about the recommendation physical therapist to get a CP to see a neurologist. providers usually spoke to the residents to give updates. SCUC to follow up with and the BOM to obtain a nt #4 to see a neurologist and pointment. lent #5's current FL2 dated diagnoses included major er, arthritis, metabolic ellulitis of left lower extremity, but hematuria, and				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
	CORRECTION	IBERTH TOTAL ON HOMBER	A. BUILDING:			
		HAL034098	B. WING		R 08/05/2022	
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TE	PRACE		D SALISBURY ROA			
5ACE111 16		WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X3) COMPLETI DATE
{D 273}	Continued From page	ge 60	{D 273}			
	-There was an order	for a physical therapy				
		erapy (OT) evaluation with				
	ambulation/walker a	nd to check her right lower				
	extremity strength.					
		ntation the order was faxed				
	on 07/27/22 at 2:00pm, but there was no documentation where the order was faxed to.					
		ann à thatai				
	Review of Resident	#5's progress notes for July was no documentation of a				
	PT/OT order dated (
1	documentation the order was sent to a home					
		valuation of services.				
	Review of the facility	's home health notebook				
	revealed no docume Resident #5.	entation of PT services for				
		pecial Care Unit Coordinator				
	(SCUC) on 08/03/22	at 4:20pm revealed:				
	-Home health referra	als were documented by the d to the business office to				
		ith the home health provider.				
2	-If there was an urge	ent need, the SCUC would				
	schedule services w	ith the home health provider.				
		CUC on 08/04/22 at 12:29pm				
	revealed:	OT evaluation dated 07/25/22		<u>8</u>		
	was accidentally fax	ed to the pharmacy on				
	07/27/22.					
	-She did not know if	anyone followed up to see if				
		T evaluation had been				
а.	processed.					
p	Interview with a repr	resentative form Resident #4's				
	home health provide	er on 08/05/22 at 8:34am				
8	revealed:					
	-Resident #5 was cu	rrently receiving occupational d physical therapy from				
	merany and receive					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMF	E SURVEY PLETED
6) - 0943		HAL034098	B. WING		08	/05/2022
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		2609 OLI	SALISBURY ROA	D.		
SALEM TE	RRACE	WINSTO	N SALEM, NC 271	27		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	1D PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{D 273}	Continued From pag	je 61	{D 273}			
	02/11/22 through 04 -There had been no services for Residen 08/04/22.	/08/22. other orders received for PT it #5 until yesterday, on 08/04/22 was for PT/OT				
	(PCP) on 08/05/22 a -She had not been r on 07/23/22, howeve her fall when she vis -When she saw Res observed Resident a and her right leg did to, so she ordered p occupational therapy	otified Resident #5 had a fall er she did become aware of sited her on 07/25/22. ident #5 on 07/25/22, she #5 had right side weakness not move like she wanted it hysical therapy and y for Resident #5. acility to follow up with the				
	2:08pm revealed: -The SCUC was res orders for physical t	dministrator on 08/04/22 at ponsible for following up with herapy/occupational therapy. T should have been followed I.				
	and follow-up relate orders for two urinal behavior that were r resident having an e diagnosis of a urinar for physical therapy and balance which i home health agency high fall risk, had ab a rollator walker and receive the walker of	ensure health care referral d to a resident, who had ysls tests due to changes in not obtained resulting in the emergency room visit and a ry tract infection, and an order due to a decline in mobility had not been referred to the y (#1); a resident who was a onormal gait, and an order for d a wheelchair but did not or wheelchair resulting in a fall recommendation from the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING;			E SURVEY IPLETED
		HAL034098	B. WING		0	R B/05/2022
iame of P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			010012022
AL 254 T			D SALISBURY ROA			
	ERRACE		N SALEM, NC 271			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	000507101	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE E APPROPRIATE	(XS) COMPLE DATE
{D 273}	Continued From page	62	{D 273}			
	physical therapist to s or confirm Parkinson's resident's shuffling ga his risk for falls and the from his primary care resident, who had righ restricted movement in for physical therapy the home health agency. to the health, safety, a which constitutes a co Violation.	ee a neurologist to rule out a disease due to the it pattern which increased e referral was not obtained provider (#4); and a t side weakness and n her left leg, and an order at was not referred to the This failure was detrimental nd welfare of the residents ntinuing Unabated Type B				
D 310	10A NCAC 13F .0904(Service	e)(4) Nutrition and Food	D 310			
	 (e) Therapeutic Diets I (4) All therapeutic diet supplements and thick 	s, including nutritional				
	cup was served as orde					
1-	The findings are:					

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 100		(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING		R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
SALEM TI	ERRACE		D SALISBURY R N SALEM, NG 2		
(X4) ID	SIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 63	D 310		
		5's current FL2 dated			
	06/16/22 revealed:			D310 10A NCAC 13F .0904€(4)	
	arthritis, metabolic er	major depressive disorder, icephalopathy, ulcer to left kdown of the skin, and		Nutrition and Food Service	9-21-27 11 Diet 5730"
	cellulitis of the left low			To ensure ongoing compliance, al	ll Diet m Jon
		for a magic cup on the lunch		Orders will be reviewed by Media	cal
	meal tray daily.			Records and updated lists will be	
	Review of Resident #	5's electronic Medication		generated and given to the Dietar	у
	Part - a printer and a state of the state of	d (eMAR) for May 2022		Department and to the SCU and t	he AL
	revealed:			Coordinators. Each Coordinator	will make
		for magic cup on the lunch cheduled for 12:00pm.		sure that Resident Care staff and .	Activity
		tation a magic cup was		staff have access to special diet li	sts in-
		opportunities in May 2022.		cluding lists of residents who rece therapeutic diets, nutritional supp	
	Review of Resident # revealed:	5's eMAR for June 2022		and thickened liquids as ordered l	by
		for magic cup on the lunch		the physicians. The list will be up	
	the second se	cheduled for 12:00pm. tation a magic cup was		regularly by Medical Records and	-
		opportunities in June 2022.		in a discreet location where staff access but the general public will	
	Review of Resident # revealed:	5's eMAR for July 2022		A spreadsheet has been put into p for both therapeutic diets and sup	
		for magic cup on the lunch			•
		cheduled for 12:00pm.		Attachment F: Updated Diet Ord	der Sheet
		tation a magic cup was opportunities in July 2022.		Attachment G: Therapeutic Diet Spreadsheet	
	through 08/04/22 rev			Attachment H: Supplement Spre	eadsheet
		for magic cup on the lunch			
		cheduled for 12:00pm.			
		tation a magic cup was oportunities in between			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY	
			A. BUILDING.		5		
		HAL034098	B. WING	······································	08	R 08/05/2022	
IAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		2609 01	D SALISBURY ROA	AD.			
ALEM TE	RRACE		N SALEM, NC 271				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	aı	PROVIDER'S PLAN OF		(XS) COMPLET	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO		DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC			
D 310	Continued From pag	je 64	D 310				
	Observation of the lunch meal service in the						
1							
		SCU) on 08/04/22 between					
	12:00pm and 12:34	om revealed:					
		lent #5 on 08/04/22 at					
i	12:34pm revealed:						
		she was supposed to get a					
	magic cup with her I	unch meal daily.					
}	-She did not get a m	agic cup with her lunch meal					
	today and had not b	een served a magic cup					
	previously.						
-	Observation of the k	itchen freezer on 08/04/22 at					
	1:43pm revealed:			-			
	-There was a box of	f 4-ounce magic cups in a box					
	in the freezer.	5 1					
		jic cups in the box and 20					
	magic cups were re						
	Interview with a dist	ary aide on 08/04/22 at					
	1:44pm revealed:	aly alue of ourowize at					
		as responsible for ordering					
	magic cups for resid						
	The distance staff all	aced magic cups on the lunch					
	maal trave for reside	ents who had orders for magic					
	cups with their meal	is or on the cart for residents					
	who were supposed	to have magic cups between					
	meals.	re nave magie sube bemoon					
	The medication aid	es (MA) and personal care					
	- me medication au	the magic cups from the					
	freezer for residents						
		esident in the SCU who had					
1	orders for manic cu	ps, and she received a magic					
	oun with her hreakfe	ast and supper meal tray.					
	-She did not know F	Resident #5 had an order for					
	magic cups with her	funch meal trav					
	Magic cups with her	ary staff know Resident #5					
	-NO ONE IEL LIE LIEL	ceive magic cups and magic					
	was supposed to re	n placed on Resident #5's					
	cups had never bee meal tray.	n placed on Resident #5's					

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	i Health Service Reg of Deficiencies F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		COMP	SURVEY LETED
		HAL034098	B. WING		08	05/2022
	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE,	ZIP CODE		
AME OF PR	ONDER OR SON LIER		SALISBURY ROA			
ALEM TE	RRACE		SALEM, NC 2712			
				PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLET DATE
D 310	Continued From page	ge 65	D 310			
	The Special Care I	Init Coordinator (SCUC) was				
	supposed to let the	dietary staff know when a				
	resident was to be s	served a magic cup.				
				5		
	Telephone interview	with a MA on 08/05/22 at				
	10:09am revealed:	• • • • • • • • • • • • • • • • • • •				
	-She thought Resid	ent #5's magic cup was on her	0			
	lunch meal tray dail	y. Desident #Fig magic cup Was				
	-It she documented	Resident #5's magic cup was on her lunch meal tray, then				
	given and it wash to	hen to get a magic cup for				
	her.	nen te ger a magie oop te:				
	1101.					
	Interview with the S	CUC on 08/05/22 at 10:22am	1			
	revealed:					
		t #5 had an order for a magic				
8	cup with her lunch i	neal tray daily.				
	-She worked at the	facility in a different capacity				
8	prior to becoming S	CUC on 08/01/22, and she				6
1	had asked about m	agic cups for Resident #5.				
9	-She was told by di	etary staff that a nutritional sufficient replacement for a				
	supplement was a	esident #5 did not have a				
	magic cup on her tr	av				
	"She should have o	otten clarification earlier, but				
	she got clarification	from the Administrator on				
	vesterday, 08/04/22	2 that Resident #5 should have				
	received magic cur	s instead of nutrilional				
	supplements on the	e lunch meal tray daily.				
	-The MAs must hav	e assumed without checking				1
	to see that a magic	cup was on the lunch meal				
		umented the magic cup was		2		
	given.	ponsibility to make sure the				
	manic cup was on i	the lunch meal tray, document,	1			
	and to follow up will	the kitchen if the magic cup	1			
	was not on the tray					
	lelephone interview	w with the facility contracted 5/22 at 10:37am revealed:				
	pnarmacy on ud/us	AZZ at 10.01 ani revealeu.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a		E SURVEY PLETED
					R
		HAL034098	B. WING	0	/05/2022
AME OF PI	RÖVIDER ÖR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
SALEM TE	RRACE		D SALISBURY R		
			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
D 310	Continued From page	e 66	D 310		
	tray daily. -The facility was resp magic cups through t	supply the facility with			
	care provider (PCP) of revealed: -Resident #5 had an cup daily with the lun becoming her PCP in -She did not know wh for a magic cup daily.	y Resident #5 had orders o serve Resident #5 a magic	2		
	2:08pm revealed: -She did not know Reserved a magic cup of ordered. -She previously inform SCUC or her if a med was not in the facility. -She would have exp with kitchen to ask wit receiving a magic cup	ected the MAs to follow up ny Resident #4 was not o on her lunch meal tray.		D 358 10a NCAC 13F .1004(a) Medication Administration All medications will be in place in the	ando, d-S1-5
{D 358}	(a) An adult care hor preparation and admi	Medication Administration ne shall assure that the inistration of medications, prescription, and treatments	{D 358} ,	 medication administration carts to be administered as per physician order. Med Tech's will be retrained in regards to checking medications ie: the resident name,, order and dosage on each medication before administerin medications. 	g

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If continuation sheet 67 of 105

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 10 - 10	E CONSTRUCTION	(X3) DATE S COMPL	
		HAL034098	B. WING		F 08/0	{ 5/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SALEM T	EPDACE	2609 OL	D SALISBURY F	ROAD		
		WINSTO	N SALEM, NC	27127		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLE DATE
(D 358)	Continued From pag	je 67	{D 358}	Cart audits that have been done	by shift	
	(1) orders by a licer	sed prescribing practitioner		supervisors will now be done by	u the COIL	
	which are maintaine	d in the resident's record; and		Coordinator and the AL Coordi	nator	
		tion and the facility's policies		until such a time that the staff is		
	and procedures.			seen as qualified to do them. A		
	This Rule is not met	as evidenced by:		for cart audits has been develop	ad Car	
	Based on observatio	ns, record reviews and		Attachment I. Addendum- (W		
		y failed to administer		In addition, a procedure has bee		
		ed for 3 of 6 sampled 1 #6) who had orders for an		developed to offer an added che		
		on (#1), a vitamin and		new orders. See Attachment J.	GK IOF	
	mineral supplement	(#6), and a stool softener		We are working with our pharm		in h
	(#3).			the problem of mode endered th	acy to solv	e
	The findings are:			the problem of meds ordered thr		
	me monge are.			EMAR system. When medicatio	on orders	
	1. Review of Resider	nt #6's current FL2 dated		cannot be ordered through the sy	stem, the	
	06/29/22 revealed:			using the Med Tech will fax the		
		vascular dementia, muscle lemia, and type 2 diabetes.		to the pharmacy using the Medip		
		for Cerovite Senior (a		Pharmacy, LLC/Reorder sheet.A	ttachemntl	K.
		mineral supplement), 1 tablet		After faxing, the Med Tech will	attach the	
	daily.			fax confirmation to the sheet and	l put it into	
	Paview of Pasident t	6's July 2022 electronic		the coordinator's mailbox. Upon		
	medication administr			to work, the coordinator or desig		
	revealed:			confirm delivery of the medicatio	on.	
		for Cerovite Senior tablets	1	If it has not been delivered, the		
Ì		ily scheduled at 9:00am. Itation that Cerovite Senior		coordinator will contact the phar	macy to se	e
		red daily from 07/01/22		The coordinator will document a	ny	
	through 07/31/22.	Generaliti in produktiti ■d" shfitti shtipeti di disariqi non 22 dati — Neneusi dati		follow up in the resident record.		
	Review of Resident #	6's August 2022 eMAR on		Attachment E: Signature sheet	for	
1	08/03/22 revealed:	a all radiust FAFF CMULT All	1	Med Tech training.		
		for Cerovite Senior tablets		Attachment I: Sample Cart Aud		e
1		ily scheduled at 9:00am.		Attachment J: Medication Con	firmation	
		tation that Cerovite Senior ed daily from 08/01/22		Procedure		
	through 08/03/22.			Attachment K: Medipack Pharn	nacy,, LLC	1
	Ih Service Regulation		1	Reorders form		<u></u>

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FORM APPROVED

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
		IDENTITION TOMBER:	A. BUILDING:		COMF	LETED
		HAL034098	B. WING		679577	R /05/2022
iame of P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		0012022
ALEM T	RRACE		D SALISBURY RO			
		WINSTO	ON SALEM, NC 27			
(X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC	TATEMENT OF DEFICIENCIES	CI	PROVIDER'S PLAN OF		(X5
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPI DAT
<u>10 17</u>				DEFICIENC		
(D 358)	Continued From page	e 68	{D 358}	165		
				••		
	Observation of the m	edication pass for Resident				1
	#6 on 08/03/22 at 9:0	0am revealed:				
	- The medication aide	(MA) prepared four oral				
	Was not included with	lent #6 and Cerovite Senior the other oral medications.				1
	-The MA documented	Cerovite Senior as				
	administered at 9:00a		1			
	Observation of Reside	ent #6's medications on				
	hand on 08/04/22 at 1	2:00pm revealed there was				
	a medication card for	Resident #6 dispensed on				
	08/03/22 with 29 of 30) tablets remaining of				
	Cerovite Senior tablet	s.				
	Interview with a MA or	n 08/03/22 at 9:20am				
	revealed:			-		
	-She had clicked the v	vrong button on the eMAR				
		ninistered when she meant				
	to document it as not a Resident #6's Carovit	e Senior supplement was				
1.	on order from pharma	cv.				
	The eMAR system wa	as currently "offline" so she	1			
1	was not able to check	when the medication refill				
1	had been requested from	om the pharmacy.				
		send another refill request				
	hat day. The MAs were suppor	sed to reorder medications	1 1			
	when the quantity reac	hed the last row on the				
l r	nedication card, usual	ly when there were 8				
t	ablets remaining.					
-	The MAs could reques	st medication refills by			ļ	
0	licking a refill button th	ne eMAR.				
		th a representative from				
ti	ne facility's contracted	pharmacy on 08/03/22 at				
	:45pm revealed:	0 - 1 - 1 - 1 - 1				
		Senior tablets had last 20/22 for 30 tablets which				
	as a 30-day supply.					
	Service Regulation		LL			

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If continuation sheet 69 of 105

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Division of Health Service Regulation

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION		SURVEY
		HAL034098	B. WING		R 08/05/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT		1_08	05/2022
ርጓል፤ ምልክ ም						
SALEM T	ERRACE		D SALISBURY RO			
(X4) ID	SUMMADY STA	TENEL OF DEPENDENCE	ON SALEM, NC 27	127		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5 COMPL DAT
{D 358}	Continued From page	69	{D 358}			
-The pharm request unti -If the Cerov starting on 0 have run out Inferview wit (SCUC) on 0 -Resident #6 outside of the 2022, so the supply of Cel	request until earlier tha -If the Cerovite had be starting on 06/21/22, th have run out on 07/20/	en administered daily ne 30-day supply would 22.				
	Interview with the Spec (SCUC) on 08/04/22 at -Resident #6 had not b outside of the facility fro 2022, so there would me supply of Cerovite table -She did not know why	10:00am revealed: een on any extended stays om June 2022 through July ot have been an extra ets on hand,		_		
	documenting the Cerov daily for the last 45 day they only had a 30-day -It was possible the MA the Cerovite as adminis 07/21/22 through 08/02/	Ite tablets as administered s since 06/20/22 when supply. s who had documented tered to Resident #6 from				
	prior to 07/20/22.					
	o the pharmacy once the	erovite Senior tablets. d to send a refill request e quantity of tablets				
r u	eached the shaded area Isually when it was down If the medication refill wa	a on the medication card, n to 8 doses, as not available by the				
ti ti	me the medication was	due to be administered, for calling the pharmacy				
fc	etting the SCUC know so illow-up on the refill required When Resident #6 would	o that she could Jest.				
C	erovite Senior tablets th preone different from w	e SCUC in charge was				

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Livision	or Health Service Reg				COLLA APEF
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	12) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	a tere and definitions are	OWSTRUCTION!	(%) DYTE SURVEY
			A. BUILDING:		COMPLETED
		HAL034098	B. WING		R 08/05/202
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE		1 0010012021
AL EM TE	IDDAOC		D SALISBURY RO		
FALEM TE			N SALEM, NC 271		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE DA
{D 358}	Continued From page	e 70	{D 358}		
1	-She did not know if t	he previous SCUC had been			
i	notified of Resident #	6's Cerovite needing to be			
	refilled.	-			
[-If a medication was r	not available during a			
	medication pass, the	MAs were supposed to			
	document the medica	tion as not administered,			
inifi	initials with a circle an	on the eMAR as the MA's			
Т	Telephone interview v	vith Resident #6's primary			
		n 08/05/22 at 9:00am			-5
1 m m	revealed:				
	-She was not aware it	hat Resident #6 had missed			
	doses of Cerovite Ser	been ordered for Resident			
	#6 by her previous PC	CP, but there was no specific	1		
	indication for use docu				
		eral tablets were sometimes			
	prescribed for elderly	patients, especially with			
	dementia, to ensure th				
'	nutrients they needed.				
-	Telephone interview w	ith a MA on 08/05/22 at			
	10:15am revealed:				
		Resident #6's Cerovite as			
	administered on 07/30	722 and 07731/22. r Resident #6 being out of		51	
	Cerovite.	r rooldent #0 being out of			
		ocumented the medication			
	as administered if it ha				
	Attempted telephone in	nterview on 08/04/22 at			
1	11:00am with a MA wh	o documented Resident			
#	#6's Cerovite as admin	istered on 08/01/22 and			
C	08/02/22 was unsucces	ssful.			
E	Based on observation a	and record review it was			
	letermined that Reside				
0.7438	nterviewable.				

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If continuation sheet 71 of 105

FORMALE OF ORDER

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUFPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION	(CC) DATE SURVEY COMPLETED
		HAL034098	B. WING		R
VAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STATE		08/05/2022
			D SALISBURY RO		
SALEM T			N SALEM, NC 271		
(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 DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA
(D 358}	Continued From page	9 71	{D 358}		••••••••••••••••••••••••••••••••••••••
	08/26/21 revealed:			~	
	12/08/22 revealed the lorazepam (a controlle anxiety) 0.5mg, take of twice daily as needed Review of Resident # 06/08/22 revealed the	ed drug used to treat one half tablet (0.25mg total) (PRN) for anxiety. I's physician order dated re was an order to increase ose from 0.25mg twice daily		2	
	Medication Administra revealed: -There was an entry fo one half tablet (0.25m -There was documenta 0.25mg PRN was adm 06/01/22 through 06/3 -There was an entry fo two half tablets (0.5mg start date of 06/08/22 a	or lorazepam 0.5mg, take g) twice daily PRN. ation that lorazepam inistered 15 times from		.	
1 	half tablets (0.5mg) twi ablet (0.25mg) twice d There was documenta 0.25mg PRN was admi	azepam 0.5mg, take two ce daily, and one half aily PRN. tion that lorazepam nistered 19 times from N dose had increased to		_	

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If conlinuation sheet 72 of 105

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL1/ IDENTIFICATION NUMBER:	a parta de assessante encorra	CONSTRUCTION	(20) DATE	
			A. BUILDING:		COMP	LETED
	······································	HAL034098	B. WING		(R 05/202:
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT			031202
SALEM T	FRRACE		D SALISBURY RO			
	······································	WINSTO	N SALEM, NC 27			
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF COR	RECTION	0
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE #	SHOULD BE NPPROPRIATE	COM D/
{D 358}	Continued From pag	e 72	{D 358}	DEFICIENCY)		
	Review of Resident #	\$1's July 2022 eMAR		-		
	•	for lorazepam 0.5mg, take				
	one half tablet (0.25n	ng) twice daily PRN.				
	-There was documen	tation lorazepam 0.25mg				
PR thr	PRN was administere through 07/31/22.	ed 8 times from 07/01/22				
		for lorazepam 0.5mg, take				
	one tablet (0.5mg) tw	ice daily PRN.				
-Then	-There was documen	tation lorazepam 0.5mg				
	through 07/31/22.	ed three times from 07/01/22				
	Review of Resident #	1's July 2022 CSCS				
	revealed; -The CSCS was for lo	razepam 0.5mg, take two				
	half tablets twice daily daily PRN.	, and one half tablet twice				
	-There was document	ation lorazepam 0.25mg				
	PRN was administere through 07/31/22.	d 12 times from 07/01/22				
	Observation of medica	ation on hand for Resident				
	#1 on 08/03/22 at 3:40 There was one medic)pm revealed: ation card for lorazepam				
1	0.5mg tablets take one	e tablet twice daily as				
	needed. •There was a dispense	ad date of 07/27/22 and				
	dispensed quantity of 3	30 tablets,				
-	There were 12 tablets	out of 30 tablets	[[
"	emaining.					
1	elephone interview wi	th a representative from		÷		
	he facility's contracted ::45pm revealed:	pharmacy on 08/03/22 at				
		er to increase Resident #1's				
F	RN lorazepam from 0	.25mg twice daily PRN to				
0	.5mg twice daily PRN	on 06/08/22,				
-	i ne tacility still had ha	If tablets on hand from the ler and from Resident #1's				
	Service Regulation	and norm resident #15				

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If continuation sheet 73 of 105

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A. BUILDING:		(22) DATE SUP COMPLET	
		HAL034098	B. WING		R 08/05/	20.22
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	719 CODE		2024
			D SALISBURY RO			
SALEM TI	ERRACE		ON SALEM, NC 271			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	ECORRECTION	0151
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPL DATI
{D 358}	Continued From page	2 73	{D 358}			
	were going to use up	/22 for the order to				
100	dispensed 30 tablets. Telephone Interview v					
	behaviors, such as cr					
	medications including -On 06/08/22 she incr lorazepam PRN dose PRN to 0.5mg twice d	eased Resident #1's from 0.25mg twice daily				
	-She expected when s lorazepam for Resider ensure the previous or	she wrote a new order for nt #1, the facility would rder was discontinued so				
	the current dose was. -There would be no ac	des (MA) understood what				
		azepam PRN aside from on behaviors not being as		_		
	(SCUC) on 08/04/22 a					
	-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 -The pharmacy was at medication orders from	discontinued. ble to add or remove h the eMAR but the facility				
4	needed to approve the happen.	changes, which did not				

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division	or Health Service Re	miation			EOF	NA APPECO
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X') PROVIDEP/SUPPLIER/CLI	(22) MURTIPLE (CONSTRUCTION	172.047	SURVE /
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
						_
		HAL034098	B. WING		08	R /05/2022
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI			100/2022
			LD SALISBURY RO			
SALEM T			ON SALEM, NC 27			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (E COBRECTION	
PREFIX TAG	REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE A)	CTION SHOULD BE	(X5) COMPLE
			TAG	CROSS-REFERENCED TO DEFICIE		DATE
{D 358}	Continued From pag	je 74	{D 358}			
	-The SCUC was res	ponsible for completing				
1	eMAR audits which	would include checking the				
	eMAR for accurate of	orders compared to the				
	physician orders in t	he resident record.				
1	-She had just started	her role as SCUC within the				
	last week, so she ha eMAR audits.	d not yet completed any				
		hen the previous SCUC had				
	last completed an au	idit of Resident #1's eMAR.				6
	-The MAs were supp	losed to check every				1
medication three tim	es before administering it					
6	and should have rep	orted to her that there were				
	double entries for lon	azepam on Resident #1's				
	entry.	uld remove the incorrect				
	1nterview with the Adi 3:00pm revealed:	ministrator on 08/04/22 at				
	-She was not aware t	hat Resident #1 had two				
	entries on her eMAR	for PRN lorazepam and that				
e	the MAs had been ad	ministering the 0.25mg dose				
1	Instead of the 0.5mg	dose in June and July 2022.	1			
	MARs for popurasi	onsible for checking the				
	ave completed the la	but the SCUC who would ast eMAR audit no longer				
	worked there.	as email abuil no longer				
10.016	Once the MA adminis	stered lorazepam to				
1	Resident #1 and saw	that there were two entries				
10	on the eMAR to docur	nent under, the MA should				
t	ave reported it to the	SCUC so that the incorrect	1			
dose entry could be rer		emoved.				
h	nterview with a MA or	08/04/22 at 4:00pm				
n	evealed:					
	She had documented	administration of				
	prazepam 0.25mg PR	N to Resident #1 three				
	mes in July 2022. There were no entries	on the MAR to				
		0.5mg PRN for Resident				
#	1 so she administered	the dose that was				
	Service Regulation		<u> </u>			

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	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIFLE C	CHETRUCTION		E SURVEY IPLETED
		HAL034098	B. WING		0	R 8/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
SALEM TE			D SALISBURY RO			
			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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
{D 358}	Continued From page	75	{D 358}			
	ordered in the eMAR.					
		ering 0.5mg of lorazepam				
1	PRN at the end of July	y 2022 once that order entry				
	was added to the eMA	AR because she assumed				
	the dose had increase	d due to Resident #1's				8
	behaviors.					
1	Based on observation	s and record review, it was				
	determined that Resid	ent#1 was not				
	interviewable.	6m#1 Wd5 10t				
	3. Review Resident #3	's current FI 2 dated				
		noses included diabetes				
	mellitus type II, osteoa	rthritis, hyperlipidemia.				
	tardive dyskinesia, uns	steady gait and depression.				
	Review of Resident #3	's medication orders				
		order dated 05/17/22 for				
1	senexon-S 50-8.6mg N	londay, Wednesday and				
1	Friday at bedtime (use	d to treat constipation).		-		
I	Review of Resident #3	's July 2022 electronic				
г	medication administrati	on record (eMAR)				
	revealed:					
	There was an entry for					
		Wednesday and Friday at				
6	3:00pm.					
	-mere was documenta	tion senexon-S 50-8.6mg	1			
F	Friday at 8:00pm from (/ Monday, Wednesday and 07/01/22 through 07/31/22.				
F	Review of Resident #3':	s August 2022 MAD				
	evealed:	CARGE EVER EMILIT				
	There was an entry for	senexon-S 8.6mg				
s	cheduled on Monday,	Wednesday and Friday at				
8	:00pm.					
		ion senexon-S 50-8.6mg				
W	as administered every	Monday, 08/01/22 at				[
8	:00pm and Wednesday	/, 08/03/22 at 8:00pm.				
1-	bservation of Resident					

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Livision of Health Service Regulation

	T OF DEFICIENCIES DF CORRECTION	(21) FROVIDER/SUPPLIER/CL14 IDENTIFICATION NUMBER:	(CONSTRUCTION		e survey Pleted
		HAL034098	B. WING		08	R 3/05/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	00	, OOILOLL
SALEM TE	RRACE		D SALISBURY RO			
			N SALEM, NC 27			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN C	E CORRECTION	
PREFIX TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
{D 358}	Continued From pag	je 76	{D 358}			
[hand at the facility or	n 08/04/22 at 2:58pm				i.
-	revealed senexon-S	8.6mg was not available for				
	administration.	oroning was not available for				
8						1
	Telephone interview	with a pharmacist from the				
	facility's contract pha	rmacy on 08/04/22 at				
	9:40am revealed:					
	-There was an order	for senexon-S 8.6mg				
	Monday, Wednesday	and Friday.				
1	-On 06/28/22, the ph	armacy dispensed 12 tablets				
	of senexon-S 8.6mg.					1
	-Because Senexon-S	was to be administered on				
	monuay, weanesday	and Friday; the 12 tablets of ve lasted the resident until				
		administration being on		-		
	Monday 07/25/22.	a automistration being on				
		automatically refilled, the				
	facility had to call and		1			
		08/04/22), no one at the				
1	facility had called to r	equest a refill of Resident				
	#3's senexon-S.					
1	Interview with Reside	nt #3 on 08/04/22 at				
	11:58am revealed:					
	She did not know her					
	She did not know if s	enexon-S was				
	administered,					
-	She had been a little	nauseated lately, but she	1			
C	lid not tell anyone bed	cause it was not bad.				
	She had not experien	ced constipation or difficulty	1	•		
	aving a bowel mover	nent.		-		
		ident Care Coordinator				
0	RCC) on 08/04/22 at	12:06pm revealed:				
	The facility medication	ns were not automatically				
	efilled.					
1-	The medication aide (MA) who administered	1			
		e of senexon-S should			3	
		dication using the eMAR				
	ystem. Service Regulation					

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If continuation sheet 77 of 105

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STATEMEN	DT Health Service Read FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(32) MULTIPLE C	OVSTRUCTION		e survey Pleted
		HAL034098	B. WING		01	R 3/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E. ZIP CODE		10.000
			D SALISBURY RO			
SALEM TI	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{D 358}	, 5		{D 358}	<u> </u>	an a	
	working when the nex should have reordere -The MA's were support medication label with administering a medic medication and right of -If the medication was supposed to documer medication was admin -If Resident #3's sene the MA should not have medication as adminis -The MA should have see why the medicatio -The MA should have medication was not av -The facility was doing eMAR audits to if iden available. -The medication and e done within the past tw	besed checked the the eMAR before sation to ensure the right lose was administered. available the MA was at on the eMAR the histered. xon-S was not administered we documented the stered on the eMAR. contacted the pharmacy to on was not in the building. also let her know the vallable. weekly medication and tify medications were				
	11:34am revealed: -The MA that administration dose should have reor the eMAR system. -If the system had went the medication; when the MA should have made if the medication order -The next time the medi- administration the MA off that she administer was not available. -The MA should have reor -The MA should have reor			-	·	

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	7 of deficiencies of correction	(21) PROVIDER/SUFPLIER/CLP. IDENTIFICATION NUMBER:	()(2) MULTIFLE C A. BUILDING:			S SURVEY PLETED	
		HAL034098	B. WING		0	R 08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
SALEM T	FRRACE	2609 OL	D SALISBURY RO	AD			
			ON SALEM, NC 271				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(NP)	
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
{D 358}	Continued From pag	je 78	{D 358}			-	
	-When the MA attern	pted to administer the					
	medication and it wa	is not available, the MA					
	should have reorder	ed the medication.					
	-There was no excep	otional accuse why Resident					
1	#3's senexon-S was	not administered for 4		-			
	administration dates	and the MA signed the					
	eMAR as it she adm	inistered the medication.					
		cations to be available and to					
	be administered as o						
	medication cart audit	osed to complete weekly					
	discovered senexon-						
					÷	2 ⁶⁶	
ļ		that documented she					
		nt #3's last three doses of :					
	Senexon-S on 08/04/	22 at 10:15am revealed					
	last dose of senexon	ministered Resident #3's					
[-She thought that she						
	medication using the						
		wn but she did not check to					
i.	see if the order went	through.	1 1	-			
		ontinually went down and					
	sometimes did not rea	order medications.	1				
	-The next administrat						
	documented that she	administered the					
		unable to explain why.					
	-She thought that she	called the pharmacy				2	
1	regarding the medical	lion but was not sure.			2	1	
	-She did not documer						
	pharmacy and she did						
	Administrator and RC available.	C the medication was not				}	
1		plain why she did not				1	
		for the third time but					
		inistered the medication.					
		redication was not in the				ļ	
		that she should not signed					
		ministered the medication.					

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	7 OF DEFICIENCIES OF CORRECTION	(X): PPOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and an and a second second second second		(X3) DATE SURVEY COMPLETED R 08/05/2022	
		HAL034098	B. WING			
NAME OF P	PROVIDER OR SUPPLIER	STREETA	ODRESS, CITY, ST	ATE, ZIP CODE		
SALEM T	ERRACE		D SALISBURY I			
			N SALEM, NC			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		
PREFIX TAG	REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
(D 358)	Continued From pa	ge 79	{D 358}			v
	Attempted telephon	e interview with Resident #3's		D367 10A NCAC 13F .1004(j) Medi	'	
	Primary Care Provid	der (PCP) on 08/04/22 at		-		6217
	12:26pm was unsue	ccessful.		Administration All medications will be fully de	- and a start of a	1-01-0
				Documentation for PRN medic	ocumented.	ongo
D 367	10A NCAC 13F .100	04(j) Medication	D 367	•	020202	0
	Administration	*		include reason for the prn, resu	lting	
	100 NCAC 12E 100	04 Medication Administration		effect from the prn.		
i	(i) The resident's m	edication administration	8	Med Tech's will be retrained or		
	record (MAR) shall I	be accurate and include the		documentation process for med		
	following:			Med Tech's will be advised to r	emind	
	(1) resident's name;			physicians that they need to sen	d	
	(2) name of the med	lication or treatment order;	8	discharge orders for current ord		
	(3) strength and dos administered;	age or quantity of medication		changing dosages for residents.		
		dministering the medication		Med Tech's will be retrained on	the use of	
	or treatment;	animotoring the medication		Medication Refusal forms and t		
	(5) reason or justifica	ation for the administralion of		Physician Notification of Resid		ľ
	medications or treatment	ments as needed (PRN) and		of Medications or Dosage Omis		
	documenting the res	ulting effect on the resident;		See Attachment L a & b.	sions P&P,	
1	(6) date and time of a(7) documentation of	auninistration; fany omission of				
1	medications or treatr	nents and the reason for the		Resident Care Management is w		
1	omission, including r	efusals; and,	4	with the pharmacy to fix the pro		
	(8) name or initials o	f the person administering		of the EMAR system not syncin	0	
	the medication or tre	atment. If initials are used, a		administration information when		
	signature equivalent	to those initials is to be intained with the medication	1	out of range while medications a	are being	
	administration record			given.		
1				Attachment E: Signature shee	t for	
	This Rule is not met	as evidenced by:		Med Tech training.		
	Based on observation	ns, interviews and record		Attachment L (a) Physician No	tification -	f
1	reviews, the facility fa	ailed to accurately document		Resident's Refusal of Medicati		7
1	Automistration of Met Medication Administr	dications on the electronic ation Record (eMAR) for 1 of				
	5 sampled residents	(#1) who had an order for a		Dosage Omissions Policy & Pr		
	scheduled anti-anxiet	ly medication.		Attachment L (b) Physician N		
				of Resident's Refusal of Medic	ations or	
	The findings are:		1	Dosage form.		

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Division of Ficalith Service Regulation STATEMENT OF DEFICIE/CIES (X1) PROVIDER/SUPPLIER/CLIA (22) AULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R HAL034098 B. WING 08/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID IN PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 367 Continued From page 80 D 367 Review of Resident #1's current FL2 dated 08/26/21 revealed: -Diagnoses included schizoaffective disorder and moderate intellectual disability. -She was constantly disoriented. Review of Resident #1's physician order dated 12/08/22 revealed there was an order for lorazepam 0.5mg, take two half tablets (0.5mg total) twice dally. Review of Resident #1's June 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily scheduled at 9:00am and 9:00pm. -There was documentation lorazepam 0.5mg was administered twice daily from 06/01/22 through 06/30/22 except for the 9:00pm dose on 06/17/22 with the documented reason being "out of the facility." Review of Resident #1's June 2022 Controlled Substance Count Sheet (CSCS) revealed: -The order was for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily and one half tablet (0.25mg) twice daily as needed (PRN). -There was documentation lorazepam 0.5mg was administered twice daily at 9:00am and 9:00pm from 06/01/22 through 06/30/22 except for the 9:00pm dose on 06/14/22 and 06/17/22. Review of Resident #1's July 2022 eMAR revealed: -There was an entry for lorazepam 0.5mg, take two half tablets (0.5mg) twice daily scheduled at 9:00am and 9:00pm. -There was a second entry for lorazepam 0.5mg, take one full tablet (0.5mg) twice daily scheduled Division of Health Service Regulation

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Division of Health Service Reputation

	PT OF DEFICIENCIES OF CORRECTION	(21) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:	1	COMSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING		R 08/05/2022	
NAME OF F	PROVIDER OR SUPPLIER	2609 OL	ADDRESS, CITY, STATE D SALISBURY RO DN SALEM, NC 271	AD		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DATE	LETE
	at 8:00am and 8:00 07/26/22. -There was docume administered under dose on 07/26/22, 1 07/31/22. Review of Resident revealed: -The order was for half tablets (0.5mg) (0.25mg) twice daily -There was docume lorazepam 0.5mg d 9:00pm on 07/26/22 07/31/22. Review of Resident revealed: -There was an entry two half tablets (0.5 8:00am and 8:00pm -There was a secon take one full tablet (at 8:00am and 8:00pm -There was a secon take one full tablet (at 8:00am and 8:00pm -There was a secon take one full tablet (at 8:00am and 8:00pm -There was a secon take one full tablet (at 8:00am and 8:00pm -There was docume administered under dose on 08/01/22. Review of Resident revealed there was of 8:00pm on 08/01/22 Observation of medi #1 on 08/03/22 at 3: -There was one med 0.5mg tablets, take one eded.	Dpm, with a start date of entation lorazepam 0.5mg was both entries for the evening 07/27/22, 07/28/22, and #1's July 2022 CSCS lorazepam 0.5mg, take two twice daily and one half tablet / as needed. entation that only one ose was administered at 2, 07/27/22, 07/28/22 and #1's August 2022 eMAR for lorazepam 0.5mg, take mg) twice daily scheduled at d entry for lorazepam 0.5mg, 0.5mg) twice daily scheduled om. ntation lorazepam 0.5mg was both entries for the 8:00pm #1's August 2022 CSCS documentation only one use was administered at	D 367	-		

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STATEMENT	of Health Service Requ FOF DEFICIENCIES OF CORRECTION	18100 (X1) PROVIDER/SUPFLIER/CLI2 IDENTIFICATION NUMBER:	1 C C	OUSTRUCTION	(2%) DATE COMP	SUPVEY PLETED
 		HAL034098	B. WING			R /05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
SALEM TE		2609 OL	D SALISBURY RO.	AD		
		WINSTO	N SALEM, NC 271	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	82	D 367			
	dispensed quantity of -There were 12 tablet remaining.			-		
	the facility's contracted 2:45pm revealed: -They dispensed 180 lorazepam 0.5mg for I an order to take two h scheduled and one ha -The MAs would have medication card to dis doses and the PRN do -They received an ord PRN lorazepam from 0 0.5mg twice daily PRN -The facility still had ha they were going to use from the pharmacy for -They last dispensed h Resident #1 on 07/27/ administer 0.5mg twice dispensed 30 tablets. -They had received a t	Resident #1 on 05/20/22 for alf tablets twice daily alf tablet twice daily PRN. been using the same pense both the scheduled oses. er to increase Resident #1's 0.25mg twice daily PRN to N on 06/08/22. alf tablets available that e up prior to getting a refill the increased PRN dose. orazepam 0.5mg for 22 for the order to		÷		
	health provider (MHP) revealed that she expe new order for lorazepa facility would ensure th discontinued so that th understood what the cu	ith Resident #1's mental on 08/04/22 at 10:45am acted when she wrote a m for Resident #1, the he previous order was e medication aides (MA) urrent dose was and could hent under the previous		-		
	Interview with the Spec (SCUC) on 08/04/22 at h Service Regulation					

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FORM APPROVAL

UNISION OF HEALTH SET VICE HOC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		JAION (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIFLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY
	·	HAL034098	B. WING		10.2% of the	R 105/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	E ZIP CODE		
0.61 556 70			D SALISBURY RO			
SALEM T	EKNAGE		N SALEM, NC 271			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN	OF CORRECTION	(145)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETE DATE
D 367	Continued From page	9 83	D 367			
	-The previous SCUC	who was working at the time				
	that Resident #1's se	cond lorazepam entry was				
	placed on the eMAR	was responsible for ensuring				
1	the current lorazepan	n dose was entered on the				
		were no duplicate entries.				
	-The pharmacy was a					
	medication orders from	m the eMAR but the facility				
9	needed to approve th					
	-The SCUC was resp	onsible for completing				
	eMAR for accurate or	ould include checking the				
	physician orders in the					
		her role as SCUC within the	1 1			1
		not yet completed any				
	eMAR audits.	·······································				
		en the previous SCUC had	1	-	85.8	
	last completed an aud	lit of Resident #1's eMAR.	1 1			
	-The MAs were suppo					
	medication three times	s before administering it				1
		rted to her that there were				
		zepam on Resident #1's				
	eMAR so that she cou	ld remove one of the				
	entries.					
	Interview with the Adm	inistrator on 08/04/22 at				
	3:00pm revealed:					
		at Resident #1 had two				
		or scheduled lorazepam.				
		nsible for checking the				
		out the SCUC who would				
		st eMAR audit no longer				
	worked there.			a		
		lered lorazepam 0.5mg to				
		hat there were two entries tent under, the MA should				
		SCUC so that the extra	1			
	entry could be remove					
		the SCUC on 08/04/22 at				
11100000000000000000000000000000000000	3:50pm revealed:		1			

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- 2019 Ex (201, 943)	CF CORRECTION	(21) PRCVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.2	2LE CONSTRUCTЮН 3:	()(3) DATE SURVEY COMPLETED
	·	HAL034098	B. WING		R 08/05/2022
NAME OF I	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY, S	STATE, ZIP CODE	- GOIGGILGEL
SALEM 1	ERRACE		DLD SALISBURY		
1844 mg page 7	·····		ON SALEM, NC		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E (XS) COMPLI ITE DATE
D 477	-She had documente lorazepam 0.5mg to entries on the eMAR -She had not noticed documented she adm Resident #1 and sinc issues with their eMA documentation had n second entry and doc -She did not administ doses to Resident #1 Interview with a MA o revealed: -She had documented lorazepam 0.5mg to F entries on the eMAR to 07/27/22, 07/28/22, at -She only administere 0.5mg to Resident #1. -She would have notic a second dose errone have seen her documented to a second have noticed to entries on the eMAR for lorazepam.	ed that she administered Resident #1 under both on 07/26/22 and 07/31/22. there were two entries, she ninistered one dose to the the facility was having SR system she thought her of saved so she clicked the cumented it again. The two separate 0.5mg on 07/26/22 or 07/31/22. In 08/04/22 at 4:00pm d she administered Resident #1 under both for the 8:00pm dose on and 08/01/22. d one dose of lorazepam the dif she was administering ously because she would entation on the CSCS. here were two separate or Resident #1's scheduled and record review, it was ent #1 was not Special Care Unit	D 367	D 477 10A NCAC 13F .1409 Special Ca Unit Orientation and Training All staff have received 6 hours and of Special Care Dementia education All staff will receive 6 hours and 20 of Special Care Dementia education during orientation. The Business Of will ensure completion of training butilizing the New Hire Checklist at conclusion of Orientation.	9-21-2 Ongo 20 hours n D hours of 1 Office
	Orientation And Trainin	Special Care Unit Staff g e that special care unit staff		Attachment B: New Hire Checklist Attachment M: Orientation	
· · · · · · · · · · · · · · · · · · ·		and openations unit stall	- I	Acknowledgement	

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	of Health Service Real					PM APPEA	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY IPLETED	
		HAL034098	B. WING			R 08/05/2022	
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			105/2022	
AL EM T	ERRACE		D SALISBURY RO				
			N SALEM, NC 271				
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	I ID I	PROVIDER'S PLAN O	FCORRECTION	1 0	
TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X COMP DA	
D 477	Continued From page	e 85	D 477				
	 training: (1) Prior to establishi residents with a menta administrator shall dou 20 hours of training sp qualified mental health 10A NCAC 27G .0104 unit to be operated. T in place a plan to train unit that identifies cont evaluations and sched achievement. (2) Within the first we employee assigned to special care unit shall orientation on the natu residents. (3) Within six months staff shall complete 20 to the population being 	tules regarding training sek of employment, each perform duties in the complete six hours of re and needs of the of employment, direct care hours of training specific served. raining required in Rule er, direct care staff all complete at least 8 Jucation annually that is		-			
	failed to assure 4 of 6 s B, Staff D, and Staff E) care unit facility had cor prientation and training served within the first w	I record review, the facility sampled staff (Staff A, Staff who worked in the special mpleted the six hours of specific to the population		·			
1	The findings are:	erennel care aida					
	Service Regulation						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLU IDENTIFICATION NUMBER:	(X2) MULTIPLE O A. BUILDING:	OVSTPUCTION		E SURVEM	
		HAL034098	B. WING		. 01	R 08/05/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
SALEM T	ERRACE		D SALISBURY ROADN SALEM, NC 271			8	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	1	
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 477	Continued From page	je 86	D 477			· [
	(PCA)/medication at revealed: -Staff A's date of him	ide (MA) personnel record		n.			
	- There was no docu	n in the first week of hire.					
	Attempted telephone 08/05/22 at 1:38pm	a interview with Staff A on was unsuccessful.					
C	Coordinator (RCC) c	with the Resident Care n 08/05/22 at 1:23pm					
		ired the business office					
	-The business office Staff A completed SC -She was not sure with	a still at the facility full-time. was responsible to ensure CU training. ho specifically provided the was responsible to make		-			
	sure the training was						
	Refer to telephone in accountant on 08/05/	terview with the corporate 22 at 3:00pm.					
		terview with the previous ger (BOM) on 08/05/22 at					
	Refer to telephone in Administrator on 08/0						
	2. Review of Staff B's (PCA)/medication aid revealed:	personal care aide e (MA) personnel record					
-	-Staff B's date of hire - There was no docun	was 06/14/22. nentation of special care in the first week of hire.		-			
-	5 10 10 10 10 10 10 10 10 10 10 10 10 10	vith the Resident Care					

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	T OF DEFICIENCES	(X1) PROVIDER/SUPFLIER/CLIA	(X2) MUI TIPLE C	DUSTRUCTION	0:0) DATE SURVEY	• ••
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034098	B. WING		R 08/05/2022	2
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE		• • • • • • • • • • • • • • • • • • • •	00
	2. T		D SALISBURY RO			
SALEM T	ERRACE		IN SALEM, NC 271			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	a	PROVIDER'S PLAN OF (
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPL HE APPROPRIATE DAT	LETE
D 477	Continued From page	2 87	D 477			
	revealed:					
j		training to work in the				
	assisted living and the					
		d the third shift but she also				
	assisted as needed w	/ith folleting, bathing.				
	dressing, ambulation					
		SCU training had been				
1	provided for Staff B.	Ū				
	-The business office v	vas responsible for ensuring				
	all trainings were com	pleted.				
	Refer to telephone int	erview with the corporate				
ľ	accountant on 08/05/2		1			
1		F				
	Refer to telephone int	erview with the previous				
		ger (BOM) on 08/05/22 at			1	
	3:09pm.					
	Refer to telephone inte	erview with the				
	Administrator on 08/0					
	3. Review of Staff D's	nersonal care aide				
		(MA) personnel record				
17.1	revealed:				8	
	-Staff D's date of hire	was 06/14/22.				
	- There was no docum	ientation of special care				
		in the first week of hire.				
	Attempted telephone i	nterview with Staff D on				
	08/05/22 at 2:56pm wa					
	Telephone interview w	ith the Resident Care				
	Coordinator (RCC) on					
	revealed:	- Provinsi				
Í	-Staff D was crossed to	raining to work in the	1			
	assisted living and the	SCU.				
		nly in the SCU since she				
	was hired at the facility					
	-Staff D was responsib					
38	administration, and as:	sisted as needed with			n <u>ni kao n</u>	
sion of Heal	th Service Regulation			12 13 18 19 19 19 19 19 19 19 19 19 19 19 19 19		

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	TOF DEFICIENCIES DF CORRECTION	(21) PRCVIDEP/SUPPLIER/CLIA IDENTIFICATION NUMBER:	to card a second control provide a second	CONSTRUCTION (6:	C) DATE SURVER COMPLETED
	_	HAL034098	B, WING		R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
SALEM T	ERRACE	2609 OL	D SALISBURY RO	AD -	
		WINSTO	N 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETE DATE
D 477	Continued From page	88	D 477		
	feeding as needed.	bulation/transferring and			
	Refer to telephone into accountant on 08/05/2	erview with the corporate 2 at 3:00pm.		*	
		erview with the previous ler (BOM) on 08/05/22 at		-	
	10:15am revealed: -She started working a through an agency in a -She was offered a full Care Coordinator (SCI started her role as SCI -She had completed S starting as SCUC on 0 remember what day sh training.	5/22 at 1:33pm. with Staff E on 08/05/22 at t the facility as a MA June 2022. -time position of Special JC) on 07/26/22 and JC on 08/01/22. CU orientation prior to 8/01/22 but could not		-	
	accountant on 08/05/22 Refer to telephone inte	rview with the corporate 2 at 3:00pm. rview with the previous er (BOM) on 08/05/22 at			

Refer to telephone interview with the Administrator on 08/05/22 at 1:33pm.

Telephone interview with the corporate

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Division	of Health Service Req	ulation			5 (NO 162 70W), 00/20/202 (4 PP: 30/V) -
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIFLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	8, WING		F 08/0	R 15/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
SALEM T	ERRACE		D SALISBURY R N SALEM, NC 2			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ið PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 477	Continued From pag	e 89	D 477			
	accountant on 08/05	/22 at 3:00pm revealed:				

-The previous BOM left sometime in June 2022, but still helped the business office two to three days per week. -She was not sure if the previous BOM would Division of Health Service Regulation

trainings.

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business office part-time.

personnel records.

training.

revealed:

completed.

the business office.

personnel record.

08/05/22 at 1:33pm revealed:

-She was aware Special Care Unit (SCU) training was required within the first week of hire. -In July 2022, she came to the facility to help the

-Two weeks ago, she started working on

-She was not aware some employees had not received the required 6 hours of special care unit

Telephone interview with the previous business office manager (BOM) on 08/05/22 at 3:09pm

-The business office was responsible for making

-She left the business in May 2022 and she was not sure why some staff SCU training was not

-She had observed the paperwork went through several hands and sometimes never made it to

-The SCU training was usually provided within the first week of orientation and should be in the

Telephone interview with the Administrator on

-The special care unit orientation and training was supposed to be completed during orientation, which was done the first week of hire.

-The business office was responsible for making sure all personnel records were complete. -The previous BOM was responsible for making sure personnel records included the required

sure all trainings were completed.

LASS Consellin Service Reputetion STATE VEHICLE DEFICIENCIES (21) PROVIDER/SUPPLIEP/CLIM (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED. A. BUILDING: R B, WING HAL034098 08/05/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2609 OLD SALISBURY ROAD SALEM TERRACE WINSTON SALEM, NC 27127 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 477 Continued From page 90 D 477 have still been responsible for making sure SCU orientation and training had been completed, -The corporate accountant started helping the business office out at the end of June 2022 or early July 2022. -She thought the required trainings and documents had not been completed due to the D 912 G.S. 131D-21(2) Declaration turnover in the business office. of Resident Rights ingoin (D912) G.S. 131D-21(2) Declaration of Residents' Rights {D912} All staff has had a NC Healthcare G.S. 131D-21 Declaration of Residents' Rights Personnel Registry check completed. Every resident shall have the following rights: 2. To receive care and services which are All potential new hires will be adequate, appropriate, and in compliance with screened through the NC Healthcare relevant federal and state laws and rules and regulations. Personnel Registry prior to attending orientation. Upon a job offer being made, the This Rule is not met as evidenced by: Business Office Manager will submit Based on observation, record review, and interview, the facility failed to assure all residents the paperwork to the Healthcare received care and services which were adequate, Personnel Registry. Upon receipt of the appropriate and in compliance with relevant results showing no substantial findings. federal and state laws and rules and regulations related to staff qualifications-North Carolina orientation will be scheduled for the new Health Care Personnel Registry and criminal employee. If there are substantial findings. background checks, personal care and the paperwork will be given to the supervision, health care and medication aide Administrator to review. At that time training and competency. the offer of employment may be recinded. The findings are: The Business Office Manager will utilize the New Hire 1. Based on interviews and record reviews, the facility failed to ensure 4 of 6 sampled staff (Staff Checklist to ensure that records are in A, B, D and E) had no substantlated findings compliance. listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. [Refer to Attachment B: New Hire Checklist Tag 137, 10A NCAC 13F .0405(a)(5) Other Staff

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER: HAL034098		CONSTRUCTION	СОМ	E SURVEY PLETED
	ROVIDER OR SUPPLIER				<u> </u>	8/05/2022
	NOTIDER OR SUPPLIER		ADDRESS, CITY, STAT			
SALEM T	ERRACE		D SALISBURY RO			
(X4) ID	SUMMARY :	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR	ECTION	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) Complet Date
{D912}	Continued From page	ge 91	{D912}			
	Qualifications (Type	B Violation)].				
	facility failed to ensu A and Staff D) had a completed upon hire NCAC 13F .0405(a) (Type B Violation)].	reviews and interviews the tre 2 of 6 sampled staff (Staff criminal background check e. [Refer to Tag 139, 10A (7) Other Staff Qualifications reviews, observations, and				
	interviews, the facilit for 2 of 5 sampled re to a resident who ha fall resulting in injurie had a history of falls, resulting in pain and	y failed to provide supervision sidents (#4 and #5) related d 2 falls within a week with 1 es (#5) and a resident who sustained 3 falls with 1 fall a decrease in ambulation 70, 10A NCAC 13F .0901(b)				
	interviews, the facility referral and follow up sampled residents (# orders for urinalyses orders for a rollator w a recommendation to neurologist (#4); and	tions, record reviews and railed to ensure health care were completed for 3 of 5 1, #4, and #5) who had and physical therapy (#1); ralker and a wheelchair, and obtain a referral to see a an order for physical therapy 3, 10A NCAC 13F .0902(b) 2 Violation)].				
 	reviews the facility fai staff (Staff A, Staff B, administered medicat medication aide traini nour medication aide nedication clinical ski verification, and valida	ions, interviews, and record led to ensure 4 of 6 sampled Staff D and Staff E) who ions had completed the ng, including the 5, 10, or 15 training course, the Ils checklist, employee ation of successfully taking cation alde examination.				

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	57 DEFICIENCIES F CORRECTION	(33) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		HAL034098	B. WING	······································	R 08/05/2022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	name and the second	
		WINSTO	ON SALEM, NC	27127	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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
{D912}	Continued From page	je 92	{D912}		
	Care Home Medicat	S. § 131D-4.5B (b) Adult ion Aides; Training and tion Requirements (Type B			
D935	G.S. <u>§</u> 131D-4.5B(b) Training and Compe	ACH Medication Aides; lency	D935		
	G.S. § 131D-4.5B (b Medication Aldes; Tr Evaluation Requirem	aining and Competency		D 935 G.S. 131D-4 ACH Medication A Training and Competency	ides 9.21-2 onge
	home is prohibited fr any unsupervised me that individual has pr medication aide durin an adult care home of of the following: (1) A five-hour trainin Department that inch in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitu- bleeding occurs or the exists. (2) A clinical skills ev NCAC 13F .0503 and (3) Within 60 days fro individual must have a. An additional 10-ho developed by the Dep	of medication rs for Disease Control and s on infection control and, if tion practices and oring or testing in which e potential for bleeding aluation consistent with 10A d 10A NCAC 13G .0503. on the date of hire, the completed the following: pur training program partment that includes on in all of the following:		All Medication Aides who have m medications at a previous facility 24 months prior to their hire date complete a 5 hour training progra developed by the Department that training and instruction in the foll The Key Principles of Medicati Administration The federal centers for disease of and prevention guidelines on control and safe injection pra procedures of monitoring or t which bleeding occurs or the for bleeding exists. The Business Office Manager will utilize the New Hire Checklist to ensure that records an compliance. <i>Attachment B: New Hire Checkli</i>	in the will m t includes lowing: on control infection ctices and esting in potential l re in

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	t of Deficiencies DF Correction	(2) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		CPSTRUCTION		SURVEY PLETED
		HAL034098	B. WING		08	/05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
SALEM T	ERRACE		D SALISBURY ROA N SALEM, NC 271			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	THE APPROPRIATE	COMPLE DATE
D935	Continued From pag	e 93	D935			
	Prevention guideline applicable, safe injec procedures for monit	rs of Disease Control and s on infection control and, if tion practices and oring or testing in which re potential for bleeding				
	by the Division of He	eveloped and administered alth Service Regulation in section (c) of this section.				ti i
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews the facility fai staff, who administer employee verification medication aide durin (A; B, D and E); 1 of (medication clinical sk administering medica sampled staff comple	that they had worked as a g the previous 24 months 5 sampled staff completed a ills checklist prior to				
	The findings are:					
	revealed: -Staff A was hired on -There was document the medication clinica	e (MA) personnel record 04/20/22. ation Staff A had completed				
	the 5, 10, or 15-hour r -There was no docum verification.	entation Staff A completed nedication aide training. entation of an employee				
F		entation Staff A had taken tion aide examination.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI4. IDENTIFICATION NUMBER:	()(?) (4ULTIPLE C A. BUILDING:			e Survey IPleted
		HAL034098	B. WING		R 08/05/2022	
iame of P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
SALEM TI	ERRACE		D SALISBURY ROADN SALEM, NC 271			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	0/0
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE	(X5) COMPLET DATE
D935	Continued From pag	e 94	D935			
	Attempted telephone 08/05/22 at 1:38pm v	interview with Staff A on was unsuccessful.			10	
	Review of residents' June and July 2022 electronic medication administration record (eMARs) revealed: -There was documentation Staff A administ					
ti n	through 06/30/22.	asions from 06/01/22				
		tation Staff A administered asions from 07/01/22				
1	Refer to interview with 08/04/22 at 5:35pm.	h the facility's nurse on				
	Refer to telephone in Care Coordinator (RC	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	erview with the corporate 22 at 3:00pm.				
		erview with the previous ger (BOM) on 08/05/22 at				
1	revealed:	PCA/MA) personnel record				
		06/14/22. ation Staff B completed the ication aide training on				
	-There was no docum the medication clinical	entation Staff B completed skill checklist. entation of an employee				
	verification.	enanon or an employee	1			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	():2) i4ULTIPLE CO A. BUILDING:	0:0)	DATE SURVEY COMPLETED	
40		HAL0340 <u>98</u>	B. WING		08/05/2022	
NAME OF PI	ROVIDER OR SUPPI.IER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TE	RRACE		D SALISBURY ROANN SALEM, NC 271			
	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET	
D935	Continued From page	e 95	D935			
	-There was no documentation Staff B had taken or passed the medication aide examination.					
		July and August 2022 administration records				
	(eMARs) revealed:					
		ntation Staff B administered casions from 07/01/22				
		tation Staff B administered				
	medications on 3 occ through 08/04/22.	casions from 08/01/22				
8	Telephone interview v 2:41pm revealed:	with Staff B on 08/05/22 at				
	(unable to recall the	he facility since June 2022 exact start date), but she				
		vorking mid-June 2022. the mostly worked on the				
	-She administered m	edications to the residents. r medication alde training,				
	began working at the					
	going to provide addi had been provided.	rbally told her that she was tional training, but nothing				
	-She had taken and p	bassed the medication aide starting work at the facility.				
	Refer to interview wit 08/04/22 at 5:35pm.	h the facility's nurse on			27	
		terview with the Resident CC) on 08/05/22 at 1:23pm.				
	Refer to telephone in 08/05/22 at 1:33pm.	terview the Administrator on				
	Refer to telephone in	terview with the corporate				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIEP/CLI/. IDENTIFICATION NUMBER:	(X2) KULTISUS CO A. BUILDING:	OFSTRUCTION		SURVEY PLETED
				allocate to the		R
		HAL034098	B, WING			105/2022
VAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
SALEM TE	ERRACE		D SALISBURY ROA N SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
D935	Continued From pag	e 96	D935			
4	accountant on 08/05	/22 at 3:00pm.				
		terview with the previous ager (BOM) on 08/05/22 at				
	3. Review of Staff D's aide/medication aide revealed: -Staff D was hired on	(PCA/MA) personnel record				
		ntation Staff D had completed				
	verification for Staff E -There was no docum	nentation of 5, 10 or 15-hour				
		nentation Staff D had taken				
		cation aide examination. July and August 2022 eMARs				
		tation Staff D administered ccasions from 07/01/22				
	-There was documen	tation Staff D administered asions from 08/01/22				
	Attempted telephone 08/05/22 at 2:56pm v	interview with Staff D on vas unsuccessful.				
	Refer to interview wit 08/04/22 at 5:35pm.	h the facility's nurse on				
		terview with the Resident CC) on 08/05/22 at 1:23pm.				
	Refer to telephone in	terview with the				

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STATEMENT	OF DEFICIENCIES OF DEFICIENCIES OF CORRECTION	ation (%1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034098			(X3) DATE SURVEY COMPLETED R 08/05/2022
				7/2 0005	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		
SALEM TE	ERRACE		D SALISBURY ROA		
		WINSTO	N SALEM, NC 271		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D935	Continued From page	e 97	D935		
	Administrator on 08/0)5/22 at 1:33pm.			
	Refer to telephone in accountant on 08/05/	tervlew with the corporate 22 at 3:00pm.			
		terview with the previous ger (BOM) on 08/05/22 at			
	 4. Review of Staff E's, medication aide (MA), personnel record revealed: Staff E was hired on 07/26/22. Staff E completed the Medication Administration Clinical Skills Validation Checklist on 07/28/22. There was no documentation 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. 				
	electronic Medication (eMARs) revealed: -From 07/01/22 throu documented the adm 15 days. -From 08/01/22 throu	inistration of medications on			
	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 because she needed	II-time position of Special r (SCUC) on 07/26/22 and			

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	FOF DEFICIENCIES OF CORRECTION	UIEIIO.; (X1) PROVIDEF/SUPPLIER/CL4. IDENTIFICATION NUMBER:	A. BUILDING:			e Survey Pleted
		HAL034098	B. WING		08	R /05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
SALEM T	ERRACE		D SALISBURY ROANN SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D935	she had completed t -The facility should h file. Refer to interview wit 08/04/22 at 5:35pm. Refer to telephone in Care Coordinator (Refer to telephone in Administrator on 08/05/ Refer to telephone in accountant on 08/05/ Refer to telephone in business office mana 3:09pm. Interview with the fac	I not remember exactly when he training and her MA exam. have her training record on th the facility's nurse on herview with the Resident CC) on 08/05/22 at 1:23pm. herview with the 05/22 at 1:33pm.	D935		Υ)	
	over one month. -She was still new an trainings that were re -She had completed skills checklists but si the checklist forms. -She did not document sure what staff had co -She had also provide MAs but not all the M -She did not print the training, but she had -If the MA did not hav result, then she had r -To her knowledge sh	some medication clinical topped when she ran out of nt the training and was not ompleted the training. ed 15-hour training for some As. certificate for the 15-hour				

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FORM APPENDIAD

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	a Health Service Requ					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		()(3) DATE COMP	SURVEY LETED
		HAL034098	B. WING			R 05/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
OAL ERA TO		2609 01	D SALISBURY RO	AD		
SALEM TE		WINSTO	ON 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
D935	Continued From page	99	D935			
	medication atde exam	ination.				
	Coordinator (RCC) on revealed: -When MAs were hire consisted of starting th working with another I -The nurse was suppor before they started tra- cart. -The MA was verbally previous medication a verification of taking a alde examination. -The business office w MAs hired had certifice -The business office h business office manag 2022 or early June 200 -She did not know who	d, the training provided nem out on the first shift, MA for training. used to check the MA off ining on the medication asked to submit any ide training, including nd passing the medication was responsible for ensuring ation as a medication aide. ad been without a full-time per (BOM) since late May 22.				
	Telephone interview w 08/05/22 at 1:33pm re	ith the Administrator on vealed:				
	-The business office w sure all personnel reco	as responsible for making ords were complete.				
	-The previous BOM wa	as responsible for making s included the required				
		it sometime in June 2022, iness office two to three				
	days per week.	tant started helping the				
		he end of June 2022 or				
	-The facility's nurse wa	as supposed to provide t she had only worked at ver one month				
	-She thought the requi th Service Regulation					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	(22) MULTIFLE C A. BUILDING:	CHETRUCTION		(A3) DATE SURVEY COMPLETED	
· · · · ·		HAL034098	B. WING		R 08/05/2022		
Ame of P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
ALEM TI	ERRACE		D SALISBURY RO				
(X4) ID	CIRRINATIVO		N SALEM, NC 271	27	-		
PREFIX TAG	EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO FICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO DRY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THI DEFICIENCY)		TION SHOULD BE COMP THE APPROPRIATE DAT			
D935	Continued From pag	e 100	D935				
	documents had not b turnover in the busing	een completed due to the ess office.					
	Telephone interview	with the cornorate		·			
	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 completed.						
	She started working at the facility in July 2022 trying to help with the paperwork.		1				
	-Two 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 initial	ly went to the corporate					
	office, and then came to the business office.						
	-When she was the Bo	OM she noticed the gh several different hands,					
	and sometimes never	made it to her					
	-Obtaining the MA trai						
	responsibility, but she	had to make sure the					
1	paperwork was availal	ble in the record.					
1	The facility failed to en	sure four staff who worked					
i	as MAs and administe	red medications to					
		ed the medication aide					
	training and competen						
	administering medications including the 5, 10, or						
F	5 hour medication aide training course (A, D and						
	E); the clinical skills checklist (B); and had proof of prior employment verification during the						
F	previous 24 months (A	, B, D and E) resulting in					
F	ossible medication en	rors. The facility's failure					
		health, satety, and welfare	1				
	of the residents and co	nstitutes a Type B					
I V	/iolation.		1				

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	7 OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER.			(X3) DATE SURVEY COMPLETED		
	·····	HAL034098	B. WING		R 08/05/2022		
MAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE	15 15 16 16 1 6		
			D SALISBURY F				
Salem T	ERRACE		N SALEM, NC 2				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	61 F		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE		
D935	Continued From page	a 101	D935				
	The facility provided accordance with G.S this violation.	a plan of protection in . 131D-34 on 08/05/22 for		•			
	Refer to Tag 358, 10/ Medication Administr	NCAC 13F .1004(a) atlon.					
				D 992 G.S. 131D-45 Examination an	3		
	CORRECTION DATE VIOLATION SHALL N 20, 2022.	FOR THE TYPE B IOT EXCEED SEPTEMBER		screening			
	20, 2022.			All staff has had a drug test scre	ening. q.21.2		
D992	G.S.§ 131D-45 (a) E>	amination and screening	D992	All staff results were negative.	ening. 9-21-2 -121050		
	the prosence of contr for applicants for employ icensed under this Ar conditioned on the ap examination and scre substances. The exam- be conducted in accor Chapter 95 of the Ger procedure that utilizes may be used for the e of applicants and may the results of the appl screening indicate the substance, the adult of the applicant unless the the adult care home w applicant's prescribing controlled substance in	ment by an adult care home ticle to an applicant is plicant's consent to an ening for controlled nination and screening shall dance with Article 20 of heral Statutes. A screening a single-use test device xamination and screening be administered on-site. If cant's examination and presence of a controlled are home shall not employ he applicant first provides to ritten verification from the physician that every		All potential new hires will be screened for the presence of con substances prior to attending or Upon a job offer being made, th Business Office Manager will p the paperwork for drug and alco to the potential employee. Upon results showing no drugs or alco orientation will be scheduled for employee. If there are positive r are the result of prescription me the potential employee will be g opportunity to get physician ver will not affect their potential em The Business Office Manager w the New Hire Checklist to ensur screening is completed and recor compliance.	new hires will be the presence of controlled tior to attending crientation. ffer being made, the fice Manager will provide k for drug and alcohol screening al employee. Upon receipt of ng no drugs or alcohol, ill be scheduled for the new there are positive results that of prescription medications, employee will be given the o get physician verification and t their potential employment. Office Manager will utilize Checklist to ensure that the		
	physician to treat the a psychological conditio			Attachment B: New Hire Chec.	klist		

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STATEMENT	<u>I Health Service Requ</u> FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: HAL034098	(X2) MULTIPLE C	CIISTRUCTION		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
			D SALISBURY RO			
SALEM T	ERRACE		ON SALEM, NC 271			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D992	Continued From page substance, the presci and the condition for prescribed. If the rest employee's examinat the presence of a cor care home may requi and screening to veril examination and scree This Rule is not met Based on interviews a facility failed to ensur screening for the pres substances was comp staff (Staff A and Staff The findings are: 1. Review of Staff A's (PCA)/medication aid revealed: -Staff A was hired on -There was no docurr a drug screening. Attempted telephone 08/05/22 at 1:38pm w Refer to telephone int	 a 102 nibed dosage and frequency, which the substance is ult of an applicant's or ion and screening indicates introlled substance, the adult re a second examination fy the results of the prior eening. as evidenced by: and record reviews, the e an examination and sence of controlled pleted for 2 of 6 sampled f E) prior to hire. a personal care aide (MA) personnel record 04/20/22. nentation Staff A completed interview with Staff A on vas unsuccessful. terview with the Resident CC) on 08/05/22 at 1:23pm. 	D992			
Division of He	Refer to telephone int accountant on 08/05/2	terview with the corporate 22 at 3:00pm. , medication aide (MA), aaled:				

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STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL:ER/CLIA IDENTIFICATION NUMBER:	(22) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034098	B. WING			R /05/2022
			ADDRESS, CITY, STATE	7/8 0005		
NAME OF Pr	ROVIDER OR SUPPLIER		D SALISBURY ROA			
SALEM TE	RRACE		N SALEM, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	(X5) COMPLET DATE
D992	Continued From pa	ge 103	D992		na tata da a	
1	-There was no drug screen completed upon hire available for review in her personnel record.					
	10:15am revealed:	v with Staff E оп 08/05/22 at				
	through an agency l	g at the facility as a MA in June 2022. full-time position of Special				
		SCUC) on 07/26/22 and				
-	drug screen betwee	completing a pre-employment in her hire date of 07/26/22 f 08/01/22 but could not				
		t day. the result of her drug test in . she did not know if it would				
		since she was so new.				
		nterview with the Resident RCC) on 08/05/22 at 1:23pm.				
	Refer to telephone i Administrator on 08					
	Refer to telephone i accountant on 08/01	nterview with the corporate 5/22 at 3:00pm.				
		with the Resident Care on 08/05/22 at 1:23pm				
	-When new hires ca	me to the facility for an lionist gave them paperwork				
	-The new hires were	e given a form to complete e to a lab to have the drug				
		ame back by email to the ager (BOM).				
	Telephone interview	with the Administrator on				
<u> </u>	Ith Service Regulation	an 1919-1919 - 10 m				

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		(X1) PROVIDER/SUPPLIER/CLI/. IDENTIFICATION NUMBER:	TION NUMBER: A. BUILDING:		(X3) DATE COME	SURVEY
		HAL034098			R 08/05/2	
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STATE	. ZIP CODE		
SALEM TI	ERRACE	2609 OL	D SALISBURY ROA N SALEM, NC 271	\D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) Complet Date
D992	08/05/22 at 1:33pm r -The business office to drug screens were cc -If an employee drug the BOM was respon- the drug screen. -She thought the drug turnover in the busine -She had not checked identify missing pape Telephone interview to accountant on 08/05/ -She started helping to but had not completer -Two weeks ago, she	evealed: was responsible for ensuring ompleted. screen was not completed sible for checking to obtain g screen was missed due the ess office. d personnel records to rwork. with the corporate 22 at 3:00pm revealed: the facility out in July 2022 d personnel records. started working on t was unaware of employees	D992			

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Attachments

Attachment A: Salem Terrace TB Test Policy & Procedure

Attachment B: New Hire Checklist

Attachment C: LHPS For Staff

Attachment D: Fall Prevention Protocol

Attachment E: Signature Sheet for Med Aide Training

Attachment F: Updated Diet Order Sheet

Attachment G: Therapeutic Diet Spreadsheet

Attachment H: Supplement Spreadsheet

Attachment I: Cart Audit Schedule

Attachment J: Medication Confirmation Procedure

Attachment K: Medipack Pharmacy, LLC/Reorder Sheet

Attachment L: (a) Physician Notification of Resident's Refusal of Medications or Dosage Omissions P&P
(b) Physician Notification of Resident's Refusal of Medications or Dosage Omissions Form

Attachment M: Orientation Acknowledgement

Tuberculosis Testing Policy & Procedures

Policy

All admitting Residents and new employees, that comes in contact with residents, must be screened for tuberculosis in compliance with control measures adopted by the Commission for Health Services. Each staff member is required to have a two-step test for tuberculosis or a chest x-ray that is documented for no active TB.

Procedure

- In accordance with applicable state regulations, all employees are required to provide Brookstone of Clemmons proof of negative TB testing within the 12 months prior to or upon beginning employment at Brookstone of Clemmons.
- In accordance with applicable state regulations, all admitting Residents are required to provide Brookstone of Clemmons proof of negative TB testing prior to admission.
- A second test at no charge to the staff member or resident will be provided upon hire or admission to complete the two-step testing. Test will be read within 48 – 72 hours.
- The RN administering and/or reading the results of the PPD will record the results. The
 results will be maintained in the Staff member's employment file to be located in the
 Administrator's office or in the Resident's health record to be maintained by the
 Resident Care Department.
- TB testing will be administered upon hire or admission and read within 48 72 hours. A second test will be given within 7-21 days to complete 2 step testing. Test will be read with 48 72 hours.
- If an employee or resident has tested positive previously for TB through use of a PPD, he/she will be required to provide Brookstone of Clemmons with a copy of a chest xray showing documentation that the employee or resident is negative for TB. Upon hire or admission, a screening will be done using the TB Questionnaire and the completed Questionnaire will be placed into the employees employment file or the resident's health record. A subsequent screening will be done if the employee or resident becomes symptomatic.
- All TB tests will be administered by an RN or LPN with RN oversight.
 - The TB serum will be kept refrigerated and will only be used when within the date allowed. The vial will be initialed and dated when opened for the first time. The nurse will cleanse the vial top with alcohol prior to drawing up the serum.
 - The nurse administering will cleanse the forearm of the recipient with alcohol and allow the spot to dry prior to administering.
 - Intradermal technique will be used in administration. The dose of 0.1 will be used.
- Staff with positive results will be referred to their primary care physician or the health department to obtain information on acquiring a chest x-ray. The staff member may not attend work until a clear bill of health is documented and turned in to the Executive Director

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New Hire Checklist

Employee Name	Position
Date of Birth	Hire Date
ALL EMPLOYEES Orientation Acknowledgement	
Job Description (s)	
W-4	
NC 4	
Employee Information Sheet	
Direct Deposit	
Copy of Drivers License/Picture ID – (Expires)	(State)
Copy of Social Security Card	
1-9	
E-verify Verification	
Time System P&P	
Healthcare Registry Check	
Criminal Background Information/Disclosure	
Release Form	
Criminal Background Confirmation	
Signed Application	
Authorization & Release	<u></u>
Telephone Reference Check Sheet	. <u></u>
Team Member Handbook Acknowledgement	a .
Team Member Emergency Notification Form	
Disaster Plan Review Acknowledgement	
Resident Rights	
Bad Weather Policy & Procedure	
Infection Control Training	
Diabetic Training	
6 Hour Dementia Orientation Date Completed	
20 Hour Dementia Training Certificate	
Dietary Orientation or Assessment Orientation NEW HIRE CHECKLIST	Updated 8-2022

HEALTH FILE ON ALL EMPLOYEES

HEP B Acceptance/Declination		accept	decline
Two Step TB	Dates	<u> </u>	,
Pre-Employment Drug Test (Effective 10/01/2013)			
Employee Health Policy Agreement (Dietary Employees ONLY)			
Servesafe Certification (Dictary Employees ONLY)		<u> </u>	
RESIDENT CARE			
Personal Care Assistant/ CNA			
PCA or CNA Certificate or Listing by N (or name on Health Care Registry verifying CNA Training)	ame on Registry		
Skills Checklist		<u> </u>	
LHP Checklist			
PCA Agreement			
CPR Certification (good for 2 yrs.)	0	. <u> </u>	
Med. Techs			
PCA or CNA Certificate or Listing by N (or name on Health Care Registry verifying CNA Training)	lame on Registry		
Skills Checklist			
LHP Checklist		. <u> </u>	
CPR Certification (good for 2 years)	Expiration Date		
Job Description for MA/SIC (Indicate w	/hich one)	<u> </u>	
MA License or proof of license			
Medication Adm. Clinical Skills Checklist (RN signs off before they work Mcd. Cart)			
Facility Med. Aide Verification (Verification worked as Med Aide in last 24 Months Form (effective 10/01/2013)		
Med. Aide 15-hour Training Certificate (15 hr. class and Mcd Aide test needed if Facility Med. Aide	c Verification. Not provide	d (effective 10/01/2013)	
Motor Vehicles Consent			

Updated 8-2022

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Licensed Health Professional Support Skills Checklist

Willacksonen/ C

Team Member Name:

Position:

Hire Date:

	Satisfactory	Instructor's	
Skill/Competency	Completion Date	Initials	Comments
PT or OT			
Application/Removal of Prosthetic			
Devices			
	[
Ambulation using Assistive Devices			
Range of Motion Exercises			
Respiratory Therapy			
Oxygen Administration and	[
Monitoring (controls, tubing, &			
cleaning)			
Medication Administration		<u> </u>	
Collecting and Testing of FSBS			
Insulin Injection (measure, SQ inj.,			
abnormal blood sugars)			
Inhalation of Medication by machine			
(nebulizer treatments)			
Enemas, Suppositories, and Vaginal Douches			
Transfers			
Transfering of Semi or Non			
ambulatory residents (bed to chair,	1		
chair to commode			
Body Alignment and Positioning			
Other			
Applying/Removong Ace bandages,			
TED hose, & Binders			
Care for Pressure Ulcers			
Clean Dressing Changes Urinary Catheter Care (positioning,			
securing, cleaning, and emptying)			
Maintaining Intake and Output Feeding Techniques for Swallowing			
Problems			
Care of well established Colostomy			
or lieostomy			
		. (t	
Moniotoring of continous positive ai	r]		1
pressure devices (CPAP & BIPAP			
Application of Prescribed Heat			
Therapy	<u> </u>		
Alternative Care Practices to Restraint Use	1		
Nestiduit Ose			

Team Member Signature:

Date:_____

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Insturctor's Initials/Signature:

Date:_____

LHPS Shills

Fall Intervention Drotocol

1. Investigation etiology of fall. Assess environment for hazards and correct.

SIC/MT is to take immediate action in correcting any environmental hazards.

المرتبقة والتعويم وألتك تنتيك ومنواق أبجا والمار وتتريج إوليها والمحافظ

QHachman 1 1)

 Obtain vital signs - checking BP lying, sitting and standing to assess for postural hypotension.

Document vitals on the Resident Incident/Accident Report

- 3. Notify physician as defined on Resident Incident/Accident Report
- 4. Notify physician for a review of medications and evaluation for repeat falls. *To be done by RCD or Designee*
- Refer to Home Health for PT evaluation for strengthening and balance training if a fall while ambulating.
 To be done by RCD or Designee
- If a fall from wheelchair, refer to Home Health for PT evaluation for balance training and positioning.
 To be done by RCD or Designee
 - Do not put resident back into the wheelchair without some changes to ensure safety.
- 7. If falling from bed, initiate a low bed situation with mattress on floor and matt beside it.

Place bed with one side against the wall.

This should be done immediately. Do not put a resident who has fallen out of bed back into bed without making these changes.

Putting something up against the bed is not an acceptable solution.

- 8. Alarms obtained for wheelchair and bed. Check the alarms for working condition whenever moving resident.
- 9. Encourage staff to anticipate needs of resident and act proactively before an incident occurs.
- 10. Anyone admitting with notation or suspicion of fall risk will be automatically referred to Home Health for evaluation.

To be done by RCD or Designee

11. A "High Fall Risk" List of Residents will be kept posted in the AL Medication Room.
 SCU Resident List will be posted in the SCU office.
 If you identify a resident that is not on the list but might benefit from a Fall Risk
 Assessment, it is your responsibility to alert the SIC so that it can be documented on and

followed up by the RCD.

12. Increased resident rounds will be assigned by the RCD/SCC if indicated for repeat falls.

Resident Incident/A	Accident Repo	ort			Page (1 of :	3 - Fall	Packet
Resident Name:				-				
Date of Incident:		Time:	AM	PM	Shift	1st	2nd	3rd
Type of Incident: ((Check all that	apply)			******************			
Fall			Sudden illn	ess			Elopem	ient
Skin Tear			Disruptive	Behavior			Equip.	Related
Alleged Al	ouse from Emp	loyee			81) 201		Alleged	Abuse
Other (de	scribe)						from re	esident
Describe Incident:	***************************************		····	····				
- 22 X	3							establish a a b
	-,-							
Describe the action	taken in resp	onse to t	he incident:					
						373		
Location of Incident								
Resident			Resident E	athroom				Hallway
Living Ro		•	– Common I		/Bath	1		Dining Rm
Activity R		2	Outdoors	-				
	ises (describe	1	-					
Other (de		<u> </u>						<u> </u>
							10	
Vital Signs:	B/P	/	Pulse:		Respir	atio	ns:	
If fall - document B/	P Lying/Sittin	g/Standin	g	в/Р		_	B/P	/
Was EMS called:	YES NO	Was resid	dent transpo	rted to ho	ospital		YES N	0
Physician Notified: _				Date:			Time:	
Family Member Not	ified:			Date:			Time: _	
Licensure Agency No	otified:			Date:)		Time: _	
Staff Completing Re	port:			Date:			Time: _	
Resident Care Direct	or Signature:	. <u> </u>						
Executive Director S	ignature:							

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II Investigation			
esident Name		Room #	
jury Discovered AM PM pe of Injury (check all that apply) Scratch Abrasion Other (<i>explain</i>) escribe Injury (size, color, appearance, b		Bruising	Skin Tear Redness
esident Interview (check all that apply)	Interviewable	Noi	n-Interviewable
1. Date of Injury 2. How did injury occurFall Was	Time of Injury Fell/Hit against hit by	AM PM	
3. Location that injury occurred (check a Shower/bath Dinir		Hallw Activity Room	
4. Witnesses to injury (name & position)			
TAFF INTERVIEW (name & position)			
1. Description of Resident at time of disc			
 Description of Resident at time of disc 2. Description of Resident at last observation 	ation prior to injury		
	ation prior to injury Ill that apply) ng Area	Hallway Activity Room	Resident Room Outside
 Description of Resident at time of disc Description of Resident at last observation Location that injury occurred (check a	ation prior to injury III that apply) ng Area t apply) Prolonged Use of trollable movements	Hallway Activity Room Recent Injection Aspirin Rec Resident thras Was hit by	Resident Room Outside Recent Venipuncture cent Fall hes about
 Description of Resident at time of disc Description of Resident at last observation Location that injury occurred (check a	ation prior to injury III that apply) ng Area t apply) Prolonged Use of trollable movements brasion, Redness or Swel	Hallway Activity Room Recent Injection Aspirin Rec Resident thras Was hit by ling (check all that ap Self i	Resident Room Outside Recent Venipuncture tent Fall hes about ply) nflicted
 Description of Resident at time of disc Description of Resident at last observation Location that injury occurred (check a	ation prior to injury III that apply) ng Area t apply) Prolonged Use of trollable movements brasion, Redness or Swel brasion, Redness or Swel brasion, Redness or Swel 	Hallway Activity Room Recent Injection AspirinRecident thrasResident thrasWas hit by ling (check all that apSelf iSelf i	Resident Room Outside Recent Venipuncture rent Fall hes about ply) nflicted
 Description of Resident at time of disc Description of Resident at last observation Location that injury occurred (check a	ation prior to injury III that apply) ng Area t apply) Prolonged Use of trollable movements brasion, Redness or Swel brasion, Redness or Swel brasion, Redness or Swel 	Hallway Activity Room Recent Injection FAspirinRec Resident thras Was hit by ling (check all that ap Self i Self i	Resident Room Outside Recent Venipuncture tent Fall hes about ply) nflicted

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24 Hour Post Fall Checklist

Resident Name:

Date & Time of Fall:

1. Always keep this 24-Hour Post Fall Checklist with the 24-Hour Report Book until completion.

2. The SIC must make entries in the resident care notes a minimum of every 8 hours post fall for 24 hours.

3. Circle Y or N each 8, 16, and 24 hours and follow the directions.

4. The 24-Hour Post Fall Checklist will be filed with the Accident form and the post fall checklist.

8-Hour Documentatic Date: Time:

16-Hour Documentati Date: Time:

24-Hour Documentati Date: Time:

					6.5
1. Does the resident have new or unusual complaints of	8 Hou	rs	16 Hours	24 Ho	urs
pain/discomfort?	Y	N	Y N	Y	N
If yes: Have the SIC assess or call the doctor for	Initials:		Initials:	Initials	
direction and notify the family or responsible party.					
Document these contacts in the resident care notes.	5				
If no: Document Post Fall check-up with date/time in					
resident care notes					
2. Does the resident have a change in walking ability	8 Hou	rs	16 Hours	24 Ho	urs
(i. e. limp)?	Y	N	Y N	Y	Ν
If yes: Have the SIC assess or call the doctor for	Initials:	5	Initials:	Initials	:
direction and notify the family or responsible party.					
Document these contacts in the resident care notes.					
If no: Document Post Fall check-up with date/time in	1				
resident care notes					
	8 Hou	re	16 Hours	24 Ho	MIRS
3. Does the resident have any outward rotation of the leg(s) or	Y	N	Y N	Y	N
arm(s)? If yes: Have the SIC assess if or call the doctor for	Initials:		Initials:	Initials	
direction and notify the family or responsible party. Document			A Heldisi		-
these contacts in the resident care notes.					
If no: Document Post Fall check-up with date/time in resident					
care notes	L				
4. Does the resident have increased drowsiness?	8 Hou	rs	16 Hours	24 Ho	urs
If yes: Have the SIC assess or call the doctor for	Initials:	17 14 13	Initials:	Initials	:
direction and notify the family or responsible party. Document					
these contacts in the resident care notes.				1	
If no: Document Post Fall check-up with date/time in resident					
care notes				L	
5. Does the resident have trouble or is reluctant to get out of	8 Hou	rs	16 Hours	24 Ho	ours
bed?	Y	Ν	Y N	Y	N
If yes: Have the SIC assess or call the doctor for	Initials:		Initials:	Initials	:
direction and notify the family or responsible party. Document					
these contacts in the resident care notes.	1			1	
If no: Document Post Fall check-up with date/time in resident	1			1	
care notes			1		

Investigation of	Bruises, S	ikin Tear	s, Scratches, ETC	*	
To Determine Etiology (or Origin of li	njury			
Resident Name				Room #	
Injury Discovered		AM/PM	By: (name & position)_		
Type of Injury (Check all	that apply)	•	Bruising		Skin Tear
	Abrasion		Scratch	Swelling	- Redness
•	Other	Explain:	•• •••••		
Describe injury (Color,	size, appeara	ince, bieedi	ng, etc.)		
Resident Interview (Ch	eck all that a	ipply)		n - 5	
	Interview al	ble	Non- Inter	view able	
1. Date of Injury					
2. How did injury occur	?	-			
	Fall	0 N	Fell/Hit Against		
	Was hit by	•			
10 -00000-000	Other (expl	əin)			
3. Location that injury	- occurred (che	eck all that a	pply).		Res. Room
	Hallway		Dining Room		Shower/Bath
	Activity Rm		Outside		-
	Other - plea	se identify	-		
4. Witness to injury (na	- ame & Positio	on).			
Staff Interview (Name &					
1. Description of Reside		f discovery			
tana tamanaking Jamestekan na si					
2. Description of Reside	ent at last ob	servation pr	ior to injury.		
3. Location that injury	occurred (che	eck all that a	pply).		
	Hallway		Dining Room		_Shower/Bath
	Activity Rm		Outside		_Res. Room
	Other - plea	se identify			
4. If investigating a Bru	ise (answer/d	check all tha	t apply).		Recent Injection
Recent Ven	ipuncture	0.000	Resident on Anticoagu	llant	Recent Fall
Prolonged	Aspirin use		Res. has spastic/uncor	ntrollable mov	rements
Resident th	rashes abou	t	Was hit by	/:	<u> </u>
Self - Inflict	ed		Fell/Hit area on:	-	
Other (expl	ain):		-		
5. If investigating a Skir	n Tear, Scrato	h, Abrasion	Redness or Swelling (a	nswer/check a	all that apply):
					_Self-Inflicted
Other (expl	ain):				
	havior (expla	ain):			······
6. Notifications (enter	1000		pplies:	Physician	R/P
Supervisor			y Personnel		Other (explain)
7. Note recommendati				ack of page.	
8. Date Care Plan Revis				102 (15	

Investigation of Bruises, Skin Tears, Scratches, ETC. QI Incident Management

7-2009				t Fall QI & A	idual Residen	individual Resident Fall QI Individual Resident Fall QI & A QI Incident Management	individual Resident Fall Q QI Incident Management	Individu QI Incīdi
<u>O</u> Other	Z Bruise/Hematoma B Burn	ansfer	 Fall during transfer Other 					
<u>D</u> Death		Fall from toilet/shower chair	4. Fall from toil		h. Other		Ŷ	d. Hallway
C Change in level of consciousness		-	3. Fall from bed		g. Outside		Shower/Tub Room	c. Showe
<u>H</u> Head Trauma	vital signs	Fall from wheelchair/Geri chair	2. Fall from whe		f. Lobby		0m	b. Bathroom
<u>F</u> Fracture	No apparent injuries	bulating	1. Fall while ambulating	-	e. Dining Room		nt Room	a. Resident Room
通知語は語言の意思に思いていた。	Resulticode:		Type code	and the second			Location Coder	Locatio
						2		
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								T
							- (
	Repeat Fall							_
Comments	By MD for	YES/NO	(See Code)					*******
Completion/	Documentation	Last 180 Days	Outcome	(See Code)	Involved	(See Code)	i	
Follow up/	Medical Record	Other Falls	Resident	Type	Restraints	location	Time	Date
Room:		Admit Date:					t Name:	Resident Name:
						in binder	To be maintained in binder	To be m
					QI & A Log	Individual Resident Fall QI & A Log	lual Res	Individ

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Resident Other Date Time Location Type Results Follow Up/Completion/Comments Name Fall Last 180 Days (See Code) (See Code) (See Code) (See Code) (See Code) YES/NO YES/NO Image: Code Image: Code <t< th=""></t<>
Fall Last 180 Days YES/NO See Code) (See Code) (See Code) YES/NO
180 Days YES/NO
YES/NO
Location Code:
a. Resident Room e. Dining Room 1. Fall while ambulating No apparent injuries E Fracture
b. Bathroom f. Lobby 2. Fall from wheelchair/Geri chair <u>V</u> Change in vital signs <u>H</u> Head Trauma
d. Hallway h. Other 4. Fall from toilet/shower chair <u>L</u> laceration <u>D</u> veath 5. Fall during transfer <u>Z</u> Bruise/Hematoma <u>O</u> Other
6. Other Brunn
Kesident QI A Log QI Incident Management

Resident Fall QI & A Log

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7/2009

Facility:		Station:		- - -	Month Ending:	ng:	l	
- 1977年春日の「大学の「大学の大学の大学の大学の大学の大学の大学の大学の大学の大学の大学の大学の大学の大			Description		1.11		Shift	
ate a Room A Fast Name A	Bruise	me	Skin Tear	Med Error	Other (State)	Contributing Factors AM PM NOCS	M PM	Nocs
	-							
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Incident Report QI/CQI Log

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Incident Report QI/CQI Log QI Incident Management

7-2009

Med Tech Training

Topics

Fall Prevention Protocol

Diet/Supplement Spreadsheets

Medication Confirmation Procedure

Medication Re-Order Process

Medication Administration Review

Physician Notification of Resident's Refusal of Medication or Dosage Omission P&P and Form

Obtaining Medication Order Discontinue Order when dosages change.

PRINT	SIGNATURE

CP (Contractor C

Salem Terrace Diet Order Sheet

Resident Name DOB Physician

The following are the only diets provided by Salem Terrace. Please indicate your choice for the resident.

DIET TYPE	Check of	16				
	Regular	<u>, and a second second</u>	<u></u>			
	Ciples .	No Added Salt				
·····	No Con	centrated Sweets				
Special Prep	aration	Check any that ap	ply			
	Ground					
	Mechar	nical Soft				
	Choppe	ed				
	Pureed					
	Thicker	ned Liquids			a .	
		_Honey Consiste	ncy	Nector	Consiste	ency
						
Other Instruc		Check any that ap	the second s			
Ma	y have 4	ounces of wine or				-ioma
	c	_Daily	Weekly	the second s	cial occa	1910118
Ma	y have a 1	regular diet on ho	lidays and	special occasions	6.	
Ma	y use a sa	alt substitute			12	
	25025					
Fin	ger foods			As needed		
		For all foods	<u></u>	_As needed		
Doi	uble port			NTI	4	
		At all meals		When requested	4	
Ho	use Supp			0 doiler		3x daily
	<u> </u>	_1 x daily	 	_2 x daily		- JA daily
		4x daily		As snacks betw	roan meal	e
		With meals				
		Supplement Sh	ake	Magic		22-Sep
					updated	zz-sep

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Diet Order Spread Sheet Updated

For other information see the Resident Diet Order Sheet

Necto Tion.

				 	 	 	 	,	 	T	t	7	T	<u> </u>	1
Honey of Nector	Thickened	Liquid	H or N												
	Purced														
	Chopped														
	Mechanical	Soft													
	Ground														
	Regular/ No No Concentrated Ground Mechanical Chopped Pureed Thickened	Sweets													
	Regular/ No	Added Salt													
	Regular)													
		Resident Name													

affactionent G.

Officion end th

Supplement Spread Sheet Updated__

ay		<u> </u>				 					
Times per Day											
In Between Meals											
With Meals											
Shake											
Magic Cup											
Resident Name											

aldachment I

Cart Audits

Monday

500 Hall (1st Shift)

112A-114A

500 Hall (2nd Shift) 500P-502A

Wednesday

500 Hall (1st Shift)

503B-506B

500 Hall (2nd Shift) 507A-514B

Cart audits must be done weekly and turned in to your RCC. If meds can not be ordered through EMAR, please pull label off pack and place on Med Order Form and fax to pharmacy. Wait for confirmation and attach to order form then place in RCC folder

Gitcherhend J

Medication Confirmation Procedure

When reordering medications outside of the EMAR System, the following steps will be taken.

- 1. The Med Tech will fax the order to the pharmacy.
- Med Tech will attach the fax confirmation to the order and place the order in the coordinator's mailbox.
- 3. The coordinator or designee will confirm delivery of the medication.
- 4. If the medication has not been delivered, the coordinator or designee will contact the pharmacy to see when the medication will be delivered.
- 5. The coordinator will document any obstacles to delivery in the resident record.

Fax: 1-800-524-7052 Medipack	Medipack S PHARMACY SERVICE - SOLUTIONS - SUCCESS Pharmacy, LLC	Fax: 1-336-773-1217 C/Reorders
Facility:		axed (Initial):
	n de fait d'Al Marin (1996) (1996) gans gap air an gar gan an suair gadh agus gap an an gan an ann an ann an an	
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Carlachonsent (A) Physician Notification of Residents Refusal of Medications or Dosage Omissions Policy & Procedure

Policy

All medication that is refused by residents and/or doses that are omitted will be reported to the physician to ensure that all healthcare providers are kept informed as to the health and wellbeing of their patients.

Procedure

- 1. Based on the MAR Review, all occurrences of omitted or refused medications will be reported to the physician based on the following criteria.
 - · One dose of Coumadin missed or refused
 - One dose of insulin missed or refused
 - 3 doses of any other medication not consecutive within a 30 day period.
- 2. The information will be reported to the physicians utilizing the Physician Notification of Resident's Refusal of Medications or Dosage Omissions Form. The completed form will be faxed to the physician. Once faxed, the faxed copy will be maintained in a notebook along with the confirmation of faxing until the form is returned with the physician's signature. The signed fax will be placed in the resident chart and the copy with the fax confirmation will be destroyed.

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Salem Terrace Assisted Living 2609 Old Salisbury Road, Winston Salem, NC 27103 336-785-1935 FAX: 336-785-2735

Physicians Notification of Resident's Refusal of Medications or Dosage Omissions.							
Please review& sign to ackn	owledge information.	Please fax back to facility.					
Physician:							
Resident Name:	has refused or missed						
the following medications or trea	atments:						
Indicate Refusal or Omission	Date	Medication or Treatment					
		······					
	,						
		ταν τη					
Acknowledged							
Instructions or Or	der Changes						
,··	<u> </u>						
		······································					
· · · · · · · · · · · · · · · · · · ·		······································					
Physician Signature:		Date:					

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diving a solution of a sector of sea black much have completed of facility employment, paperwork, training, supplied all Training Certificates and /or licenses, have proof of negative. TB and have a negative drug screening.

Welcome & Introductions

attachment M.

History & Mission

Tour of Building and Grounds

Time clock operation, Break room & OSHA posters Staff smoking areas, Med Room which contains Infection Control Supplies, Locations of MSDS books, Exit Doors Alarms; Locks; Training Schedules

Handbook/Policy Review

Infection Control Training

Diabetic Training

Restraint Training

Mental Health Intervention Review

Management of physical aggression or assault by a resident. Mental Health Intervention techniques.

Resident Rights

Resident Elopement Policy & Procedure

Identification & Supervision of Wandering Resident

Handling of Resident Grievances

Disaster/Fire Safety Review

Staff Responsibilities

Supervised Smoking; Mandatory In service Training; Resident Security

Housekeeping Chemical Review

Skills Checklist/LHPS Checklist

My orientation has been completed per this schedule.

Employee Signature

Date

Witness

Orientation Acknowledgement