CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONSTRUCTION	(X3) DATE SURY COMPLETE	
	•	345092	B. WING		05/12	
NAME OF PR	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
GRACE H	EALTHCARE OF WINSTO	ON SALEM		1900 W 1ST STREET		
0.0.02.11				WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 166 SS=D	RESOLVE GRIEVAN		F 16	This Plan of Correction is submitted	as required :	43/11
	facility to resolve griev	ht to prompt efforts by the vances the resident may with respect to the behavior		under State and Federal law. The faci submission of the Plan of Correction constitute an admission on the part of that the findings cited are accurate, the findings constitute a deficiency, or the	does not f the facility nat the at the scope	
	by: Based on observation interviews and record respond to repeated v (Residents #151) sarr	out getting assistance with		and severity determination is correct. facility makes no such admissions, the made in the Plan of Correction cannot against the facility in any subsequent administrative or civil proceeding. F-166	e statements of the used	
	6/2/10. The resident's include seizure disord and depression. The and depression include seizure disord and depression. The and depression indicated that resident assistance with all actimpaired range of morand lower extremities. During an interview and 12:20PM, Resident # oxygen tube in place, night stand with head the spoke with the unit workers (SW) about a dialing numbers on the	tivities of dally living. He had toon on both sides of upper		1 Resident # 151 was interviewed on the Administrator and 2 rd Floor Unit Cool identify and address any outstanding cool 100% audit on 5/25/2011 of resident cool been logged for the previous 30 days to they all have been resolved. A 100% audit on 6/3/. Director of Nursing, Unit Coordinators, Director, Social Service Director, and Stone of the ensure there are any undocumented of concerns are resolved. 3. An inservice for all licensed nurses nursing assistants and employees of the Services Department, Dietary Department Department, Maintenance and Houseke Department, Activities Department and office staff was conducted on 05/23/11 05/31/11 by the Director of Nursing, So Director and Staff Development Coordinators.	conducted a coems. conducted a coems that had ensure that dit of all 2011 by the Dietary coial Workers r unresolved and certified Social ent, Therapy eping administrative through coial Services nator and policy.	X0) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: IS1C11

Facility 10: 923570

If continuation sheet Page 1 of 45

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SUP COMPLET	
			A. BUI	LDING		ا ا	
		345092	B, WIN	IG			2/2011
	OVIDER OR SUPPLIER	ON SALEM		19	REET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE.
F 166	The staff was only allo on and start the computer on and start the computerezes he needed as computer. He was told assist with the computer and feels like. In order to go the computer he has to staff assistance. The staff assistance. The staff assistance. The staff assistance of the computer was to the to the computer was to the told the computer was to the told the computer was to the computer was to the computer to the computer to the computer to the computer equipment reach on a side table. Charged on top of the dangling on the floor. The has to constantly to administrator about hi and the computer, but as to the computer, but administrator about hi and the computer, but as to constantly to administrator about hi and the computer, but as to constantly to administrator about hi and the computer, but a computer was to constantly to a	ear piece for the phone. Dived to put the head piece outer. If the computer sistance with restarting the d that activity director could ter. He indicated that he y time of the day when he get staff assistance to use to use the call bell to get voice activation is set up at tre it goes to energy saving the would like to start using tetimes during the 4 hour vill shut down and needs to time was established with sit) at one point when he one call but it has not been a on 5/9/11 at 12:54 PM, whone rang four staff (2 ministrative staff #1 and #2) om passing out lunch. The ed standing in front of the phone rang, no staff inswer the call. The call light to pof bed in which it was out int to roll head to activate. was pushed away out of The cell phone was being light and the ear piece was Resident#151 indicated that	£	166	4. The Social Services Director will condof all concerns and comments received to are responded to and addressed. These audiconducted daily, five days per week for for twice weekly for four weeks then two time for two months and/or 100% compliance, will be brought to the monthly Quality As Performance Improvement Meeting by the Services Director and will be noted and the monthly Quality Assurance Performance Improvement Committee as and the plan will be revised to ensure concompliance. The Quality Assurance Committee as and the plan will be revised to ensure conconsists of the Administrator, the Director Staff Development Coordinator, MDS Co Admission Coordinator, Rehabilitation Medical Director, Director of Social Serv Environmental Services, Director of Main Dietary Manager, and the Activities Directors.	ensure they lits will be ur weeks, es a month The results surance e Social eviewed in uce dis identified et they arise linued mittee r of Nursing, ordinator, anager, ices, ntenance,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION	(X3) DATE SU COMPLET		
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F 166	During an interview of community support age the computer and cell because he did receive computer. The conceit that he wanted to call Activities staff would a he rang the call light to make a call. The coindicated the facility hand did an in-service indicated that she tho monitoring and assistiphone access. She acrecently received the needed assistance witurning on the computer or his cell plant when Resident #151 had cottimes regarding not go computer or his cell plant when Resident #151 rher regarding the cell completed a grievance information to her immediant Administrator, Unit MacDirector of Nurses (Do it was discussed during she did not know when or monitoring occurring grievance to the appropriate that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when her that the staff would assist the coff the activity staff the Resident #151 when the computer would assist the coff the activity staff the Resident #151 when the computer would assist the coff the activity staff the Resident #151 when the computer would assist the coff the activity staff the staff would assist the coff the activity sta	in 5/9/11 at 1:12PM, the gency indicated that she felt phone issue was resolved we the cell phone and the rn with the cell phone was his daughter after 8:00pm. assist during the day when to let them know he needed ommunity support staff and established a schedule with staff. She also uight the facility had been and the resident with the cell dided that the resident had computer and that he th applying the headset and the ent #151 indicated that implained to her several esting assistance with his mone. She indicated that reported these concerns to pone and the computer she included the indicated supervisor,	F	166				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION_	(X3) DATE SURVEY COMPLETED	
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F 166	assisting. However, s was being monitored she was also uncerta following the grievan Resident #151. She is the grievance. The facility concern r 10/28/10 were review documented as not r phone. Response was use phone as neede worker or activities a 11/19/10, documented and reposition and a The response was the call director of nursing cannot dial when he staff had a program resident. Review of a facility and the comm 2/16/11 and 2/22/11, concerns with getting assistants to use the staff reporting to resident with the use response from the facility and it did nothers. A scheduled to all nursing assistants documented concern phone number on cetthe resident was assistant was assista	sW) were responsible for she was uncertain how this or tracked. She added that ain whether the concern ce process was resolved for stated that she only fills out reports (grievance) dated wed. Concerns were eceiving assistance with cell as the resident was able to d with assistance from social	F 166			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG		
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	EALTHCARE OF WINST	ON SALEM		1900 W 1ST STREET		
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F 166	Continued From page phone between 8-9Pl Review of the in-servitiled provide care and only had 14 staff on so ther in-services presersident's assistance noted in-service was and neglect. Review of the MAR fr 2011, was inconsisted phone logs revealed a throughout the day. The whether calls were an location nursing staff assisted Resident #15. During an interview of unit manager (UM) include any nursing counit manager (UM) include any nursing couning the phone or conclude any nursing countries.	dice records dated 2/21/11, displayed assistance with cell phone ign in sheet. There were not bented regarding the with cell phone. The last dated 12/20/10 on abuse on January 2011-March in the with phone logs. The avariation of calls the log does not reveal inswered. The MAR was the documented when they 51 with phone calls. In 5/11/11 at 1:49PM, the dicated that a journal was esident #151 in which staff ocumenting anytime a for him. The journal would are and assistance with imputer. She added that the easo include this information. It she was the only person esident #151 cell phone did a telephone log was kept ed. She added that the voice activation, however he are to dial and answer the was available for the phone was available for the restated that all Resident use his modifed call light to needed assistance with	F 16			
	making calls. She ind	ioated that off the				1

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	JLTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
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F 166	nursing staff should 8-9pm of when they using the cell phone call light should be it placed on resident's should also be within further stated that se held with Resident # community support administrator on how concerns of not havithe phone or computissue to Resident #1 indicated that the prestaff would assist Revisits and upon requabsence of the active would also assist the was third back up. Se monitoring process the parties were following the phone or computing the further state activation was set up #151 that all he had and let staff know he however, if the nursing assisting other change, etc., then a She also indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone or computing an interview DON indicated that a support of the phone	ration record(MAR) the be documenting between assist Resident #151 with . She also indicated that the n reach, headset should be head daily and the computer n reach for access. She everal discussions had been 151 social workers, staff, DON, nursing staff and v to handle Resident #151 ng access/assistance with ter and how to resolve the	F	166			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPL	E CONSTRUCTION	(X3) DATE SUP	
TAND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLET	נט
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		345092	B. WIN			05/1:	2/2011
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F 166 SS=D	care/treatment that w Nursing was also exp the evening on the M provided for phone ca in-service was done w telephone concerns a to the resident. Revied dated 2/21/11, reveal were in-serviced. She floors. She indicated expected to assist wit She was uncertain wit consistently performing she added that the un responsible for ensur the resident at night, plan should reflect wit in meeting the needs of the call pattern and grievance log, the DC monitoring and chang ensure the resident waneeded. During an interview of Administrator indicated to assist the resident and the computer. The should be accessible should be following the indicated after review plan should be speciff designated staff woul and check status and of the grievance proce 483.15(e)(1) REASO OF NEEDS/PREFER	as provided to the resident. Decreted to document during AR of when assistance was alls. She added that an with nursing to address the and how to administer care by of the in-service record and 5 nursing staff and 9 NA and added that staff did rotate that the activity staff was the the calls during the day. The ther activity staff was and this process. In addition, and supervisor was and the care plan and DN added that the care plan and DN indicated some ples should have occurred to was getting the assistance of the resident and staff with using the telephone are telephone and computer for the resident and staff are established plan. He also of care plan that the care ic to his needs and do be assigned to monitor meet the resolution process edures. NABLE ACCOMMODATION		246			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	A. BUI	LDING		COMPLETE	
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	ROVIDER OR SUPPLIER	ON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104				
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F 246	Continued From page services in the facility accommodations of in preferences, except with individual or othe endangered. This REQUIREMENT by: Based on observation staff interview, the far assistance and modificate personal equipment (assist with maintaining for a physically challed #151). Resident #151 was refered for the properties of the resident or long term memory making problems. The resident #151 requires activities of daily livin motion on both sides extremities. The MDS Resident #151 also refered to the resident extremities. The MDS Resident #151 also refered to the resident extremities. The MDS Resident #151 also refered to the resident extremities. The MDS Resident #151 also refered to the resident extremities. The MDS Resident #151 also refered to the resident extremities.	with reasonable individual needs and when the health or safety of residents would be in a safety of residents would be in a safety of residents would be in a safety of resident interview and collity failed to provide for 1 sampled resident's cell phone and computer) to a safety of independence anged individual. (Resident eadmitted to the facility on a scumulative diagnoses seizure disorder, spasticity, ression. The quarterly MDS) dated 3/17/11, thad no short term memory problems or decision e MDS indicated that ad total assistance with all g. He had impaired range of of upper and lower is also indicated that		246	DEFICIENCY)	nd the I were Director of ras assisted e Activities ents that hine if any of ration utilizing ents were Director of dinator on d nursing rding the e been ith using e assistance he that they onducted by ce Director then three y for two esults will be they assurance will be the Director of will be ormance he director of will be ormance he director of will be	\$\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\
	extremities. The MDS also indicated that Resident #151 also needed assistance with socialization. Reviewed care plan dated 3/25/11, read in part: 1. Resident is at risk for decreased socialization due to being bed bound. Resident requires in-room visits with 1:1 interaction to maintain socialization and mental awareness. The goal				Quality Assurance Performance Improve Committee consists of the Administrator of Nursing, Staff Development Coordinator, Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director Social Services, Environmental Services Maintenance, Dietary Manager, and the Director.	tor, MDS or, Director of to, Director of	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				1	0. 0000 0001	
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E 246	Castianad Evam nage	o 9		246			[
F 246	Continued From page			240	'			
		actively participate with					-	
		cialization at least once						
		review. The approaches						
		resident being mindful of						
:		y of daily living, meals and						
		agazines, music, word					-	
•	, •	and/other activities for						
	1	olve reside resident in						
		events as tolerated, offer	1					
•		ctivities within dietary						
		opy of and to read the			L			
!		ites to the resident, offer to						
	1	dent's mail as desired, offer						
		pice, on 9/21/10: staff will						
		ng cell phone s time allow						
		lirect resident care of daily						
		uest assistance with laptop						
		ble to assist during weekly in				•		
		iff may also assist upon						
	request if time permit	ts not to interfere with daily						
	work task.							
	*							
		n on 5/9/11 the cell phone						
	ring at 12:54PM 4 sta							
		l and#2) outside of room			1			
	passing lunch. The 4				·			
		esident's room as the phone						
		d the room to answer the						
		s attached to the top of bed						
		reach for the resident to roll					·	
		mputer equipment was			1			
		each on side table. The cell						
	phone was being cha	arged on top of the light and						
	the ear piece was da	ngling on the floor.					ì	
		ted that he has to constantly			1		į	
	tell the DON and adn		1					
		one and the computer but						
		olp me use it by myself. I			1			

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA
(X2) MULTIPLE CONSTRUCTION
(X3) DATE SURVEY
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AND PLAN OF	AND PLAN OF CORRECTION IDENTIFICATION NOMBERS		A. BUII	.DING		С		
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NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 9 wouldn't bother them if I could do it myself. During observation on 5/10/11 at 9:00AM, the cell phone was on the charger on top of the light fixture. The head set to the computer was hanging on side of bed and computer was on night stand across the room, the ear piece to telephone was under the resident's body. The phone rang and there were two nursing assistants and two nursing staff in the hall. No-one entered the room. All were standing in from of Resident #151 room. The call light was position above Resident #151's head out of turn reach During an observation on 5/10/11 at 3:40PM, the resident's bed. The cell phone was on top of light fixture. During an observation 5/11/11 at 11:21AM, the cell phone was on top of light fixture, ear piece on floor, computer at foot of bed and call light fixed to bed at shoulder level.			1900	FADDRESS, CITY, STATE, ZIP CODE W 1ST STREET STON-SALEM, NC 27104				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE	
F 246	wouldn't bother them During observation of phone was on the christure. The head set hanging on side of be night stand across the telephone was under phone rang and there assistants and two not not not not not not not not not no	if I could do it myself. In 5/10/11 at 9:00AM, the cell arger on top of the light to the computer was ad and computer was on e room, the ear piece to the resident's body. The exercise were two nursing ursing staff in the hall. I com. All were standing in 1 room. The call light was ent #151's head out of turn In on 5/10/11 at 3:40PM, the as positioned above head, set on night stand at foot of cell phone was on top of light In 5/11/11 at 11:21AM, the p of light fixture, ear piece on of bed and call light fixed wel. In 5/11/11 at 12:15PM, dent #151 indicated that omplained to her several getting assistance with his ohone. She indicated that reported these concerns to I pone and the computer she ce form and submitted the	L.	246				

Facility ID: 923570

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY	
-AND-PLAN OF	CORRECTION	- IDENTIFICATION NUMBER:	A. BUILDING		COMPLE		
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	ROVIDER OR SUPPLIER	TON SALEM	19	EET ADDRESS, CITY, STATE, ZIP COD 00 W 1ST STREET INSTON-SALEM, NC 27104	DE .		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 246	not know whether the monitoring occurring grievance to appropindicated that the ac staff would assist the of the activity staff the Resident #151 when addition, when nursithe social workers (Sassisting. However, was being monitores he was also uncert following the grievance she was also uncert following the grievance. During an interview unit manager (UM) in kept on the unit for was responsible for service was provide include any nursing using the phone or unursing notes would she further stated the who had access to password/account a of the calls he receiphone was set up for would need assistant phone. An ear piecuse and a head set computer. She furth #151 had to do was let staff know that he making calls. She ir medication adminis	gene was any follow-up or gonce she submitted the riate department head. She stion plan was that activity a resident and in the absence he nursing staff would assist in he used the call light. In ting staff was unable to assist asw) were responsible for she was uncertain how this dor tracked. She added that ain whether the concernance process was resolved for stated that she only fills out on 5/11/11 at 1:49PM, the indicated that a journal was Resident #151 in which staff documenting anytime a documenting anytime a documenting anytime a documenting anytime and assistance with computer. She added that the laiso include this information. In the she was the only person Resident #151 cell phone and a telephone log was kept wed. She added that the or voice activation, however he had a telephone log was kept wed. She added that the or voice activation, however he had a telephone log was kept wed. She added that the or voice activation, however he had a telephone log was kept wed. She added that the or voice activation, however he had a telephone log was kept wed. She added that the or voice activation, however he had a telephone log was kept wed. She added that the or voice activation, however he had a telephone log was kept wed. She added that all Resident was available for the learned assistance with	F 246				

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE	CONSTRUCTION	COMP		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		C 05/12/2011		
		345092	B. WIN	G				
	ROVIDER OR SUPPLIER	STON SALEM		190	ET ADDRESS, CITY, STATE, ZIP CODE 10 W 1ST STREET NSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 246	8-9pm of when the using the cell phonocall light should be placed on resident should also be with further stated that held with Resident community suppor administrator on he concerns of not had the phone or compissue to Resident indicated that the pattern of the activation and upon readsence of the activation because the phone or comparties were follow the phone or comparties were getting assisting other change, etc., then she also indicated was not receiving. During an interview SW director indicated were getting assist process for resolv	y assist Resident #151 with the She also indicated that the in reach, headset should be is head daily and the computer in reach for access. She several discussions had been #151 social workers, it staff, DON, nursing staff and bow to handle Resident #151 ving access/assistance with outer and how to resolve the #151's satifaction. She process included that activity Resident #151 during the 1:1 quest for use the phone, in the ivity staff, the nursing staff he resident and department She was uncertain of what the is for ensuring that whether all ving up on the assistance with botter access. She added that do the phone log Resident #151 is per day with assistance from intated that once the voice up it was agreed with Resident and to do was to use the call light he wanted to make a call, resing assistants/nursing staff her residents during meals, shift activities or SW would assist. If that she was unware that he assistance with the computer. W on 5/11/11 at 2:20PM, the attend that the recurrent concerns trance using the cell phone. The ing the issue was that activity him during the day and nursing	F	246				

CENTERS FOR MEDICARE & M	MEDICAID SERVICES	OMB NO. 0938-0391						
	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SUR			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	•		- 1		
		B. WIN	10		(
	345092	b. Will			05/12	2/2011		
NAME OF PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE				
OD 4 OF HEALTHOADE OF WINETC	AN CALER		19	900 W 1ST STREET				
GRACE HEALTHCARE OF WINSTO	N SALEM		l w	VINSTON-SALEM, NC 27104				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ŧx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
and SW was the back- resident continuously concerning his comput however she was unce issue for him. She was monitoring whether the receiving assistance. It responsible for follow- his satisfaction or com- she had no response. During an interview or activity director indicate to visit with the resider activities. The activitie phone calls, and activit Review of the 1:1 part March and April revea occurring. She added the resident with phone added that she docum- general notes. Review revealed that May 1 can March =1 Feb=4, Jans log revealed at the time provided by activities of call log. During a follow-up inte 2:20PM, the unit mana pattern was established because that was the resident stated that he therefore the nursing shim upon request duri that the expectation w	during the evening hours -up. She added that the submits grievance ter or the cell phone, ertain how to resolve the s also uncertain who was e resident was actually When asked who was up with resident regarding upletion of the grievance 1 5/11/11 at 2:20PM, the ted that she was scheduled nt 1x a week to do 1:1 s included assisting with ities of resident's choice. dicipation record for Feb, all that 1:1 activities were that she would also assist the calls upon request. She mented these calls in the w of the activity notes all was made, April=2, =5. Review of the telephone the indicated assistance was did not match the presented erview on 5/11/11 at ager indicated that the call ed on the MAR for 8-9pm, time frame in which the e wanted to call his family, staff was instructed to assist ing this hour. She indicated	F	246					

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB N	IO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE S	
AND PLANTO	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	1150
			8 14/14/0		- (C	
		345092	B, WING		05/	/12/2011
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u>=</u>	
			19	000 W 1ST STREET		
GRACE H	EALTHCARE OF WIN	SION SALEM	l w	INSTON-SALEM, NC 27104		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CO		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH		COMPLETION DATE
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION)	TAĞ	DEFICIENCY		
5 040			F.040			
F 246			F 246			
		not match what was reported as				
		ing during this hour. She				
		s uncertain who was		Į		
		re whether the resident was				
		ce. Reviewed the care plan and		<u> </u>		
		assistance would be provided		1		
		interfere with the care of other				
		her stated the care plan should				Í
		the resident's call pattern				
		w-up should be done to ensure				1
	assistance was be	ing provided.				
	During on intension	v on 5/11/11 at 3:25PM, Nurse				
		lurse#6. Nurse#6 indicated				
	that pursing staff u	vas expected to document on				
		y assisted the resident with				1
		s. Nursing also should				
	document in the jo					
		that was provided. The				
	headest should be	kept on the resident or on the				
	nillow or in the con	nputer for easier access. The				
	call light should be	positioned so that the resident				
	could turn his head	to access. The cell phone	1			
	was voice activate	d but he did need assistance to		L-		
		e phone. She indicated that				
	she had assisted h	nim in making calls when he	ļ			
	told her who he wa	anted to call. She indicated that				
		now to operate the computer				
	and the only thing	she did was ensure the				
		se and the headset was in				
	place. Nurse#4 inc	licated that she knew that				
	nursing was to doo	cument on the MAR when they	***************************************			
	provided assistance	ce with phone calls. She added		!		
	that she had not a	ssisted the resident with phone				
		e#5 indicated that she had		}		
		ent with the use of the phone				
		he headset for the computer				
	and phone were in	niace. The resident was able	l	1		l .

PRINTED: 05/26/2011

FORM APPROVED

Facility ID: 923570

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) ML	JLTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUIL	DING	·····	COMPLETE	´
				_		C	
	•	345092	B. WIN	Э <u> </u>		05/12	2011
NAME OF DE	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FR	OVIDER OR SUFFEILIN				00 W 1ST STREET		
GRACE H	EALTHCARE OF WINST	ON SALEM		W	INSTON-SALEM, NC 27104		
					PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	x I	(EACH CORRECTIVE ACTION SHOU		COMPLETION
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
					DEFICIENCY)		
				1		1	
F 246	Continued From page	∍ 14	F	246			
		ithout difficult to let staff		1			
		f was expected to ensure					
	that the ear niece an	d headset and computer	İ	ļ		[
	were close enough for	or the resident to access.		1		ļ	
	Calls were document	ed on the MAR and care in		1			
	the journal.					1	
						ļ	
ŀ	During a follow-up in	terview with Resident #151					
	on 5/11/11 at 3:30PN	1, Nurse#7 was present.					
		ted that Nurse #7 had		j	*		
	assisted him with usi	ng his cell phone and		1			
	ensuring that his hea	dset was in place and the		1			
	computer was on. Re	esident #151 acknowledged					
		ne of few that did assist him					
İ		t #151 indicated that all he		1			
l i		to ensure that he made his					
	phone calls when he	needed and the head piece					
	for the phone/compu	ter was within reach. He					
	indicated that many t	imes the phone would ring ne call light to get staff to					
	and he would push to	the phone but no-one would					
	come in and answer	vait until someone came by					
	to recall the number	because he could not					
		esident #151 stated that					
	because his family w	as on a different time zone					
		e between 7-9pm to make					
	these calls and it doe	es not always happen even					
	when he uses the ca	II light. Staff tended to ignore					
	the call light. During	the day when he needs to					
	make his local calls a	activities was busy and					
	nursing assistance w	ould not assist because they					
	were told that only th	e nurse's could do it. "It just					
	gets me real upset a	nd angry that the nursing					
	doesn't assist me wh	en I need them to all I want					
	was for them to dial	the number. Same thing with		:			
	my computer, all the	y have to do was turn it on					
	and make sure I hav	e my headset on. Sometimes					
	my headset is across	s the room. Everybody keeps]		

Event ID: IS1C11

PRINTED: 05/26/2011 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 05/12/2011 345092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1900 W 1ST STREET GRACE HEALTHCARE OF WINSTON SALEM WINSTON-SALEM, NC 27104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 246 F 246 Continued From page 15 telling me they don't know how to operate the computer, they could be trained on how to turn it on and unfreeze the screen when I need it." He added that nurse #7 was the only one who was consistent with helping with the computer. During a follow-up interview on 5/12/11 at 8:00AM, the DON presented an action plan to changes in Resident#151 access and assistance to use the cell phone and computer. She indicated that she would be contacting outside sources to assist with obtaining assistive devices for resident to use a hands free device for computer and staff would be assigned to assist resident with computer and cell phone usage. F 252 F 252 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE SS=E **ENVIRONMENT** F 252 The facility must provide a safe, clean, comfortable and homelike environment, allowing 6/3/11 1. An audit was conducted on 5/11/11 and 05/12/11 the resident to use his or her personal belongings by the Housekeeping Manager Administrator, and to the extent possible. Director of Nursing to ensure there were no odors on 2nd, 3rd, and 4th floors. An audit was conducted by the Housekeeping

This REQUIREMENT is not met as evidenced by:

Based on observations, resident interviews, staff interviews, family interviews and record review the facility failed to maintain an environment free from lingering odors on 3 of 5 floors (2nd, 3rd and 4th floors).

Findings include:

A strong lingering (to remain existent) odor of urine was noted on the 4th floor (long hall) on 5/9/11 at 12:15PM. The lunch meal was being the facility. No residents were found to be affected. The Staff Development Coordinator conducted an inservice on 05/12/11 through 05/31/11 for all licensed nurses and certified nursing assistants on identifying and removing the source of odors. An In-Service was conducted for facility housekeepers by

Manager on 05/12/11 to ensure there were no odors in

A daily audit for odors on all floors and elevators will be conducted by the Housekeeping Manager three times daily, five days per week for four weeks, then

Facility ID: 923570

the Housekeeping Director on 05/14/11 to ensure that

sources of odors are identified and removed timely.

PRINTED: 05/26/2011 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING.		С	
		345092	B. WIN	G		05/12	
	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 00 W 1ST STREET		
GRACE H	EALTHCARE OF WIN	ISTON SALEM		w	INSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FOCE.		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 252	A lingering stool of 3:10PM on the 3rd On 5/9/11 at 4:55 noted down the lefloor. During an intervier resident #234 ind lingering odor of story interviewed on 5/member indicated week and noticed "sickness" when a described the smboil." On 5/10/11 at 2:5 odor was noted of A lingering strong 2nd floor (long has observation from An interview was 8:23AM with hou indicated her dail dayroom tables, moping and emp breakfast trays a employee restroonce the trays for the floor, she wo		L.	252	daily for two months and/or 100% completesults of this audit will be noted and rever monthly Quality Assurance Performance Improvement. The results will be brough monthly Quality Assurance Performance Meeting by the Administrator. Any issues identified will be addressed by the Quality Performance Improvement Committee as and the plan will be revised to ensure concompliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, Some Development Coordinator, MDS Coordinator, Rehabilitation Manager, Medical Director Social Services, Environmental Services Maintenance, Dietary Manager, and the Director.	t to the Improvement s or trends ty Assurance s they arise ntinued formance staff nator, or, Director of Director of	

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 05/12/2011 345092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1900 W 1ST STREET GRACE HEALTHCARE OF WINSTON SALEM WINSTON-SALEM, NC 27104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 252 F 252 Continued From page 17 such as windowsills, the air conditioner unit, and sweep and mop each room. She stated the facility usually deep cleaned one to two rooms during the week. HK #1 stated she did notice odors in the facility. When asked what type of measures the facility used to combat odors HK #1 stated her supervisor informed the HK staff not to use air fresheners due to some of the residents not being able to tolerate them. She did indicate they used a disinfectant to cut down on the odors. HK #1 stated the nursing assistants would sometimes spray air freshener in the hallways but she did not know where they got it. During an interview on 5/12/11 at 9:41AM, the HK supervisor indicated the facility used a "foul odor digester" to combat odors in the facility. He stated the foul odor enzymatic was what the HK staff had been using this week. The HK supervisor indicated the gray and yellow bins (for soiled linens and soiled incontinent products) on the hallway were to be emptied every two to three hours. The lids on the bins should be closed. The HK supervisor stated he was not aware of any concerns the resident or family members might have in regards to lingering odors. On 5/12/11 at 11:20AM, a strong lingering odor of urine and stool was noted on the 3rd floor (short hall). On 5/12/11 at 1:07PM, an odor of urine was noted on the 3rd floor by the elevators and down the short hallway on the 3rd floor. An interview was conducted with the director of

Facility ID: 923570

nursing (DON) on 5/12/11 at 2:19PM. The DON indicated she expected the facility to be free from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B, WING		С
		345092	15, 1,,,,,		05/12/2011
	OVIDER OR SUPPLIER EALTHCARE OF WINST	DN SALEM	.	STREET ADDRESS, CITY, STATE, ZIP CO 1900 W 1ST STREET WINSTON-SALEM, NC 27104	ODE
(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	THE APPROPRIATE COMPLETION DATE
F 252	Continued From page	e 18	F 2		<i>(</i> e)3(1)
F 253 SS=C	483.15(h)(2) HOUSE MAINTENANCE SEF The facility must prov	IVICES ide housekeeping and s necessary to maintain a	F 2	230, 209, 300, 305, 306, 30 311, 313, 326, 329, 314, 31: 424, 425, 417, 409, 410, 41: 412, 429, 520, 522, 524, 53: 513, 505, 515 were cleaned	8, 208, 227, 226, 1, 302, 304, 312, 5, 400, 407, 412, 8, 411, 413, 426, 0, 529, 528, 521,
	This REQUIREMENT by: Based on observation facility failed to ensure in the resident's room resident rooms. Resionserved with large were as follows: 200, 205,213,214,221,218, 05,306,301,302,304, 5,400,407,412,424,4,426,412,429,520,52505,515. During initial tour on 11:00AM, the following 201,203,205,213,214,09,300,305,306,301, 9,314,315,400,407,4,411,413,426,412,42521,513,505,515. The were observed with oparticles inside and on system. During a follow-up of 10:54 AM to 11:45AN 200, 201, 203, 205, 226, 230, 209, 300, 300, 300, 300, 300, 300, 300, 3	is not met as evidenced an and staff interview the that heating and air units as were clean for 50 of 123 dent rooms that were directly volumes of dust/food debris 201, 203, 8,208,227,226,230,209,300,3 \$\frac{3}{3}12,311,\frac{3}{3}13,326,\frac{3}{2}9,\frac{3}{3}14,\frac{3}{3}125,417,409,410,418,411,413 2,524,530,529,528,521,513, 6/9/11 at 10:35AM to ag resident rooms, 200, 4,221,218,208,227,226,230,2 302,304,312,311313,326,32 12,424,425,417,409,410,418 9,520,522,524,530,529,528, where the enting and air systems dirty grey bulld up, food butside of the heating abservation on 5/10//11 at M, of the identified rooms 213, 214, 221, 218, 208, 227,		Housekeeping Director. 2. A 100% audit of all facil units was conducted by the Manager on 05/11/11 and 01 all facility heating and air units was conducted by the Manager on 05/11/11 and 01 all facility heating and air units and cleaning technic schedule for cleaning heating within the building. 4. A weekly audit of twenty air units on all floors and withe Housekeeping Manager units are clean. This audit with weekly times four weeks, the months and/or 100% complis of this audit will be noted an monthly Quality Assurance Improvement. The results withe monthly Quality Assurance Improvement Meeting by Actissues or trends identified withe Quality Assurance Perfor Improvement Committee as a plan will be revised to ensure compliance. The Quality AssPerformance Improvement Coft the Administrator, the Director of Social Services, Iservices, Director of Mainter Manager, and the Activities I	Housekeeping 5/12/11 to ensure nits were clean. Ager conducted an ng staff on ques and the g and air units -five heating and Il be conducted by to ensure that the ill be conducted en monthly for four ance. The results d reviewed in the Performance Ill be brought to toe Performance diministrator. Any Ill be addressed by mance they arise and the e continued surance committee consists ector of Nursing, tor, MDS rdinator, lical Director, Environmental mance, Dietary

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUII	DING		С		
		345092	B. WIN	G		05/12/2011		
	OVIDER OR SUPPLIER	ON SALEM	•••	190	ET ADDRESS, CITY, STATE, ZIP CODE 0 W 1ST STREET NSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 253	07,412,424,425,417, 12,429,520,522,524, 5. The heating and a dust/food debris. During observations 10:50AM-11:22AM, t maintenance were de rooms 200, 201, 203 208, 227, 226, 230, 209,300,305,306,306,306,306,306,306,306,306,306,306	409,410,418,,411,413,426,4 530,529,528,521,513,505,51 ir units had large volumes of on 5/11/11 at our of the facility with one in the following resident , 205,213, 214, 221, 218, 1,302,304,312,311,313,326, 7, 9,410,418,411,413,426,412,, 0,529,528,521,513,505,515, eating and air systems were e systems had large heavy build up and food particles	F	253				

Event ID: IS1C11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE	(X3) DATE COMPI		
AND PLAN OF	CORRECTION		A, BUI	LDING			С
		345092	B. WIN	ie '		05/12/2011	
	ROVIDER OR SUPPLIER	TON SALEM		1900	TADDRESS, CITY, STATE, ZIP CODE W 1ST STREET STON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORF PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		SHOULD BE	(X6) COMPLETION DATE
F 253	food particles on the system. Maintenance director during the to heating systems had cleaned. During an interview housekeeper (HK#2 responsible for sweer resident rooms, furn was also responsible outside of heating system, where she had after observation cleaning. During an interview indicated that there sometimes just one split. She added that systems were clean scheduled for a dee the fronts of the head down by the housek observations of her not cleaned the head During an interview indicated she was rewindow sills, bed frasweep/mop,clean the She indicated that she we indicated that s	olumes of grey matter and inside and outside of the e stated to housekeeping our that on all the floors the dinot been thoroughly been on 5/11/11 at 11:50AM, indicated that she was eping/mopping, dusting iture. She indicated that she e for cleaning the front and system once a week. She was nad cleaned the heating was working she stated no in stated it needed a good on 5/11/11 at 12:00PM, HK#1 was 1-2 HK's per floor and the hall assignment was the only time the heating ed was when the room was picleaning. She added then thing systems would be wiped the eping. She indicated after assigned rooms that she had ting system. on 5/12/11 at 7:20AM, HK#3 esponsible for cleaning	F	253			
FORM CMS.25	67(02-99) Previous Versions O	bsolete Event ID: IS1C	 :11	Facil	ity ID: 923570	If continuation	sheet Page 21 of 4

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUII	DING.			
		345092	B. WIN	G		C 05/12/2011	
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
004051	EALTHCARE OF WINST	ON SALEM		l ''	900 W 1ST STREET		
GRACE	EALINGARE OF WINST	ON SALEM		W	/INSTON-SALEM, NC 27104	·	
(X4) ID PREFIX TAG	(FACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253 F 280 SS=G	indicated that she hat to in-service. Mainted 483.20(d)(3), 483.10 PARTICIPATE PLANTHE resident has the incompetent or other incapacitated under participate in plannin changes in care and A comprehensive cawithin 7 days after the comprehensive asses interdisciplinary team physician, a register for the resident, and disciplines as determined to the extent properties of the resident, the resident, the resident properties of the resident properties.	Id not been doing them prior mance was responsible. (k)(2) RIGHT TO NNING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to ag care and treatment or treatment.	F 28		F 280		43 11
	by: Based on staff inter facility failed to upda	views and record review the ate the care plan for 1 of 1 all erosion. (Resident #277)			A facility directed inservice for all licer certified nursing assistants regarding U Use in Long-term Care was conducted a state approved education agency. All and certified nursing assistants are required prior to resuming their work schedule.	rinary Catheter on 06/03/11 by licensed nurses	
	Findings include:						
	Resident #277 was 4/18/11. His diagnos limited to; hypertens	re-admitted to the facility on ses included but were not sion, aphasia, right	To be settled to the				
FORM ONE 35	67/02-00) Previous Versions O	hsolete Event ID: IS10	011	F	acility ID: 923570	continuation she	et Page 22 of 45

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<u> </u>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		С		
		345092	B. WIN	G		i	2/2011	
1	OVIDER OR SUPPLIER	ON SALEM		19	EET ADDRESS, CITY, STATE, ZIP CODE 000 W 1ST STREET /INSTON-SALEM, NC 27104	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 280	Review of the resider (CAA) summary, date for "Urinary Incontine Catheter." The indwe on admission due to on his sacrum and le "Resident does have several pressure ulce extremities." He is at ulcers due to his imp cognition, incontinen ulcers." Will proceed skin integrity and pro living). The CAA sum dated 1/27/11. It was admitted to facility wi bilateral lower extrem The most recent min 4/28/11 revealed the cognitive impairment on staff for bed mobil dressing, eating, tolle required extensive an hygiene. Resident #2 on the MDS. The resident #277's care dated 5/6/11, for "Pouse of indwelling cat resident not to experiented to the use of related to the use of	disorder, aspiration or ulcer, diabetes and history on. It's care area assessment ed 1/27/11, revealed a CAA once and Indwelling olling catheter was in place unstageable pressure ulcers ft hip. The CAA read in part, a catheter in place. He has ers to sacrum, hip, and lower increased risk for pressure aired mobility, impaired ce, and existing pressure to care plan to help manage vide ADLs (activities of daily mary for pressure ulcer was a noted, "Resident was th several pressure ulcers to nities, left hip, and sacrum."	F	280	4. An audit will be conducted of all r plans to ensure resident's with new orde updated diagnosis will be conducted dai per week, for four weeks, then twice we weeks, then weekly for four weeks and/compliance. An audit of all residents wi catheters to ensure securement of indwe will be conducted by the Director of Nu Unit Coordinators, Wound Care Nurse, Supervisors every shift for fourteen day for fourteen days, then three times week weeks, then weekly for four weeks and/compliance. The results of these audits and reviewed in the monthly Quality Asperformance Improvement. The results brought to the monthly Quality Assuran Performance Improvement Meeting by Nursing. Any issues or trends identified addressed by the Quality Assurance Co-Performance Improvement as they arise will be revised to ensure continued com Quality Assurance Performance Improvement Committee consists of the Administrate of Nursing, Staff Development Coordinator, R Manager, Medical Director, Director of Services, Environmental Services, Dire Maintenance, Dietary Manager, and the Director	rs or new or ly, five days ekly for four or 100% th foley llling catheters rsing and/or and Nursing rs, then daily ly for four or 100% a will be noted surance will be ce the Director of will be mmittee and the plan pliance. The ement r, the Director lator, MDS ehabilitation Social ctor of		

Facility ID: 923570

	4 FAC MEDIANDE 9	MEDICAID SERVICES				Olvio I	<u>(O. 0938-039</u>	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
STATEMENT (AND PLAN OF	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		LDING		COMPLETED		
		0.45000	B. WIN	1G	•	05	C /12/2011	
		345092		етопо	ET ADDRESS, CITY, STATE, ZIP CODE	0	112,201.	
NAME OF PR	OVIDER OR SUPPLIER				0 W 1ST STREET			
GRACE H	EALTHCARE OF WINST	ON SALEM		WI	NSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAG	FIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	included; catheter caneeded, maintain a colevel of bladder. Mor of urinary tract infect color, consistency, a was to report any unthe physician. A care impaired skin integrif mobility, contracture sacral wound and preet", dated 5/6/11, resident to not experience any skin integrif review. The intervent to nurse any red or cappropriate pressure during repositioning care for any change observations to the During an interview, nurse #1 indicated if (penile erosion) it st plan. MDS nurse #1 to the penis was not the plans should be reviewed a resident had a wound their care plan with nurse was not sure was not care planned director of nursing d	are every shift and as closed drainage bag below hitor for signs and symptoms ion: fever, and change in and odor of urine. The staff usual findings immediately to a plan titled "Potential for ty related to decreased s, pressure sore left hip, essure ulcers to bilateral noted the goal was for the rience any adverse effects ty issues through the next utions included; staff to report open areas, ensure e relieving devices in place. Monitor skin daily during s. Report any abnormal physician. on 5/12/11 at 1:37PM, MDS of a resident had a wound a mould be noted on their care was not sure why the wound to mentioned on the care plan. Inducted on 5/12/11 at ourse #3. She stated the care ised and updated at least ally. MDS nurse #3 indicated if bund, it should be noted on interventions in place. The why the penile erosion wound	F	280				

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<u> </u>	DE DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
		345092	B. WING		C 05/12/2011		
	OVIDER OR SUPPLIER	ON SALEM	19	EET ADDRESS, CITY, STATE, ZIP CODE 00 W 1ST STREET INSTON-SALEM, NC 27104	ī		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280 F 282	and if a resident had a history of a wound or a new or worsening wound. F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED		F 280 F 282	F 282 1. The Minimum Data Set Cothe ADL care guide for resident # 05/11/11 the staff assigned to resimmediately inserviced by the Direction of the Direction o	#151 on 05/11/11. On ident #151 was	6/3/1	
\$\$=D	The services provide must be provided by	ed or arranged by the facility		ensuring that resident #151 was a his personal equipment. 2. An audit of all resident care	e plans was		
	care. This REQUIREMENT is not met as evidenced			conducted on 05/27/11 to ensure needs of the resident were commistaff on the ADL care guide.	that the care planned unicated to the care		
	by: Based on observation and staff interview, to	on, medical record review he facility failed to implement st a resident with using the buter as documented in the		3. An inservice was conducted Director of Nursing and the Staff Coordinator for the facility Minin Coordinators on communicating identified in the care plan to the or	Development mum Data Set the care needs		
	plan of care for 1 of 1 sampled resident (Resident #151). Resident #151 was readmitted to the facility on 6/2/10. The resident's cumulative diagnoses include seizure disorder, spasticity, chronic pain and depression. The quarterly Minimum Data Set (MDS) dated 3/17/11, indicated the resident had no short term memory or long term memory problems or decision making problems. The MDS indicated that resident #151 required total assistance with all activities of daily living. He had impaired range of motion on both sides of upper and lower extremities. Review of care plan dated 3/25/11, read in part:			4. Audits of the care plans an will take place daily, five times p weeks, then twice weekly for for for four weeks. The results will monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends id addressed by the Quality Assuran Improvement Committee as they will be revised to ensure continu Quality Assurance Performance Committee consists of the Admit of Nursing, Staff Development Coordinator, Admission Coordin Rehabilitation Manager, Medica	per week for four ar weeks, then weekly be brought to the brought to the bromance Improvement ing. The results will by Assurance ing by the Director of entified will be note Performance arise and the plan ed compliance. The Improvement mistrator, the Director Coordinator, MDS pator, I Director, Director of		
	Resident is at rish due to being bed bo in-room visits with 1 socialization and me	k for decreased socialization bund. Resident requires :1 interaction to maintain ental awareness. The goal		Social Services, Environmental Maintenance, Dietary Manager, Director.	Services, Director of and the Activities		

Facility ID: 923570

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA. AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	COMPLETED		
		345092	B. WING			
	ROVIDER OR SUPPLIER	ON SALEM	1	REET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE		
F 282	in-room visits and so weekly through next included the staff wo using the cell phone interfere with direct of the resident requests activities staff would the weekly in room vassist upon request with daily work task. During an observationing at 12:54PM 4 st lunch. The 4 staff we of resident's room as entered the room to was attached to the of reach for the residence charged on top of the dangling on the floot that he has to constand the computer buse it by myself. I will do it myself. During observation phone was on the continue was on the continue that he had sent and the computer buse it by myself. I will be it myself. During observation phone was on the continue was on the continue that he had sent and the computer buse it by myself. I will be it by myself. I will be it by myself and the computer buse it by myself. I will be it by myself. I will be it by myself and the computer buse it by myself and the computer buse it by myself. I will be it by myself and the computer buse	cialization at least once review. The approaches uld assist the resident with when time allowed and not to esident care of daily duties. If ad assistance with the laptop be available to assist during isits, other stay may also if time permits not to interfere on on 5/9/11 the cell phone aff outside of room passing are observed standing in front answer the call. The call light top of bed in which it was out then to roll head to activate. It was pushed away out of The cell phone was being the light and the ear piece was resident #151 indicated antly tell the DON and his concerns with the phone out they do nothing to help me outlon't bother them if I could the computer was on the room, the ear piece to at Resident #151 body. The	F 282			

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CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB NO. 09:

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		DIMO		COMPLETE	D
	•		A. BUI	LDING	· .	С	
		345092	B. WING			05/12	/2011
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM				1	EET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC · 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 282	reach. During an observation Resident #151 call lighead, computer with foot of resident s bed fixture. During an observation phone on top of light computer at foot of beat shoulder level. During an interview of MDS coordinator #3 should be revised an significant changes. That when the care plan should follow the plan revised when there is concern. During an interview of DON indicated the cawas expected of the the resident. After resident and grindicated some monital have occurred to ensithe assistance needs. During an interview of Administrator indicated to assist the resident and the computer. The should be accessible.	ent #151 head out of turn on on 5/10/11 at 3:40PM, the was positioned above head set on night stand at . Cell phone on top of light on 5/11/11 at 11:21AM, cell fixture, ear piece on floor, ed and call light fixed to bed on 5/11/11 at 2:06PM the indicated that the care plan inual, quarterly and during The expectation would be an was established staff on. The care plan should be a change in condition or on 5/11/11 at 3:45PM, the are plan should reflect what staff in meeting the needs of view of the call pattern and evance log, the DON toring and changes should sure the resident was getting	F	282			

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		345092	B. WIN	3		l.	C 2/2011
NAME OF PR	Continued From page indicated after review plan should be specified designated staff wou and check status and of the grievance process of the grie	a45092 ON SALEM ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 27 v of care plan that the care fic to his needs and id be assigned to monitor d meet the resolution process cedures. ARE PROVIDED FOR	B. WIN	STREE	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) F 312 1. Resident # 191nails were cleaned trimmed by the Treatment Nurse 05/13/adverse outcomes noted.	05/1	С
	by: Based on observation terviews and recomprovide fingernall caresidents who require of daily living. (Residents who require of daily living. (Residents who reduled: The undated policy of Care of revealed the was to clean the nail and to prevent infection part, "Nail caregular trimming." The nails, infections, pail too thick to cut with	titled, "Fingernalis/Toenails, e purpose of the procedure I bed, to keep nails trimmed, tions. Some of the guidelines are includes daily cleaning and the staff should report to the here was evidence of ingrown n, or if nalls were too hard or ease.			Resident #302 nails were cleaned and on 05/11/11 by the Certified Nursing As No adverse outcomes noted. The Direct Nursing inserviced the treatment nurses 05/13/11 regarding the expectations of to fingernails and toenails and referring to podiatry as need. 2. A 100% audit was conducted by the Coordinators and the Treatment Nurses 05/11/11 for all facility residents to dete any residents needed nails trimmed and added to the podiatry list. 3. An in-service was conducted by the Development Coordinator 05/20/11 thro 06/02/11 for all licensed nurses and Cert Nursing Assistants in regards to nail can toenails and fingernail trimming and cleans.	ssistant. tor of on rimming residents e Unit on rimine if cleaned or he Staff bugh tiffied e for	
	1. Resident #191 wa 10/11/10. The resid	as admitted to the facility on ent's diagnoses included but					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345092	B. WIN				2/2011
	OVIDER OR SUPPLIER	STON SALEM		19	EET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULO BE	(X5) COMPLETION DATE
F 312	were not limited to, hypertension, diabed dialysis). The most recent mi 2/18/11 revealed the intact. He required to two staff membed daily living: bed mouse, personal hygical functional impairmed motion) on one side extremittes. He had the look back periodied he had a self assistance with act. The goal was for the needs met. Some a staff will provide or needed.	congestive heart fallure, bees and renal failure (receiving dinimum data set (MDS), dated the resident was cognitively extensive assistance from one are for the following activities of bility, transfers, dressing, toilet the end bathing. He had a tent (decreased range of the of his upper and lower in no noted behaviors during	F.	312	4. Audits will be conducted by the Coordinators and Director of Nursin facility residents to ensure that nails cleaned and/or added to the podiatry audit will be conducted weekly for futhen monthly for two months and/or compliance. The results of this audit and reviewed in the monthly Quality Performance Improvement meeting, will be brought to the monthly Quality Performance Improvement Meeting Director of Nursing. Any issues or the identified will be addressed by the Quality and the plan will be reviewed as they arise and the plan will be reviewed as they arise and the plan will be reviewed continued compliance. The Quality and Performance Improvement Committed Administrator, the Director of No Development Coordinator, Rehabilitation Manager, Medical I Director of Social Services, Environ Services, Director of Maintenance, I Manager, and the Activities Director	gfor all are trimmed, list. This our weeks, 100% will be noted Assurance The results ty Assurance by the ends usuality tt Committee ised to ensure Assurance ee consists of ursing, Staff ordinator, Director, mental Dietary	6 3 11
	3:56PM noted both fingernalls with dar fingernalls. The rescould to keep his n from the staff to do On 5/11/11 at 9AM his room. His finge matter underneath he would try to clean	hands had long thick k matter underneath the sident stated he did what he alls clean but he needed help		٠			
5000404005	67(02-99) Previous Versions	Obsolete Event ID:IS1C	15	Fa	acility ID: 923570	If continuation she	et Page 29 of 4

STATEMENT OF DEFICIENCIES (2		(X1)-PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		С			
		345092	B. WING		05	/12/2011		
""	ROVIDER OR SUPPLIER		1900	T ADDRESS, CITY, STATE, ZIP CODE W 1ST STREET STON-SALEM, NC 27104				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 312	During an observation resident on 5/12/11 to matter underneath the wanted them clear regular basis. His nate matter underneath (I staff was supposed stated he needed excomplete his activitie had been around 2 to trimmed and cleaned. An interview was concurse #3 on 5/12/11 nurse #3 (both on the treatment nurses chand fingernalis weel refuse to have, their toenails) it would be Weekly Skin Check would trim the nails needed. During an interview director of nursing (the staff to be trimmed.	on and interview with the 3:20AM, he stated the dark is nails "bothered" him and aned and trimmed on a alls remained long with dark both hands). He indicated the to trim his nails today. He attensive assistance to se of daily living. He thought it months since his nails were d. Inducted with nurse #2 and at 9:25AM. Nurse #2 and eatment team) indicated the ecked the residents' toenails kly. If a resident were to a nails trimmed (fingernails or noted on the "Resident Sheet." The treatment nurses (toes and fingernails) as on 5/12/11 at 2:06PM, the DON) indicated she expected and and cleaning the se if they were noted to be long	F 312					
	4/25/11. The reside included cancer, endisorder and chronic disease. The Minim	admitted to the facility on int 's cumulative diagnoses id stage renal disease, seizure ic obstruction pulmonary num Data Set (MDS) dated that resident needed						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M	JLTIP	LE CONSTRUCTION	COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUII	DING	<u> </u>	· c	
		245002	345092 B. WING			1	12/2011
	COVIDER OR SUPPLIER			19	EET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	/FACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
F 312	assistance with act Review of the care 1: resident require provision for ADLs will experience cle and assistance as through next revie assist resident wit completion at every Thursday and sat During observation Resident #302 was finger nails long dunderneath nine of During an observation Resident #302 was finger nails During an observation Resident #302 was finger nails During an observation Resident #302 was finger nails During an observation Resident #302 was nails on 9 of 10 find During an intervies indicated that nurthed diabetic resident assistants all other nails/toenails sho care bathing. He Resident #302 nails resident #302 nails resident #302 nails/toenails sho care bathing. He Resident #302 nails/toenails sho care bathing. He Resident #302 nails/toenails resident #302 nails/toenails sho care bathing. He Resident #302 nails/toenails resident #302 nails/toenails resident #302 nails/toenails resident #302 nails/toenails resident #302 nails/toenails resident #302 nails/toenails resident #302 nails/toenails resident #302 nails/toena	e plan dated 5/4/1, documented as assistant with and/or and the goals included, resident and increase and comfort each day needed for ADLs each day w. The approaches included the am,/PM care and recording, bath/shower every Tues, on evening. In on 5/9/11 at 2:206 PM, as sitting in his room with his irty with brown matter of ten fingernails. In on 5/10/11 at 12:15PM, as eating lunch with long dirty ation on 5/10/11 at 5:25PM, as eating dinner with long dirty agers. In on 5/11/11 at 8:44AM, gernails was eating breakfast. The volume brown matter and ager nails. In on 5/11/11 at 5:05PM, NA#3 asing was responsible for cutting ents finger/toenails and nursing ents finger/toenails ents finger/toenails ents ents ents ents ents ents ents ent	I.	312			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA
(X2) MULTIPLE CONSTRUCTION
(X3) DATE SURVEY
COMPLETED

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			
		345092	B. WING		C 05/12/2011
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM			19	EET ADDRESS, CITY, STATE, ZIP CODE 300 W 1ST STREET VINSTON-SALEM, NC 27104	
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 312	During an interview of #8 indicated that NA residents fingernalis a care and bath/showe responsible for cutting that were diabetic. Not #302 room and observation of the treatment and service indicated they should stated he was happy. During an interview of director of nursing indicated they should stated he was happy. During an interview of director of nursing indicated they should stated he was happy. During an interview of director of nursing indicated they are sidented as session and trimmed 483.25(d) NO CATHIRESTORE BLADDE. Based on the resider assessment, the facinesident who enters indicated the indicated concatheterization was right who is incontinent of treatment and service infections and to resifunction as possible. This REQUIREMENT by: Based on observation interview facility failed to secu	n 5/11/11 at 5:10PM, nurse was responsible for cutting and toenails during am/pm r. He added that nursing was gresidents nails/toenails urse #8 went into Resident red fingernails and be cut. Resident #302 that they were getting cut. n 5/12/11 at 4:00PM, the dicated that she expected provide nail care during harge nurse any resident rail care. She added that all and toenails should be kept terms.	F 312	F 315 1. The Director of Nursing assessed ron 05/11/11. The catheter for resident #3 securely anchored by the licensed nurse The family was notified by the Wound C 05/12/11. The physician was notified of 05/12/11 by the Wound Care Nurse. The Resident #277 was updated on 05/12/11 Minimum Data Set Coordinator to refler resident's current plan of care. The Direction of the MDS #1 and MD updating care plans with changes in residing care plans with changes in residing care of the MDS #1 and MD updating care plans with changes in residing care not of 13/11 to ensure that the were securely anchored, assessed, and to ordered. No other residents were found A 100% audit of all resident care plans by the Minimum Data Set Coordinators for the previous thirty days to ensure the orders and diagnosis were updated on replans.	277 was on 05/11/11. Care Nurse on the on e care plan for by the ot the extor of OS #2 on dent status, have the Wound he catheters reatments as to be affected. was conducted on 05/27/011 at all new

Facility ID: 923570

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		c	
		345092	B. WING		05/12/	2011
	OVIDER OR SUPPLIER	ON SALEM	1!	EET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC 27104		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ONTO BÉ	(X5) COMPLETION DATE
F 315	trauma on the cathet residents with indwel #277) Findings include: Resident #277 was re 4/18/11. His diagnos limited to; hypertensi hemiparesis, seizure pneumonia, multiple the sacrum and left hurinary tract infection. Review of the reside (CAA) summary, date for "Urinary Incontine Catheter." The CAA have a catheter in plucers to sacrum, hip is at increased risk for impaired mobility, imincontinence, and exproceed to care plan integrity and provide living). Review of the nurse' re-admission note dam MDS nurse #1. The open areas to his lef sacrum, behind his learea to left outer ear noted to the right hip an assessment being area. No mention was	er tubing for 1 of 1 sampled ling catheters. (Resident ling catheters. (Resident ling catheters. (Resident ling catheters. (Resident ling catheters. (Resident ling catheters are not on, aphasia, right ling disorder, aspiration pressure ulcer (stage 4 to lip), diabetes and history of line. Int's Care Area Assessment ling ling ling ling ling ling ling ling	F 315	3. An in-service was conducted by th Nursing on 05/31/11 for all the facility Set Coordinators on the process of updaresident's to reflect the resident's currer A facility directed inservice for all licencertified nursing assistants regarding Uluse in Long-term Care was conducted a state approved education agency. All and certified nursing assistants are requipered to resuming their work schedule. 4. An audit will be conducted of all replans to ensure resident's with new order updated diagnosis will be conducted dain per week, for four weeks, then twice we weeks, then weekly for four weeks and/compliance. An audit of all residents with a catheters to ensure securement of indwe will be conducted by the Director of Nu Unit Coordinators, Wound Care Nurse, Supervisors every shift for fourteen days for fourteen days, then three times week weeks, then weekly for four weeks and/compliance. The results of these audits and reviewed in the monthly Quality. Performance Improvement. The result brought to the monthly Quality Assurance Improvement Meeting be Nursing. Any issues or trends identified addressed by the Quality Assurance Cerformance Improvement as they arise will be revised to ensure continued conductive consists of the Administration of Nursing, Staff Development Coordinator, Improvement Services, Environmental Services, Dir Maintenance, Dietary Manager, and the Director	Minimum Data sting a at plan of care. sed nurses and inary Catheter on 06/03/11 by icensed nurses ired to attend esident care rs or new or ly, five days ekly for four or 100% th foley lling catheters rsing and/or and Nursing s, then daily ly for four or 100% will be noted Assurance ts will be ance ye the Director of ded will be committee se and the plan impliance. The invement or, the Director nator, MDS Rehabilitation of Social	

Facility ID: 923570

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345092	B. WING			C 05/12/2011	
İ	NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM		•	190	ET ADDRESS, CITY, STATE, ZIP CODE 00 W 1ST STREET NSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 315	The wound care noted TN (treatment nurse) measured the resident the following wounds wound stage 4, left in heel unstageable, rig right ischium possible mention was made in of the penis area. No healed wound to the Review of the "Resid Sheet", dated 4/19/1 wound to the penis. A nurse's note, dated (nursing assistant) re swollen. This nurse a edema noted at head at this time (name of received to change of indwelling catheter wyellow urine noted with pus like area at the murinary tract). A cultur drainage along with a sensitivity. On 4/26/11 a nurse's was started on antible results were back. Thy yellow urine with mucamount of drainage meatus. Review of the "Resident Resident R	had assessed and had assessed and had assessed and has wounds. The TN noted; left hip stage 4, sacral har malleolus stage 3, left had outer malleolus stage 3, edeep tissue injury. No a regards to the assessment mention was made of a	F	315			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE S		
AND PLAN OF	CORRECTION	IDENTIFICATION NOTIFICA	A, BUII	DING	<u> </u>		c
		345092	B. WIN	G		05	/12/2011
	OVIDER OR SUPPLIER	STON SALEM		1900	T ADDRESS, CITY, STATE, ZIP CODE OW 1ST STREET ISTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 34	F	315			
	dated 4/28/11. The to the penis (open of the penis (open of the penis (open of the penis (open of the penis (open of the penis (open of the penis (open of the penis (open of the penis (open of the penis (open open open open open open open open	for the penis were reported on a noted "Normal Genital Tract inimum data set (MDS), dated the resident had severe the was totally dependent bility, transfers, locomotion, dilet use and bathing. He assistance for personal #277 had no noted behaviors the resident was incontinent of the resident had multiple the ulcers during the look back of dated 5/4/11 did not make					

1		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING	A. BUILDING			
		345092	B. WING		05/1	C 2/2011	
	ROVIDER OR SUPPLIER	ON SALEM	19	EET ADDRESS, CITY, STATE, ZIP COE 00 W 1ST STREET INSTON-SALEM, NC 27104	PE		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 315	to decreased mobility sore left hip, sacral we bilateral feet", dated of for the resident to not effects from any skin next review. The interport to nurse any reappropriate pressure during repositioning, care for any changes observations to the part of the "Reside Sheet", dated 5/6/11 wound to the penis. A verbal order, dated TN read in part, "Tx (with) 1. clean (with) (with) Xeroform gauz & PRN (as needed)-leg to limit movement on 5/10/11 the treatment nurse (TN) indwelling urinary cat open area around the area resembled a wice red with a small amonoted. He referred to and stated the reside	contractures, pressure cound and pressure ulcers to 5/6/11, noted the goal was experience any adverse integrity issues through the rventions included; staff to ad or open areas, ensure relieving devices in place Monitor skin daily during Report any abnormal hysician. ent Weekly Skin Check found no mention of any 5/9/11 and obtained by the (treatment) penile erosion wound cleanser 2. cover e 3. (change) q (every) day keep (catheter) attached to ent note did not mention enis and no measurements ation and interview was at at 9:32AM with the . The resident had an heter. The TN cleansed the etip of the penis. The open lened track. The area was unt of mucus type drainage of the area as "penile erosion" int came back from the in the erosion. The resident	F 315				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE	CONSTRUCTION	(X3)	DATE SUR	
AND PLAN OF C	OKKEGIION	IDENTIFICATION NUMBER:	A. BUII	.DING		ļ	•	
,	,	345092	B, WIN	G			05/12	; 2/2011
	VIDER OR SUPPLIER	DN SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)				(X5) COMPLETION DATE
	which were contracted acial expressions of a prosion was cleaned a ubing was adjusted. In the placed a new an esident's thigh to prehe indwelling catheted neasured the penis would be found in "Interest for the resident eason as to why no the penile erosion until 5/	angled in between his legs ed). Resident #277 displayed discomfort when the penile and when the catheter. The TN stated the resident the catheter strap. The TN chorage system on the vent tension or pulling on or. The TN indicated he had wound and that information egumentary/Skin Concerns. The TN could not provide a reatment was initiated to the 9/11.	F	315				•
F F r s v	oractitioner (NP) #1 spenile wound since the e-admitted. She stated. She stated. She stated she acknowledges ince shortly after respond care staff was ner of new areas and NP indicated she was	ed it was a little swollen and ed not seeing the wound admission but stated the very good about informing keeping her updated. The sont sure if anchoring the help prevent any skin						
c ti a r r tti e	on 5/12/11 at 9:06AM hought he charted at anchoring device but eviewed the TN note notes in regards to the neasurement of the phought he measured excuse" for why the in	"clearly he did not." He is and could not find any e assessment and benile erosion. He stated he the wound but "has no information was not there. everyone's responsibility to		The state of the s	ity ID: 923570	If one lies	ualion choc	it Page 37 of 45

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OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING			
			B, WIN	IG		C	
		345092		_		05/12	2/2011
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
GRACE H	EALTHCARE OF WINST	ON SALEM		ı	900 W 1ST STREET		
				V	VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
					DEFICIENCY)		
F 315	Continued From page	e 37	F	315			
		catheter. He stated the					
	catheter tubing should be anchored to the						
	resident's leg to prevent tension and pulling.						
	During an interview on 5/12/11 at 9:25AM, nurse						
	#2 stated the resident has had the open area to						
.		st hospital admission. She					!
		anged. Only the TN does				ļ	
		lurse #3 stated there was hey could have done for the					
	not much treatment to penis wound.	ley could have dolle lot the					
	point nomin.						
		ound care observation on				ļ	
		easurements of the penile					
		d by the TN. The penile					
		3 centimeters (cm) by 1cm, a. Nurse #2 stated there was					
		and since the resident had			Table	:	
	been re-admitted. Ne	ither the TN nor nurse #2			T-re-		
		answer as to why the wound					
		if the verbal order was					
	l)	he resident's catheter tubing					
	was secured to his th	age.					
	On 5/12/11 at 1:48PM	/I NP #1 provided some				-	
	information on "Secu	ring the Indwelling Catheter."	1				
		from "Lippincott's Nursing	1				
		ticle read in part, "Optimal			& Andrews		
		dwelling catheter includes to the thigh or abdomen in a	1.				
		catheter or its retention				•	
		excessive force on the					
	bladder neck or ureth						
		514 O 14 4 - A O 14 O D B A 44 - A					
		n 5/12/11 at 2:19PM the ated the catheter tubing					
		the leg of residents who					
	had indwelling cathet						
							<u> </u>
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: IS1C1	1	Fa	acility ID: 923570	ontinuation shee	t Page 38 of 45

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345092	B. WING		05/	C 12/2011
	COVIDER OR SUPPLIER	ON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 315	An interview was con 3:18PM with MDS nu she thought the reside erosion to the penis be when he returned from initial skin assessmen "like a slit or erosion (intact like someone heat." MDS nurse #1 resident was at increasion in he had a like someone heat."	ducted on 5/12/11 at rse #1. The nurse stated ent might have had a healed refore going to the hospital, m the hospital, she did his nt. She thought there was (to the penis), the skin was ad a scar but not as bad as stated she did not think the ased risk for open areas to history of healed erosion	F3	trimmed on 05/11/11 by the Cer Assistant. The physician was notified on 0 charge nurse and an order was o Unit Coordinator on 05/12/11 to # 277 to the podiatrist. Resident by the podiatrist on 05/18/11. 2. A 100% audit was conducted Coordinators and the Treatment 05/13/11 for all facility resident toenails trim and cleaned or add podiatry list.	5/12/11 by the btained by the refer Resident #277 was seen by the Unit Nurses on s who requiring	(e[3](j
F 328 SS=D	NEEDS	NT/CARE FOR SPECIAL ure that residents receive care for the following	ro	3. An in-service was conducted Development Coordinator 05/26 06/02/11 for all licensed nurses Nursing Assistants in regards to toenails and fingernail trimming	0/11 through and Certified nail care for gand cleaning.	
	Injections; Parenteral and enteral Colostomy, ureterosts Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and. Prostheses. This REQUIREMENT by: Based on observation review the facility failures idents with diabeted contracted podiatry successions.	omy, or ileostomy care; Is not met as evidenced In, staff interview, and record and to provide 2 of 2 sampled		4. Audits will be conducted by Coordinators and Treatment Nu facility residents to ensure that trimmed, cleaned and/or added list. This audit will be conducte four weeks, then monthly for twand/or 100% compliance. The raudit will be noted and reviewe monthly Quality Assurance Per Improvement. The results will be the monthly Quality Assurance Improvement Meeting by the D Nursing. Any issues or trends in addressed by the Quality Assur Performance Improvement Corarise and the plan will be revise continued compliance. The Quality Assurance Improvement Corarise and the plan will be revise continued compliance. The Quality Assurance Improvement Corarise and the plan will be revise continued compliance. The Quality Assurance Improvement Corarise and the plan will be revise continued compliance. The Quality Assurance Improvement Corarise and the plan will be revise continued compliance. The Quality Assurance Improvement Corarise and the plan will be revised continued compliance. The Quality Assurance Improvement Corarise and the plan will be revised continued compliance. The Quality Assurance Improvement Corarise and the plan will be revised continued compliance. The Quality Assurance Improvement Corarise and the plan will be revised continued compliance. The Quality Assurance Improvement Corarise and the plan will be revised addressed by the Quality Assurance Improvement Corarise and the plan will be revised addressed by the Quality Assurance Per Improvement Corarise and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the plan will be revised and the pl	rse's for all nails are to the podiatry d weekly for yo months essults of this d in the formance irector of lentified will be ance namittee as they d to ensure ellity Assurance inmittee consists or of Nursing, MDS inator, al Director, vironmental nee, Dietary	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COMPLE	
			B. WING_			C
		345092	B. AAIIAG _		05/	12/2011
	ROVIDER OR SUPPLIER	STON SALEM	S.	TREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		I SHOULD BE	(X5) COMPLETION DATE
F 328	2/25/11. The reside included hypertensifailure, cerebral vas Minimum Data Set(Resident#293 requiassistance with acti Review of care plar resident requires as for activities of daily resident will experie each day, by next mas needed for activities and bath/shower evon evening. Review of the facility present (1/4/11, 2/1 revealed resident # The podiatry clinics 3/28/11, revealed in During an observat Resident #293 was were long 1 inch or on all of the toes. During an observat Resident #293 lying toenails was long a toes. During an observat Resident #293 sleer remain long and thi During an interview indicated that nursicut nails/toenails detection of the sident #293 sleer remain long and thi During an interview indicated that nursicut nails/toenails detections.	nt's cumulative diagnoses ion, diabetes, acute renal ccular accident. The annual MDS) dated 3/4/11 revealed ired total to extensive	F 32	8		

Event ID: IS1C11

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			CONSTRUCTION	COMPLETE		
ANDIDATO	00/(/(20//0.1	1,52,1111,151,1111,1111,1111	A. BUI	LDING		، ا	.	
		345092	B. WIN	G		1	2/2011	
	OVIDER OR SUPPLIER			1900	T ADDRESS, CITY, STATE, ZIP CODE W 1ST STREET STON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 328	toenails and stated respossible for cutt responsible for rep should be cut. She report the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the cutt	I that nursing would be ting toenails and NA was orting when the nails/toenails indicated that she did not of Resident #293 toe nails. Ition on 5/11/11 at 11:18AM, solving in bed and his toenails uncut. If on 5/11/11 at 12:08PM, unit stated if the staff esidents in need of toenail not swere added to the podiatry esidents were "automatically" If observation on 5/11/11 at indicated that nursing was of the times. NA should report to dent nails/toenails need to be indicated that once a week a led to cut/trim resident observed resident's toenails y should have been cut If on 5/11/11 at 5:20 PM, NA#4 indicated that once a week a led to cut/trim resident observed resident's toenails at night endicated that she expected on provide nail care during of charge nurse any resident at nail care. She added that all list and toenails should be kept	F	328				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	,	_			. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUI	LDIN	G	00,111	1
		0.45000	B. WIN	1G			2/2011
		345092		1		03/12	2/2011
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GRACE H	EALTHCARE OF WINST	ON SALEM		!	WINSTON-SALEM, NC 27104		
		FATERIT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORREC	CTION	(X5)
(X4) ID PREFIX	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	PREF	łΧ	(EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	3	CROSS-REFERENCED TO THE APP DEFICIENCY)	KOFKIATE	
			 				
F 328	Continued From pag	o 41	F	328	3		
1 320	Continued From pag	041			.,		
	The undated policy t	itled, "Fingernails/Toenails,					
	Care of revealed the	e purpose of the procedure					
	was to clean the nail	bed, to keep nails trimmed,					
	and to prevent infect	ions. Some of the guidelines re includes daily cleaning and					
	read in part, Ivan ca regular trimming." Th	ne staff should report to the					
	nurse supervisor if th	nere was evidence of ingrown					
		n, or if nails were too hard or					
	too thick to cut with o	ease.					
	2 Resident #277 wa	is re-admitted to the facility					
	on 4/18/11. His diag	noses included but were not					
	limited to; hypertens	ion, alcohol encephalopathy,					
	aphasia, right hemip	aresis, seizure disorder,					
	aspiration pneumoni	a, pressure ulcer, diabetes					
	and history of diffici	y audit madellossi					
	The most recent mir	nimum data set (MDS), dated					
		resident had severe					
	cognitive impairmen	t. He was totally dependent ility, transfers, locomotion,					
	dressing, eating, toil	et use and bathing. He					
	required extensive a	ssistance for personal					
		277 had no noted behaviors					
	on the MDS.		1				
	A care plan dated 5	i/6/11 revealed the resident					
	had a self-care defic	cit and required assistance					
	with activities of dail	y living. The goal was for the					1
	resident to have his	ADL needs addressed as					
	evidenced by remail	ning neat, clean, and without ext review. One of the					
	interventions was fo	r the staff to provide or assist	1				
	with nail care as nee	eded.					
			ĺ				
	Davious of the "Desi-	dent Weekly Skin Check					
	Review of the Resi	uent Weekly Skill Check					

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B, WING 05/12/2011 345092 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1900 W 1ST STREET **GRACE HEALTHCARE OF WINSTON SALEM** WINSTON-SALEM, NC 27104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 328 F 328 Continued From page 42 Sheet" revealed: For 2/1/11, the resident's finger and toenails were trimmed. On 2/9/11, the resident's finger and toenails were noted as "OK." On 2/15/11, no boxes were checked to indicate the resident's nails had been assessed. For the 3/1/11 and for the 3/8/11 weekly check, there were no check marks in any boxes to indicate whether the nails were ok or trimmed or if the resident refused. The dates of 3/16/11 and 3/22/11 found the residents nails to both be "OK." On 4/19/11, the toenails and the fingernails were noted as "trimmed." The finger and toenails were noted as "OK" on the 4/26/11 assessment. The next assessment was done on 5/6/11. The resident's nails (both) were noted as "OK." Review of the facility's podiatry list from 1/2011 to present (1/4/11, 2/1/11, 3/7/11 and 4/4/11) revealed resident #277 was not on any of the list. The podiatry clinics lists dated 1/11/11 and 3/28/11, revealed no entries for the resident. A review of resident #277's admission and discharges to date revealed, he was admitted to the facility on 1/20/11. The only hospitalization listed was from 4/2/11 to 4/18/11.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER:	A. BUI	LĐIN	·G		
		345092	B. WIN	IG_		, C 05/12/2011	
	ROVIDER OR SUPPLIER	ON SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		OULD BE COMPLETE	
F 328	manager (UM) #1 sta noticed/observed resi care, those residents list. The diabetic resident on the podiatry list. An interview was condurse #3 on 5/12/11 and nurse #3 (both on treatment nurses ched and fingernalls weekly refuse to have, their into to enalls) it would be in Weekly Skin Check Swould trim the nails (to needed. Nurse #2 ind seen by the podiatrist cut resident #277's to toes and the podiatrist cut resident #277's to toes and the podiatrist visits due to since his admission of indicated when a resident of the podiatry list to be seen absence of the podiatry list to be seen absence of the podiatron to have their toenails of the referred to an out of fact the seen and awake in bed. Du wound care it was not long thickened toenail (nurse #2, nurse #3) withinming toenails on the seen and the seen and the podiatry list to be seen absence of the podiatron to have their toenails to have their toenails to the seen and awake in bed. Du wound care it was not long thickened toenail (nurse #2, nurse #3) within the mails on the seen and the see	in 5/11/11 at 12:08PM, unit ted if the staff dents in need of toenail were added to the podiatry lents were "automatically" ducted with nurse #2 and at 9:25AM. Nurse #2 and atment team) indicated the cked the residents' toenails //. If a resident were to ealls trimmed (fingernails or noted on the "Resident heet." The treatment nurses one and fingernails) as icated "all" diabetics were. Nurse #2 stated she could remails except for his great to needed to trim those. Resident had missed the multiple hospitalizations in 1/20/11. Both nurses dent goes out to the hospital should remain on the nat the next visit, in the rist, if the residents needed trimmed they should be acility podiatrist.	F	328			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES -CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTI	PLE CONSTRUCTION	(X3) DATE SU	RVEY	
ANDEDINO	CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	G	COMPLETED		
		345092	B. WIN	lG		ſ	C 2/2011	
NAME OF PR	ROVIDER OR SUPPLIER		<u></u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	03/1	2:2011	
0040511	541 7110 4 DE OE 1411 161				900 W 1ST STREET			
GRACER	EALTHCARE OF WINS	ION SALEM		۱v	VINSTON-SALEM, NC 27104			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		(X5) COMPLETION DATE	
.,,,,			1/40	•	DEFICIENCY)	FINAIL		
F 328			F	328				
		nt would be added to the						
	podiatry list.							
	During an interview of	on 5/12/11 at 2:06PM, the			Terresease			
	director of nursing (E	OON) indicated she expected						
		the diabetic residents and						
		d to see the podiatrist on his wanted a private podiatrist						
		arrange transportation.						
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OLA		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	G 01 - MAIN BUILDING 01	JONN ETES
		345092	B. WING _		06/24/2011
	ROVIDER OR SUPPLIER	NSTON SALEM	. 19	NEET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC 27104	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APP DEFICIENCY)	ONTO BE COMPLETION
K 038 SS=D K 051 SS=D	Exit access is arrar accessible at all tin 7.1. 19.2.1 This STANDARD A, Based on obserfacility had delayed stair-wells and extered b.4th floor long hain code was entered b.4th floor stair-well 15 sec. delay c.4th floor Stair-well relock automaticall 15 sec. delay c.4th floor delayer requires more the elease under pressid. 3rd, floor delayer requires more the elease under pressid 3rd, floor delayer requires more the elease under pressident security applied to the release NFPA 101 LIFE SA A fire alarm system devices or equipment NFPA 72, National effective warning of Activation of the comanual fire alarm in extinguishing system that manual pull standard	Il irreversible process stopped d during 15 sec. delay Il door near room 417 would y if code was entered during ell door at Day Room would not sure on release device d egress lock on the short hall 15 sec. to release is on the front and rear exit d an alarm when pressure was	K 038	This Plan of Correction is submit us required under State and Feddlaw. The facility's submission of Plan of Correction does not constitute an admission on the pute facility that the findings cites a deficiency, or that the scope at severity determination is correct Because the facility makes no swadmissions, the statements mad the Plan of Correction cumnot be against the facility maintenance direct serviced and replaced the key pad of fifth floor long hall on 06/24/11 accurrently does not stop when the centered during the 15 second delay. The keypad at the fourth floor staid door near room 417 was upgraded Maintenance Director on 07/08/1 now remains unlocked if the code entered during the 15 second delay. The the Mag Lock was adjusted to proper pressure by the Maintenance Director on 06/24/11 at the fourth stairwell door near the Day Room. The Mag Lock at the third floor degress on the short hall was repaired the Maintenance Director on 06/2 and currently releases within 15 second repaired by the Maintenance Director on 06/24/11. All doors were inspected for releasing and repaired by the Maintenance Director on 06/24/11. All doors were inspected for releasing and delay times by the Maintenance Director on 06/24/11. All doors were inspected for releasing and delay times by the Maintenance Director on 06/24/11. All doors were inspected for releasing and delay times by the Maintenance Director on 06/24/11. All doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferted to the doors were found to be afferte	art of I are intee
ANDRATOR	A DIRECTORIO DE BEONI	DERISUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(Xe) DA'rE
YULWALOK	I DIUCOTORA ON LYON	a and An Oak		Administration	7/1/ 11/

Any deficiency statement ording with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclossable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Event ID: IS1C21

Facility ID: 923570

If continuation sheet Page 1 of 4

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PRINTED: 06/27/2011 FORM APPROVED OMB NO, 0938-0391

STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAYE SURVEY COMPLETED
	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	0 01 - MAIN BUILDING 01	COMPLETED
		345092	8. WING _		06/24/2011
	ROVIDER OR SUPPLIER HEALTHCARE OF WI	NSTON SALEM	1	REUT ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC 27104	,
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APP	ONED BE COMPLETION
K 056 SS=D	Continued From patests are available, power is provided, maintained in accordance of mainten There is remote an system to an appropriate of the Installation provide complete of building. The system condance with N Inspection, Testing Water-Based Fire supervised. There systems are equip	A reliable second source of Fire alarm systems are redance with NFPA 72 and ance are kept readily available. nunciation of the fire alarm wed central station. 19.3.4, and central station. 19.3.4, and signal when the phone sted from the fire alarm panel. AFETY CODE STANDARD matic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the em is properly maintained in FPA 25, Standard for the line and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler ped with water flow and tamper e electrically connected to the	K 051	3. All doors will be inspected once we for three weeks and then monthly direct monthly by the Maintenance Director. 4. The results will be noted and revisit the monthly Quality Assurance Performance Improvement Commany issues or trends identified will addressed by the Quality Assurance Performance Improvement Commant they arise and the plan will be a seeded to ensure continued compliance. The Quality Assurance Performance Improvement Commonists of the Administrator, the Director of Nursing, Smff Develor Coordinator, MDS Coordinator, Admission Coordinator, Rehabilit Manager, Medical Director, Director of Maintenance, Director of Maintenance, Director Manager, and the Activities Director Director of Maintenance, Director Manager, and the Activities Director	recidy for for fewed mittee. d be securittee evised ce mittee evised ce mittee evised yetor of evices, y etor. TIXIII conducted were by There hen the the fire o impact one were sected by weekly aly for

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Event ID: (\$1021

Facility ID: 923570

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
(X1) PROVIDER/SUPPLIER/CLA

PRINTED: 06/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEN/CLIA		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING	G 01 - MAIN BUILDING 01		
		345092	B. WING		06/24/201	1
,	ROVIDER OR SUPPLIER HEALTHCARE OF WI	NSTON SALEM	18	EET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COM	(X6) PLETION IATE
K 056 K 072 SS⊭D	A. Based on obser inch sprinkler main and there is no hear freezing. 42 CFR 483.70 (a) NFPA 101 LIFE SA Means of egress ar of all obstructions of use in the case of furnishings, decoraexits, access to, eg	ge 2 s not met as evidenced by: vation on 06/24/2011 the 8 Is in a wood structure out side it provided for protection from FETY OODE STANDARD be continuously maintained free or impediments to full instant ire or other emergency. No tlons, or other objects obstruct ress from, or visibility of exits.	K 056	4. The inspection results will be be and reviewed monthly in our Q Assurance Performance Improvement committee by the Maintenance Any issues or trends identified addressed by the Quality Assurance Improvement Consistent and the plan will be as needed to ensure continued compliance. The Quality Assurance Improvement Conconsists of the Administrator, the Director of Nursing, Smith Deve Coordinator, MDS Coordinator Admission Coordinator, Rehabit Manager, Medical Director, Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director	vality vement Director will be unde mulitee a revised unce mintee te lopment ctor of Services,	
K 147 SS=D	A. Based on obser clean linen door on between the nurses door opens into the the doors do not hat NFPA 101 LIFE SA Electrical wiring an with NFPA 70, Nat This STANDARD A. Based on obser	d equipment is in accordance ional Electrical Code. 9.1.2 is not met as evidenced by: vation on 06/24/2011 the med., 3rd, and 4th floor were not organicy receptacle.	K 147	1. The certified technician installe thermostatic baseboard heaters 06/29/11 per manufacturers' recommendations in the wood outside to prevent freezing. 2. This practice has the potential all facility residents, however a found to be affected. 3. All outside areas will be inspectimes three weeks and then months by the Maintenar Director. 4. The inspection results will be be and reviewed monthly in our Committee by the Maintenante Any issues or trends identified addressed by the Quality Assur Performance Improvement Coast they arise and the plan will be as needed to ensure continued compliance. The Quality Assur Performance Improvement Coastinued consists of the Administrator, to Director of Nutsing, Staff Dev	structure to impact one were ted weekly inthly for ace rought to Quality vement plicetor. will be aunce manitree or revised ance manitree he	 ₹/11

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Event ID: IS1C21

Facility ID: 923570

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PRINTED: U6/2//2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u>-</u>	. 0930-0391
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	IULTIPLI ILDING	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE S	URVET ETED
1357 I X/III VI	# ALILIMA LEADS		ľ		01 - MAIN BOILDING VI	06/2	4/2011
	OVIDER OR SUPPLIER	NSTON SALEM		STREE	et address, city, state, zip code 0 w 1st street vston-salem, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	ROULD BE	(X6) COMPLETION DATE
					Coordinator, MDS Coordinator Admission Coordinator, Rehabi Manager, Medical Director, Dir Social Services, Environmental Director of Maintenance, Dietu Manager, and the Activities Dir 1972 1. The door closures for the seconthird floor clean linen rooms winstalled on 06/29/11 by the Maintenance Director. 2. All facility door closures were in by the Maintenance Director of 06/29/11. 3. All door closures will be inspectively for three weeks and the for three months by the Maintenance Director. 4. The inspection results will be and reviewed monthly in our Constitute by the Maintenance Any issues or trends identified addressed by the Quality Assurpressed by the Quality Assurpressed to ensure continued compliance. The Quality Assurpressed to ensure continued compliance. The Quality Assurpressed for the Administrator, Director of Nursing, Staff Dev Coordinator, MDS Coordinator Admission Coordinator, Rehal Manager, Medical Director, Discoul Services, Environmenta Director of Maintenance, Diet Manager, and the Activities Director of Maintenance, Diet Manager, and the Activities Director of Maintenance, Diet Manager, and the Activities Director of Maintenance, Diet Manager, and the Activities Director of Maintenance, Diet Manager, and the Activities Director Director of Maintenance, Diet Manager, and the Activities Director Director of Maintenance, Diet Manager, and the Activities Director.	ditation ector of Services, ry ector. Id and exe aspected a monthly enance vought to quality vement e Director. will be mance enance enance enance in monthly enance in mon	7/8/11

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Event ID: IS1C21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
, 0,12 , 0,11 0,			A. BUILDING	01 - MAIN BUILDING 01	2010 41004		
		345092			06/24/201	7	
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) PLETION PATE	
			74 Ear	1. All dedicated medication refrigence the second, third, and fourth flor medication rooms were plugged emergency outlet receptacles an on 06/24/11 by the Mulatenant Director. 2. All medication room refrigerato floors were inspected and verification to the emergency receptant labeled on 06/24/11 by the Mulatenance Director. 3. All medication room refrigerato inspected to ensure that they are into the emergency outlet and it. This inspection will be conducted weeldly for three weeks and therefor three months by the Mulaten Director. 4. The inspection results will be be and reviewed monthly in our Quantities by the Mulatenance Any issues or treads identified addressed by the Quality Assurance Performance Improvement Compliance. The Quality Assurance Performance Improvement Conconsists of the Administrator, the Director of Nursing, Staff Deve Coordinator, MDS Coordinator, Admission Coordinator, Rehabil Manager, Medical Director, Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance, Dietar Manager, and the Activities Director of Maintenance and activities Director of Maintenance and activities Direc	crators in coor linto the dilabeled ce ce so all ed to be eptacles e plugged abeled co done a monthly name cought to unfity vement Director. Will be monittee e revised e complete countities e revised e consiste countities e revised e consiste countities e revised e consiste countities e cou	g 1	
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FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 06/27/2011 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 345092 06/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET **GRACE HEALTHCARE OF WINSTON SALEM** WINSTON-SALEM, NC 27104 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 7/8/11 This Plan of Correction is submitted as required under State and Federal K 038 K 038 NFPA 101 LIFE SAFETY CODE STANDARD law. The facility's submission of the SS=D Plan of Correction does not Exit access is arranged so that exits are readily constitute an admission on the part of accessible at all times in accordance with section the facility that the findings cited are 7:1. 19.2.1 accurate, that the findings constitute a deficiency, or that the scope and JUL 1 2 2011 severity determination is correct. Because the facility makes no such admissions, the statements made in CONSTRUCTION SECTION the Plan of Correction cannot be used against the facility in any subsequent This STANDARD is not met as evidenced by: administrative or civil proceeding. A. Based on observation on 06/24/2011 the facility had delayed egress locks on all exit door ((A) The facility maintenance director stair-wells and exterior doors). serviced and replaced the key pad on the fifth floor long hall on 06/24/11 and a. 5th floor long hall irreversible process stopped in code was entered during 15 sec. delay currently does not stop when the code is entered during the 15 second delay. (B) b.4th floor stair-well door near room 417 would The keypad at the fourth floor stairwell relock automatically if code was entered during door near room 417 was upgraded by the 15 sec. delay Maintenance Director on 07/08/11 and c.4th floor Stair-well door at Day Room would not now remains unlocked if the code is release under pressure on release device entered during the 15 second delay. (C) The the Mag Lock was adjusted to the d. 3rd. floor delayed egress lock on the short hall requires more the 15 sec. to release proper pressure by the Maintenance Director on 06/24/11 at the fourth floor e 1st floor the locks on the front and rear exit stairwell door near the Day Room. (D). doors did not sound an alarm when pressure was The Mag Lock at the third floor delayed applied to the release device. egress on the short hall was repaired by K 051 NFPA 101 LIFE SAFETY CODE STANDARD K 051 the Maintenance Director on 06/25/11 SS=D and currently releases within 15 seconds. A fire alarm system with approved components, (E). The first floor locks on the front devices or equipment is installed according to and rear exit doors sound when pressure is applied. The key pads were inspected NFPA 72, National Fire Alarm Code, to provide and repaired by the Maintenance effective warning of fire in any part of the building. Director on 06/24/11. Activation of the complete fire alarm system is by All doors were inspected for release manual fire alarm initiation, automatic detection or pressure and delay times by the extinguishing system operation. Pull stations in Maintenance Director on 06/24/11. No patient sleeping areas may be omitted provided other doors were found to be affected. that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0		CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345092	B, WIN	G		06/	24/2011
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM			•	1900	ADDRESS, CITY, STATE, ZIP CODE W 1ST STREET STON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 056 SS=D	tests are available power is provided. maintained in accordance was remote ar system to an appropriate of the line was disconnect 42 CFR 483.70 (a) NFPA 101 LIFE SA If there is an autominstalled in accordator the Installation of provide complete obtilding. The system accordance with NI Inspection, Testing Water-Based Fire I supervised. There supply for the systems are equipper systems are equippersonded in accordance with NI Inspection, Testing water-Based Fire I supervised. There supply for the systems are equippersonded in accordance with NI Inspection, Testing water-Based Fire I supervised. There supply for the systems are equippersonded in accordance with NI Inspection, Testing water-Based Fire I supervised. There supply for the systems are equippersonded in accordance with NI Inspection, Testing water-Based Fire I supervised. There supply for the systems are equippersonded in accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection and Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance with NI Inspection was not accordance wit	A reliable second source of Fire alarm systems are ordance with NFPA 72 and cance are kept readily available. Inunciation of the fire alarm oved central station. 19.3.4, 19.3.4, 19.3.4, 19.3.4 19.3.4, 19.3.4 19.3	KO	4.	for three weeks and then monthly three months by the Maintenance Director. The results will be noted and rev in the monthly Quality Assurance Performance Improvement Commany issues or trends identified with addressed by the Quality Assurance Performance Improvement Commas they arise and the plan will be a seeded to ensure continued compliance. The Quality Assuran Performance Improvement Commonists of the Administrator, the Director of Nursing, Staff Develor Coordinator, AMDS Coordinator, Admission Coordinator, Rehabilith Manager, Medical Director, Director Social Services, Environmental Settlement of Maintenance, Dietary Manager, and the Activities Director of Maintenance Director on 07/06/11 and its' components of the Maintenance Director on 07/06/11 and its' components of	iewed iewed iewed imittee. Il be ce mittee mittee inittee /8/11	

PRINTED: 06/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 345092 06/24/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1900 W 1ST STREET GRACE HEALTHCARE OF WINSTON SALEM** WINSTON-SALEM, NC 27104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY The inspection results will be brought to K 056 and reviewed monthly in our Quality Continued From page 2 K 056 Assurance Performance Improvement Committee by the Maintenance Director. Any issues or trends identified will be This STANDARD is not met as evidenced by: addressed by the Quality Assurance A. Based on observation on 06/24/2011 the 8 Performance Improvement Committee inch sprinkler main is in a wood structure out side as they arise and the plan will be revised as needed to ensure continued and there is no heat provided for protection from compliance. The Quality Assurance freezing. Performance Improvement Committee 42 CFR 483.70 (a) consists of the Administrator, the K 072 NFPA 101 LIFE-SAFETY-GODE STANDARD — K-072 Director of Nursing, Staff Development SS=D Coordinator, MDS Coordinator, Means of egress are continuously maintained free Admission Coordinator, Rehabilitation Manager, Medical Director, Director of of all obstructions or impediments to full instant Social Services, Environmental Services, use in the case of fire or other emergency. No Director of Maintenance, Dietary furnishings, decorations, or other objects obstruct Manager, and the Activities Director. exits, access to, earess from, or visibility of exits. 7.1.10 056 7/8/11 The certified technician installed thermostatic baseboard heaters on 06/29/11 per manufacturers' recommendations in the wood structure outside to prevent freezing. This STANDARD is not met as evidenced by: This practice has the potential to impact A. Based on observation on 06/24/2011 the all facility residents, however none were clean linen door on the 2nd and 3rd floors found to be affected. between the nurses station and the stair-well exit All outside areas will be inspected weekly door opens into the corridor reduces the width (times three weeks and then monthly for the doors do not have closers). three months by the Maintenance Director. K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 The inspection results will be brought to SS=D and reviewed monthly in our Quality Electrical wiring and equipment is in accordance Assurance Performance Improvement with NFPA 70, National Electrical Code. 9.1.2 Committee by the Maintenance Director. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee This STANDARD is not met as evidenced by: as they arise and the plan will be revised as needed to ensure continued A. Based on observation on 06/24/2011 the med. compliance. The Quality Assurance refrigerator on 2nd, 3rd, and 4th floor were not Performance Improvement Committee plugged into a emergency receptacle. consists of the Administrator, the 42 CFR 483.70 (a) Director of Nursing, Staff Development

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILDING	01 - MAIN BUILDING 01	COMPLETED	
		345092	B. WII	NG		06/	24/2011
NAME OF PROVIDER OR SUPPLIER				i	ADDRESS, CITY, STATE, ZIP CODE W 1ST STREET		
GRACE H	EALTHCARE OF WI	NSTON SALEM		1	STON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		,		0		ilitation ector of Services, ry ector. d and	7/8/11
				2.	by the Maintenance Director on 06/29/11. All door closures will be inspect weekly for three weeks and then for three months by the Mainten Director.	spected ed once monthly nance ought to nality ement Director. rill be nce nmittee revised nce mittee copment itation ctor of cryices,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345092	B, WI	B. WING		06/24/2011	
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF WINSTON SALEM				STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		OULD BE	(X6) COMPLETION DATE
					1. All dedicated medication refrige the second, third, and fourth flo medication rooms were plugged emergency outlet receptacles and on 06/24/11 by the Maintenance Director 2. All medication room refrigerator floors were inspected and verifies plugged into the emergency rece and labeled on 06/24/11 by the Maintenance Director. 3. All medication room refrigerator inspected to ensure that they are into the emergency outlet and late This inspection will be conducted weekly for three weeks and then for three months by the Maintenance Director. 4. The inspection results will be broand reviewed monthly in our Quexistrance Performance Improved Committee by the Maintenance In Any issues or trends identified weekly active active as they arise and the plan will be as needed to ensure continued compliance. The Quality Assuran Performance Improvement Commonsists of the Administrator, the Director of Nursing, Staff Develor Coordinator, MDS Coordinator, Admission Coordinator, Rehabilit Manager, Medical Director, Director of Maintenance, Dietary Manager, and the Activities Director	into the dalabeled ce ce con all ed to be eptacles con all ed to be eptacles con all ed to be eptacles con all ed to be eptacles con all ed to be eptacles con all to constitute con all to constitute con all to ce	718/11