PRINTED: 03/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUR		E CONSTRUCTION TO 26 2012	(X3) DATE SUF COMPLET	
		345443	B. WIN			1	C 1/2012
	OVIDER OR SUPPLIER	ABILITATION		56	EET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE INSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ì	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 221 SS=E	The resident has the physical restraints in discipline or convenitreat the resident's number of the resident's number of the resident's number of the resident's number of the resident of the	right to be free from any apposed for purposes of lence, and not required to medical symptoms. T is not met as evidenced ons, family interview, staffed reviews, the facility failed to cal symptoms for 4 of 4 with restraints and failed ic approaches to reduce is #33,117,217 and 218). It is a least the facility failed to cal symptoms for 4 of 4 with restraints and failed ic approaches to reduce is #33,117,217 and 218). It is a least the facility of the facility on the facility of the facility on the facility of the facility of the facility on the facility of the faci		221	Corrective action to be accomple those residents found to have be affected by the deficient practice. 1. Physicians orders were obtained discontinue the belt restraint on resident #33. A personal chair all added to alert staff of resident's to get up without assistance. ½ to continues to assist resident with non dominant weak arm. 2. Physicians orders were obtained discontinue the lap buddy on resident #217. Physicians input a obtained. 4. Physicians orders were obtained discontinue the lap buddy on resident #217. Physicians input a obtained. 4. Physicians orders were obtained discontinue the lap buddy on resident #217 alarm was added staff of resident's attempts to ge assistance.	een e: ned to arm was attempts ray resting her ned to ident #117. D.O.N int of and order ed to ident #281.	3/19/12
ABQRATORX	DIRECTOR'S OR PROVIDE	R/SUIPLIER REPRESENTATIVE'S SIGNATUR	E		A TITLE		(X6) DATE

Any deficiency statement ending with an asterick (*) 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.

X10 MIND TRATOR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345443	B. WIN			O 03/01/	
	ROVIDER OR SUPPLIER	REHABILITATION	:	58	EET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE INSTON SALEM, NC 27105		
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F 221	restraint. Last received of the last 2/4/08, revealed non-ambulatory. Review of the phyrevealed a self resecondary to fall lap table to wheeled decreased safety and history of fall Review of the prof/6/11, revealed non-ambulatory, while sitting and position. A self resident was una Review of the refe/6/11, 7/6/11, 8, comment section use a self release to release on confor lap tray was in symptom was ponursing who indice assessment revealed assessment professional revealed Reside Review of the refidentified the professional revealed Reside Review of the refidentified the profession and the refidentified the refidentified the profession and the refidentified the refidentified the profession and the refiden	s non ambulatory with a trunk corded fall noted on 5/1/11. It fall risk assessment dated that Resident #33 was ysician 's order dated 6/6/11, blease belt while up in wheelchair is. In addition, on 1/17/12, apply alchair when up out of bed due to a wareness related to dementia	L.	221	Corrective action to be accomplish those residents having the potent affected by the same deficient procession. 1. All residents were assessed for interventions that would be considered restraints were assessed therapy and nursing to determine restrictive device, only after all other alternative approaches have failed 2. Same as #1 3. All current residents were assess the therapy department and nursi determine that the least restrictive was necessary. 4. Same as #1. Measures put in place or systemic made to ensure that the deficient will not occur: 1. A physical restraint can only be after all other non-restraining interplace have been tried and deemed unsure keeping resident safe. The least restraint must be used first and or collaboration with the therapy department and physician families that are persistent in using when not warranted will be educated use of restraints based on medical Quarterly restraint reduction assess to performed by therapy and Nurresidents with restraints. 2. Same as #1 3. Same as #1 4. Same as #1	dered a are ed by the least her l	

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	ROVIDER OR SUPPLIER EST HEALTH AND RE	HABILITATION		56	EET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE INSTON SALEM, NC 27105		
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F 221	of trunk of restraint restraint (self release included resident with enext 90 days. The sure self release seresident is up in what frequently, reasses reduction of effective falling star programment activities and mats. Review of the restrates assessment) dated Resident #33 was abelt die to frequent transfer and ambult assistance due to coueing and monitor agreement that as best for her. She diplace. Per staff, she did not remove it up to rest her left arm. Review of occupation through 8/30/11, reseen for wheelchait demonstrated good appropriate position without discomfort. Review of the physe 9/15/11, revealed to the series of the series transfers. Resident with rolling walker assistance and later assistance as a series as a se	and risk for injury from use of se seat belt). The goals ill not injure self or others over the approaches included make set belt is in place when eelchair, check and reposition is quarterly for possible veness, call bell in reach, it, assist resident in out of room to floor. The self is in place when eelchair, check and reposition is quarterly for possible veness, call bell in reach, it, assist resident in out of room to floor. The self is in place when eelchair, check and reposition in reach, it is a self release seat falls. She would attempt to attend at without asking for elementia. She needed frequent ring for safety. Family was in elf release restraint would be one not resist having it in elemential can remove it at times but on request. She uses the tray onal notes dated 8/18/11 evealed that Resident #33 was	L.	221	All physical restraints will be more using the restraint reduction associated and nursing management quarter change in condition of resident was reduction. Assessments will be retained the QA committee meetings.	essment in epartment orly or if varrants the	

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F 221	Continued From p	F	221				
	department to add	ner assessment from therapy ress the use of the self release lusion of the lap tray.					
	Resident #33 was with lap tray in pla in place and she s difficulty. There we	ntion on 2/29/12 at 7:29AM, seated in front of her bedroom ce. There was a chair cushion at in an upright position without ere no repetitive movements or actions, both feet were place					
	nurse#1 stated that tray for meals and meals. She added an upright position leftside when she Resident had not Resident was una device independe non-ambulatory, cattempting to get	w on 2/29/12 at 7:32AM, at Resident #33 used the lap the tray was removed after I that resident was able to sit in a without tray and only leans to was tired or falls sleep in chair, had any falls in months, ble to remove any type of ntly and she was could not recall resident up unassisted. DON(director of assessments of restraints.					
	indicated that Res the time, resident forward in chair. S able to reposition forward. She was indicated that who she had fallen als	w on 2/29/12 at 7:35AM, NA #1 sident#33 used the lap tray all would attempt to stand or slid the added that the resident was self in chair even when she slid unaware of any falls. She en she slides forward was after eep in the chair. Resident was any type of device.					
		ation on 2/29/12 at 7:52AM, seated in the main dining room					

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F 221	tray was positioned eating her meal from She only required was reaching over that was placed or spilling all over the was assisting other was and that the management of the management was the residents wore they were a fall rist she indicated that removed during directly was and that the stated that anytimal lap buddy or trays would find a table chair could fit under the was an observed an or attempts to remove the way of t	or tray in place. Resident#33 If under the table and she was an the main dining room table. It meal set only. Resident#33 It tray trying to get to her meal at the main table. Food was main table and the tray. Staff or residents. If you are also only is a state of that they generally work the NA #2 indicated that the ain dining room generally istance only. She added that the lap buddy/trays because k and mobile within the facility. It he lap buddy or trays was not ning due to the potential for the tward or reach for something in expected. NA #3 stated that to falls in the dining room nave the lap buddy's or trays in residents were fall risks. NA#3 at a resident had a device like while in the dining room, staff that was at good height that the er was used. It ion on 2/29/12 at 10:45am to it #33 seated in hall in from of y, no leaning in any directions ove or stand. If you are a company to the assessment or estraints. It was all done by the	F	221				

_ ,	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345443	A. BUII B. WIN	LDING	CONSTRUCTION	COMPL	COMPLETED COMPLETED C 03/01/2012	
	OVIDER OR SUPPLIER	IABILITATION		5680	ADDRESS, CITY, STATE, ZIP CODE WINDY HILL DRIVE STON SALEM, NC 27105			
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F 221	DON(director of nurresponsible for the erestraints. She indicated that Residem reason for the use of that the therapy depincluded in the evaluation of the evaluation of the she did not have included what the arrow of documentation of continuation or redute further stated "residents and the gave into family requight". She further she updated to reflect restraints. She adderestraints were either or poor safety aware indicators or physicial use of restraints. During an interview administrator indicated and done quartely relaeased during meshould have a clinicated restraint.	on 2/29/12 at 2:49PM, the sing) stated that she was evaluations/assessments of ated that after review of the t #33 did not have a medical f restraint. She further stated eartment was not generally uation/assessment process at process included use of the in a quarterly basis. She added the a system in place that is essessment process entailed if the observations for the incline of a restraint. She	F	221				
	3/16/07. Resident #	117 cumulative diagnoses on, pulmonary fibrosis and				,	L'approprie	

,	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		CONSTRUCTION	(X3) DATE S COMPLE	
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NAME OF PR	OVIDER OR SUPPLIER	345443		STORET	ADDRESS, CITY, STATE, ZIP CODE	1 03	/01/2012
	EST HEALTH AND REHA	ABILITATION		5680	WINDY HILL DRIVE STON SALEM, NC 27105		
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F 221	1/4/12, indicated that and long term memor problems. She require areas of daily living. So not coded for any believe of physician 9/19/11, revealed that therapy was disconting referred to restorative resident to tolerate knowled to the further contracture. I should be positioned profile anti-thrust cus to wheelchair position. Review of physician or revealed that lap bud increase dignity due sanitary problems. Review of pre-restrain 2/27/12, revealed that non-ambulatory and mobility. Reason for dignity, family requestal atternatives used was nursing who indicated assessment revealed documentation availated observed releasing the assessment process lap buddy or other alta Additional review of the same process.	um Data Set(MDS) dated Resident #117 had short ry and decision making ed total assistance with all She was non-ambulatory and naviors associated with falls. order 8/21/11 and dated at occupational and physical nued and Resident #117 was e for splint management, nee splint x 4hrs to decrease in addition, Resident #117 in wheelchair with medium thion and stop drop foot rest ning to decrease falls. order dated 2/27/12, ldy while in wheelchair to to eating feces and decrease ning evaluation dated at Resident #117 was dependent upon staff for use of lap buddy was for est and sanitary reasons, is long pants. Director of d responsibility for the	F	221			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	COMPI	
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	OVIDER OR SUPPLIER	HABILITATION	<u> </u>	5680	ADDRESS, CITY, STATE, ZIP CODE WINDY HILL DRIVE STON SALEM, NC 27105	·	
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F 221	Review of care plan problems as; Resid due to need for a chouddy to aid in position eating feces and fai included Resident the use of the device decline in activities days and no injuries in 90 days. The appropriate family about the use change position every check device daily to condition, remove the puddy. She satt difficulty or repetitive crossed. There was unassisted. During an observative resident #117 was to main dining area the Resident #117 was to m	a dated 2/27/12, identified the ent #117 was at risk for injury nair that prevents rising-lap tioning and to prevent from mily request. The goals £117 would no longer require the in 90 days, experience no of daily living over the next 90 as due to the use of the device proaches included teache the of the device, assist and the entry 30 minutes to 2 hours, to make sure it is was in good device during supervised from on 2/29/12 at 7:38AM, at in main dining room without in an upright position without the movements with her legs as no attempt to stand from the lap dependent of the device of the device of the device of the device, assist and the entry 30 minutes to 2 hours, to make sure it is was in good device during supervised from on 2/29/12 at 7:38AM, at in main dining room without the movements with her legs are no attempt to stand from the lap developed and family requested that it dent. The resident did not was unable to remove it for on 2/29/12 at 8:10AM, and in front of nursing station as crossed in an upright of demonstrate any difficulty	F	221			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345443	B. WIN	G_		03/0	C 1/2012
	OVIDER OR SUPPLIER	ABILITATION			REET ADDRESS, CITY, STATE, ZIP CODE 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		
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F 221	responded appropria Lap buddy was in pla attempted to remove During an observatio resident was being fe place. During an interview of therapy director state did not do any of the determination for resident ponting an interview of Dont director of nurs responsible for the e	aff. She sat quietly. She stely to staff basic questions. ace and Resident #117 never or stand unassisted. In on 2/29/12 at 8:57AM, and by NA#4 with lap buddy in the standard or 2/29/12 at 2:39PM, and that therapy department assessment or straints. It was all done by the	I.	221			
	record that Resident reason for the use of that the therapy depincted in the evaluation for restraints and that pre-restraint form on that she did not have included what the asteroid or documentation of continuation or reduction of the stated "residents and family regave into family requiright". She further side updated to reflect restraints. She adderesidents had any regestraints were either	#117 did not have a medical frestraint. She further stated artment was not generally lation/assessment process at process included use of the a quarterly basis. She added as a system in place that esessment process entailed the observations for the ction of a restraint. She					

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F 221	indicators or physic use of restraint. During an interview administrator indicatherapy be involved and done quartely, relaeased during machinestraint. During an observative resident seated at the	ge 9 ian input in the decision for the r on 2/29/12 at 3:01PM, the ated the expectation was that in the restraint assessment Residents should be reals/actvities. The residents cal reason for the use of ion on 3/1/12 at 8:53AM, rable with lap buddy in place, i resident with meal.	F	221			
	The cumulative dia mild dementia, chrodisease, osteopros Data Set(MDS) dai Resident #217 had memory and decision required one persodaily living and trantrunk restraints and	dmitted to facility on 4/25/11. gnoses included hypertension, onic obstructive pulmonary is and anxiety. The Minimum and 8/7/11, indicated that some short and long term on making problems. She in assistance with activities of insfers. She was coded with a line falls. Reviewed the fall log 12, Resident #217 had 1 fall in		and the state of t			
	revealed lap buddy numerous falls. Review of care pla problem as Reside assistance, at risk recent fall with hip peri-prostatic fx. O The goals included	n order dated 6/14/11, to wheelchair due to n dated 11/8/11, identified the nt #217 needed 2 person factors for falls and injury, fx and repeated falls with n 6/14/11 use of trunk restraint. I Resident #217 would not fall es in next 90 days. The	The party of the control of the cont				

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F 221	approaches included reach at all times (HC remind at each conta assisance, make surbottoms. Last docum reaching for somethic superficial bruise to be required the use of a impaired cognition at The goal would be Radverse effect of resiby) no skin breakdow of motion). The approsure restraint was appresident doesnt not schair, check frequently provide opportunity for stimulation, reveiew reduction or elimination ordered. Review of the restrain form dated 7/3/11,8/revealed the assessing continue the use of law wheelchair to decreate stricitive, used to deap buddy, poor safe falls. There was no for regarding the assessing measures attempted indicated responsibility revealed there was resident #217 observed the assessing implement the or lap alternative devices.	keeping the call light within (H), keep bed in low position, act to not to transfer without the foot wear had non-skid ented fall was 9/5/11, while any and fell forward the call forward the cal	F	221			

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F 221	During an observation Resident #217 was room at the table will Resident #217 tray wand she was eating dining room table. Sonly, Resident was to get to her meal the table. Food was spin and the tray. Staff word was an interview and NA #3 indicated main dining room. In residents in the main needed set-up assist the residents wore of they were a fall risk. She indicated that they were and that the resident to lean forward they was they did he place and that they would find a table they would find a tab	f217 had not had any falls. on on 2/29/12 at 7:52AM, seated in the main dining th lap buddy in place. was positioned under the table her meal from the main she only required meal set reaching over lap buddy trying hat was placed on the main liling all over the main table were assisting other residents. on 2/29/12 at 8:00AM, NA #2 di that they generally work the NA #2 indicated that the n dining room generally stance only. She added that the lap buddy/trays because and mobile within the facility, he lap buddy or trays was not ing due to the potential for the ward or reach for something in expected. NA #3 stated that falls in the dining room are sidents were fall risks. NA#3 a resident had a device like while in the dining room, staff that was at good height that the	E	221			

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F 221	Continued From page		F	221			
	the lap buddy and sh	217 was unable to remove e was uncertain why she had ent was able to eat her meal					And the second s
	Resident #217 seate stated that she fell or	n 2/29/12 at 9:30AM, d in her room. Resident#217 nce when she first arrived w on me and foot pads and					
	never took it off. I hav and it makes me feel	ve not fallen. "I don't need it trapped." I could probably hard to stick the corners in					
	#1stated that Reside more than a year and on Resident#217 ever falling. She stated the resident falling. Resident falling. Resident falling the pillow when staff corners of the pillow was not properly sec	on 2/29/12 at 9:40AM, NA ont #217 had the pillow for at the nurses told her to put it eryday to keep her from at she was unaware of the dent #217 could not remove asked, she could not get the from the arm rest. The pillow ured it was bent at the arms thought the sitting on the resident					
	Resident seated in ro there was no repetitive	/29/12 at 10:30AM-11:00AM, nom with lap buddy in place, we movements, leaning in npts to remove lap buddy.					
	therapy director state did not do any of the	on 2/29/12 at 2:39PM, ad that therapy department assessment or all done by the DON,					
		on 2/29/12 at 2:49PM, the ing) stated that she was					

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F 221	restraints. She indicated that Resident reason for the use of that the therapy depincluded in the evaluation for restraints and the pre-restraint form on that she did not have included what the asterior of documentation of continuation or reduction further stated "resident restrained at family gave into family requision of the continuation of t	evaluations/assessments of ated that after review of the #217 did not have a medical frestraint. She further stated artment was not generally action/assessment process at process included use of the a quarterly basis. She added a system in place that assessment process entailed the observations for the ction of a restraint. She	F	221			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COMF	PLETED
		345443	B. WIN	G		e e	C 3/01/2012
	OVIDER OR SUPPLIER	DR SUPPLIER ALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Muded From page 14 DAY DEFICIENCY DAY DEFICIENCY DAY DEFICIENCY DEFICIENCY TAG TAG TO AND THE APPLICATION OF THE APPLICATION F 221 F 221 THE PROVIDER'S PLAN OF CORRES (EACH CORRECTIVE ACTION SIX CROSS-REFERENCED TO THE APPLICATION SIX CROSS-REFERENCED TO THE APPLICATION OF THE APPL					
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOULD BE	(X5) COMPLETION DATE
F 221	and gait abnormality Set(MDS) dated 1/3 #281 had some sho decision making prorequired entensive the activities of daily living dressing), needed some showing in room at least oncomit the use of restrictions of the MDS indicated in room at least oncomit the use of restrictions of the management in group walking. Additional in lap buddy for poor subnormality with fall 2/16/12, physical the bearing left lower engoing to bed/chair, and follow-up in 4 with Review of care plan problem as; Reside and injury. The goal would not have fall related to use of resapproaches include reach at all times, be as ordered, remove per protocol, observance, buring an observation of the proposition of the proposition of the protocol, observance, puring an observation of the protocol of the prot	arkinson's disease, anemia 7. The Minimum Data 1/12, indicated that Resident rt and long term memory and blems. Resident #281 o total assistance with ng(transfer/ mobility, ome supervision with eating. that Resident #281 did walk e or twice. She was not code aint due to recent admission. 1's order dated 1/25/12, ent #281 would receive imes a week times 12 weeks se, gait training and w/c p 1:1 act and difficulty review, on 2/9/12, revelaed a rafety awareness and gait s and family request. On erapy continued no weight ctremity. Transfer board when continue with upper extremity of motion with hip precautions reeks. 1 dated 2/6/12 identified the nt #281was at risk for falls 1 would be that Resident #281 or injuries or adverse effect etraint in next 90 day. The d keeping call light within ed in low position, lap buddy from restraint and ambulate re for signs and symptons of p buddy and offer frequent on on 2/29/12 at 7:52AM, seated in the main dining	F	221			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		DNSTRUCTION	COMPL	ETED DATE
		345443	B. WIN	G		03	C 5/01/2012
	ROVIDER OR SUPPLIER	HABILITATION	-	5680 W	DDRESS, CITY, STATE, ZIP CODE JINDY HILL DRIVE TON SALEM, NC 27105		
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F 221	room. Resident #26 wanted for beverag removed the lap but sat in an upright porepetitive movemer herself without diffict the table. Resident buddy to get to the as she raised the cover the lap buddy. During an interview and NA #3 indicate main dining room. It residents in the man needed set-up assist the residents wore they were a fall risk. She indicated that removed during diresident to lean for the dining area und there have been not because they did hiplace and that the stated that anytime lap buddy or trays would find a table to chair could fit under During an observative Resident #281 was remove the lap buddifficulty with position or repetitive During an interview.	taff assigned to the dining at was able to state what she be during breakfast. No staff addy from her chair. Resident sition without difficulty or onts. She was able to feed culty. She ate her meal from #281 was reaching over lap table. Her hands were shakey offee cup and food was all on 2/29/12 at 8:00AM, NA #2 dt that they generally work the NA #2 indicated that the in dining room generally istance only. She added that the lap buddy/trays because and mobile within the facility. The lap buddy or trays was not be an	F	221			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BUI		LE CONSTRUCTION	(X3) DATE SUR' COMPLETE	
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	OVIDER OR SUPPLIER			56	EET ADDRESS, CITY, STATE, ZIP CODE 880 WINDY HILL DRIVE VINSTON SALEM, NC 27105	03/01	72012
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 221	had the lap buddy was her to have it and to perfect the resident was non side and did not ambor stand. She added go to therapy and the and gait training. She #281 did not try to ge reason was the family During an interview of therapy director state did not do any of the determination. It was During an interview of DON(director of nurs responsible for the extraints. She indicated that Resident reason for the use of that the therapy depaincluded in the evaluation for restraints and that pre-restraint form on that she did not have included what the asteroid or documentation of continuation or reduction of the use of the continuation of the c	sis becuase family wanted brevent falls. She stated that weigt bearing on the left ulate without staff assistance that the Resident #281 did by were working on strenght further stated that Resident at up or do anything, the main by. In 2/29/12 at 2:39PM, do that therapy department assessment or all done by the DON. In 2/29/12 at 2:49PM, the singly stated that she was evaluations/assessments of the that after review of the #281 did not have a medical restraint. She further stated artment was not generally ation/assessment process the process included use of the a quarterly basis. She added the observations for the stion of a restraint. She	F	221			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		345443	B. WING		03	C /01/2012
	OVIDER OR SUPPLIER	ABILITATION	51	EET ADDRESS, CITY, STATE, ZIP CODE 580 WINDY HILL DRIVE JINSTON SALEM, NC 27105		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241 SS=D	Administrator indicate therapy be involved in and done quartely. Rerelaeased during meashould have a clinical restraint. During an interview of member indicated that facility nurse and was Resident #281 in lap of the assessment prouse of the restraint be director of nursing infoccurring with Reside indicated acknowledge falls and thought an aby therapy. She adden put a restraint on Reseassessment had been reviewed the case. So for Resident #281 to home. She indicated to in an upright position buddy was applied for During a follow up into 4:30PM, the administrestraints within the fee valuated. The therapeducation would be in 483.15(a) DIGNITY A INDIVIDUALITY The facility must prominanter and in an environment and in an environment.	an 2/29/12 at 3:01PM, the end the expectation was that an the restraint assessment esidents should be als/actvities. The residents areason for the use of an 2/29/12 at 4:00PM, family at she was called by the stold that they were putting buddy. She was not aware occess and she agreed to the ased on what the nurse and cormed her that was ent #281. The family ged awareness of the risk for assessment had been done and that she would not have sident #281 unless and an done or the doctor had the stated that the intent was receive therapy and return that Resident #281 could sit without difficulty and the lap or safety and facility decision. The erview on 2/29/12 at rator indicated that all accility would be reviewed and by department and family included in the new process. AND RESPECT OF	F 241			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUI COMPLET	
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	OVIDER OR SUPPLIER EST HEALTH AND REHA	ABILITATION	<u> </u>	56	EET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE INSTON SALEM, NC 27105		
(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)	OULD BE	(X5) COMPLETION DATE
F 241	by: Based on observation record reviews, the fadignified dining experience removing restraints of sampled residents (R. 281). The findings included 1. Resident #33 was 1/26/10. Resident #3 dementia, hemi pare and chronic obstructi Minimum Data Set dis Resident #33 had shand decision making required assistance was coded as non ar restraint. Last record Review of the last fal 2/4/08, revealed that non-ambulatory. Review of the care per the problem as; Resinursing for eating and feeding and risk for verificulated that Reside self with minimal ass 75-100% of each meen encouraging Resider provide verbal cues to each meal, cut up for provide adaptive equals 200.	ris not met as evidenced ans, staff interviews and acility failed to provide a rience as evidence by not uring meals, for 4 of 4 resident #33, 117, 217 and b: admitted to the facility on 3 current diagnoses included sis, hypertension diabetes we pulmonary disease. The rated 10/1/11, indicated that rort and long term memory problems. Resident #33 with all activities of daily living inbulatory with a trunk red fall noted on 5/1/11. It risk assessment dated Resident #33 was lan dated 7/27/11, identified dent #33 needs restorative dining to improve self	L.	241	Corrective action to be accomp for those residents found to har affected by the deficient practice. 1. Resident #33, during meal tire and lap buddy, was removed to resident to utilize the table space in front of her to maintain and expected expecting recognition of their individuality. 2. Resident #117, lap buddy was during meal time to maintain an residents dignity and respect in recognition of their individuality. 3. Resident #217, lap buddy was during meal time to enhance residents respect in full recognition of their individuality. 4. Resident #281, lap buddy was during meal times to maintain a residents dignity and respect in recognition of their individuality. Corrective action to be accompathose residents having the potential action of their individuality. 1. All residents that required residents that required residents dignified during meal time a dignified dining experience. 2. Same as #1 3. Same as #1 4. Same as #1	nes tray allow te that is enhance full f. s removed denhance full f. s removed dignity and fir s removed hir s rem	3/20/12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURY COMPLETE	
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	1	CROSS-REFERENCED TO THE APPRO DEFICIENCY))PRIATE	DATE
F 241	that need further eval During an observation Resident #33 was sewith lap tray in place. In place and she sat in difficulty. There were leaning in any directions of the floor. During an intervel wo nurse#1 stated that Formals. She added the meals. She added the an upright position will leftside when she was Resident had not had Resident was unable device independently non-ambulatory, coul attempting to get up nursing) handled ass During an interview of indicated that Resident the time, resident wo forward in chair. She able to reposition selforward. She was un indicated that when she had fallen alseer unable to remove an During an observation Resident#33 was sea at the table with lap to tray was positioned upon the formal from the only required means and the mean from the only required means and the means of the only required means and the means of the only required means and the means of the only required means of the only required means of the control of the control of the only required means of the only	any problems during meals luation. In on 2/29/12 at 7:29AM, ated in front of her bedroom. There was a chair cushion in an upright position without no repetitive movements or ons, both feet were place. In 2/29/12 at 7:32AM, Resident #33 used the lape tray was removed after at resident was able to sit in lithout tray and only leans to is tired or falls sleep in chair. If any falls in months, if or remove any type of and she was id not recall resident unassisted. DON(director of lessments of restraints. In 2/29/12 at 7:35AM, NA #1 ant#33 used the lap tray all added that the resident was if in chair even when she slid aware of any falls. She she slides forward was after to in the chair. Resident was	F2	241	Measures put in place or systemic made to ensure that the deficient will not occur: 1. All nursing staff was in-serviced the removal of a restraint during respect to provide dignity and respect of the individuals during the dining experiments. Monitoring Process 1. The Director of Nursing and/or designee will monitor residents with restraints to ensure that they are removed during meal times. Moni will take place 3 x week x 90 days then quarterly. Results will be reputed to QA committee.	t practice I regarding meal times chose rience. ith being itoring	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345443	B. WING		03	C /01/2012	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105	* *		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	spilling all over the was assisting other During an interview and NA #3 indicate main dining room. residents in the maneded set-up assisthe residents wore they were a fall risk. She indicated that removed during diresident to lean for the dining area und there have been not because they did high place and that the stated that anytime lap buddy or trays would find a table to chair could fit under During an interview DON stated that reduring meals, activishould be eating with During an interview administrator indicated therapy be involved and done quartely. relaeased during meals, activishould be eating with 17 yr 3/16/07. Resident included hypertens dementia. The Min 1/4/12, indicated the and long term memoroblems. She required.	main table and the tray. Staff residents. ron 2/29/12 at 8:00AM, NA #2 d that they generally work the NA #2 indicated that the in dining room generally istance only. She added that the lap buddy/trays because and mobile within the facility. The lap buddy or trays was not hing due to the potential for the ward or reach for something in expected. NA #3 stated that of falls in the dining room have the lap buddy's or trays in residents were fall risks. NA#3 of a resident had a device like while in the dining room, staff that was at good height that the en was used. If yon 2/29/12 at 2:49PM, the sidents should be relaease lities, tolleting and no resident with restraint in place. If yon 2/29/12 at 3:01PM, the sated the expectation was that d in the restraint assessment Residents should be neals/activities. If you additionally the short was admitted to the facility on #117 cumulative diagnoses sion, pulmonary fibrosis and imum Data Set(MDS) dated hat Resident #117 had short hory and decision making uired total assistance with all g. She was coded as needing	F 24	41			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1111		E CONSTRUCTION	(X3) DATE SURI	
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		345443	B. WIN	G		03/01	/2012
	OVIDER OR SUPPLIER	ABILITATION		56	EET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE INSTON SALEM, NC 27105		
(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 DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	Review of the care place the problem as; Resinutrition due to below weight loss. The goal remain stable at 5 ponext review. The appintake, weight, skin a preferences, must be provide supplements. During an observation resident was being feplace. During an observation Resident #117 was be to main dining area be the Resident #117 had November of last year buddy was removed be put back on resident was being feplace. During an observation Resident #117 had November of last year buddy was removed be put back on resident was independently. During an observation resident seated at tal NA#1 assisting and mounting an interview of DON stated that residenting meals, activities should be eating with During an interview of administrator indicate therapy be involved if and done quartely. For relaeased during meals, activities and done quartely. For relaeased during meals, chrory disease, osteoprosis	an dated 12/7/11, identified dent #117 was on altered videal body weigh and included resident would unds above weight through oraches included, monitor and labs, honor food assisted with meals and as ordered. In on 2/29/12 at 8:57AM, and by NA#4 with lap buddy in an on 2/29/12 at 7:47AM, rought from bedroom back by NA#4. NA#4 stated that do a lap buddy on since ar and at one time the lap and family requested that it ent. The resident did not as unable to remove it an on 3/1/12 at 8:53AM, believith lap buddy in place, esident with meal. In 2/29/12 at 2:49PM, the dents should be relaease es, toileting and no resident ar restraint in place. In 2/29/12 at 3:01PM, the end the expectation was that in the restraint assessment residents should be	i.	241			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLE	ETED
		345443	B. WING		03	C (01/2012
	OVIDER OR SUPPLIER	HABILITATION	5680	FADDRESS, CITY, STATE, ZIP CODE WINDY HILL DRIVE STON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 241	memory and decise required one personally living and transeded supervision Review of the care the problem as; Reand variable intake goal included residation above 5 pounds. If food preferences, and provide recompuning an observer Resident #217 was room at the table of Resident #217 tray and she was eating dining room table, only. Resident was to get to her meal table. Food was and the tray. Staff During an interview and NA #3 indicated that main dining room, residents in the moneded set-up as the resident word they were a fall rise she indicated that removed during diresident to lean foothe dining area unthere have been resident and that the place and that the	I some short and long term ion making problems. She on assistance with activities of nsfers. She was coded as	F 241			

STATEMENT OF DEFICIE! AND PLAN OF CORRECT!		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ĒD
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NAME OF PROVIDER OR		ABILITATION		51	EET ADDRESS, CITY, STATE, ZIP CODE 680 WINDY HILL DRIVE VINSTON SALEM, NC 27105		
1 // / //	AND AND RESIDENCE AND		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
lap budd would fit chair co During a Residen meal with the lap is Residen only assunable to uncertait was able During a DON state during in should it During a administ therapy and don relaease During a Residen buddy in meal aft to meal 4. Resident to meal 4. Resident puring a required activities dressing During a strivities dressing	and a table that uid fit under an observation observation of the property of t	nile in the dining room, staff at was at good height that the was used. In on 2/29/12 at 9:02AM, set up by NA#1 for breakfast in place. NA#4 indicated that of removed during meals. In on-ambulatory and could ing. Resident #217 was a lap buddy and she was ad the lap buddy. Resident meal independently. In 2/29/12 at 2:49PM, the dents should be relaease es, toileting and no resident in restraint in place. In 2/29/12 at 3:01PM, the ded the expectation was that in the restraint assessment desidents should be	II.	241			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		` ′		` '	X3) DATE SURVEY COMPLETED		
		345443	B. WIN	G		03/01) 1/2012
	OVIDER OR SUPPLIER	ABILITATION	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 6680 WINDY HILL DRIVE WINSTON SALEM, NC 27105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 241	room with lap buddy in There were three stain room. Resident #281 wanted for beverage removed the lap budds at in an upright positive movements herself without difficut the table. Resident #22 buddy to get to the tall as she raised the controver the lap buddy. During an interview of and NA #3 indicated main dining room. Not residents in the main needed set-up assist the residents wore the they were a fall risk as She indicated that the removed during dining resident to lean forwathe dining area unexpetited that anytime a lap buddy or trays whould find a table that chair could fit under to During an interview of DON stated that resident in the resident of the stated that anytime and lap buddy or trays whould find a table that chair could fit under to During an interview of DON stated that resident during meals, activities should be eating with During an interview of administrator indicated.	In place during the meal. If assigned to the dining was able to state what she during breakfast. No staff dy from her chair. Resident dion without difficulty or is. She was able to feed lty. She ate her meal from 81 was reaching over lap ble. Her hands were shakey fee cup and food was all in 2/29/12 at 8:00AM, NA #2 that they generally work the is #2 indicated that the dining room generally ance only. She added that he lap buddy/trays because and mobile within the facility. He lap buddy or trays was not ag due to the potential for the first or reach for something in the dining room the the lap buddy's or trays in sidents were fall risks. NA#3 resident had a device like hile in the dining room, staff at was at good height that the vas used. In 2/29/12 at 2:49PM, the dents should be relaease less, toileting and no resident are restraint in place. In 2/29/12 at 3:01PM, the led the expectation was that an the restraint assessment	F	241			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 241 F 371 SS=D	relaeased during me 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food fror considered satisfactor authorities; and	rals/actvities. DCURE, BERVE - SANITARY In sources approved or Dory by Federal, State or local istribute and serve food	F 241	F 371 Corrective action to be accomple for those residents found to hat affected by the deficient practice. 1. The wet bowls and cups were from the line. 2. The clear bag of frozen chicker clear bag of chicken fingers, and bag of French fries were labeled 3. The exhaust hood filters were cleaned by the Director of Dining Corrective action to be accomplished.	ve been e: eremoved en patties, if the brown and dated. e hand g Services.
	by: Based on observation record reviews, the filter bowls and cups, 2) if the 1 of 1 upright frew hen taken out of the failed to keep exhaus of dust and grease. 1. During kitchen of 11:40 a.m., 2 racks stacked on top of each other and 3 racks of red con top of each other and with water running Manager acknowled bowls, saying that the did not know who and bowls on top of	observation on 2/27/12 at of red bowls were observed ich other on the serving line, ups were observed stacked under the serving line, wet ing off the bowls. The Dietary iged the condition of the ney were clean but wet, and o had stacked the wet cups each other. The Dietary bod service worker to remove		those residents having the pote affected by the same deficient 1. The wet bowls and cups were from the line to dry properly. 2. The clear bag of frozen chicke clear bag chicken fingers, and the bag of French fries were labeled. 3. The exhaust hood filters were cleaned by the Director of Dining	ential to be practice: e removed en patties, he brown I and dated. e hand

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
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NAME OF PROVIDER OR SUPPLIER OAK FOREST HEALTH AND REHABI	LITATION	50	EET ADDRESS, CITY, STATE, ZIP CODE 580 WINDY HILL DRIVE /INSTON SALEM, NC 27105	•	
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION CATE
at 3:44 p.m., 4 racks of sobserved on the serving wet cups (50 cups) were of each other on a cart of the bowls wet on the callooked at the clock in the they had been there dry 2. During the kitchen the a.m., the following items upright freezer: 1 open of chicken patties, 1 open of chicken fingers, and 1 because (as identified by the dire of which were unlabeled subsequent inspection of 2/29/12 at 3:44 p.m., the observed in 1 of 1 uprigit plastic bags of chicken for French fries (as identified services), all of which undated. During an interview on 2 director of food services not stay on the bags. " name of the product and products. 3. During the initial tot 2/27/12 at 11:00 a.m., the	en observation on 2/29/12 salad bowls were a line, wet and 2 racks of a observed stacked on top hear the serving line. 11 at 3:50 p.m., the do not know who stored at. " The dietary aide the kitchen and stated that ing roughly 2 hours. 15 tour on 2/27/12 at 11:14 sewere observed in 1 of 1 clear plastic bag of frozen clear plastic bag o	F 371	Measures put in place or syst made to ensure that the definition of the uping process dail bowls and cups are properuse. 2. Daily inspection of the uping ensure that all items are labe 3. The exhaust hood filters where professionally, quarterly, and the Director of Dining Services. Dietary staff was in-serviced 1. The appropriate way to ail dishes. 2. Insulated dishes are not to upon each other for drying. 3. Instructed to not use dished wet or dirty. Monitoring Process The Director of Dining Service the drying process and upriges 30 days, monthly x 3 months report to QA committee.	rices will aily to ensure rly dried before light freezer to led and dated. rill be cleaned as needed by s. on: r dry insulated be be stacked es that are still less will monitor the freezer for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION		OMPLETED	
		345443	B. WIN	G		03/01) /2012	
	OVIDER OR SUPPLIER EST HEALTH AND REHA	ABILITATION		56	EET ADDRESS, CITY, STATE, ZIP CODE 680 WINDY HILL DRIVE /INSTON SALEM, NC 27105			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 371	at 3:44 p.m., the exhaustove were heavily concerning an interview of Dietary Manager revelood filters are contralled and are cleaned ever Manager further stated cleaned in November	chen inspection on 2/29/12 aust hood filters above the lated with grease and dust. In 2/29/12 at 3:50 p.m., the lated that "the exhaust acted through a company by 3 months." The Dietary and that the filters were last 2011, and the commercial in March 8, 2012, to clean	F	371				

		AND HUMAN SERVICES			\$\$C\$A	FORM	APPROVED
	*	& MEDICAID SERVICES					0938-0391
STATEMEN AND PLAN	y of deficiencies of correction	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER.	(XS) M	iULTI	PLE CONSTRUCTION	(XI) DATE SI COMPLE	
1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		The Late of the Control of the Contr	A, BUI	אולם	G 01 - WAIN BUILDING 01		
		345443	o wii	VG		03/2	7/2012
NAME OF F	PROVIDER OR SUPPLIER			STA	REET ADDRESS, CITY, STATE ZIP CODE		
OAK FO	REST HEALTH AND R	REHABILITATION			680 WINDY HILL DRIVE VINSTON SALEM, NC 27105		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	ID PREF YAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JED BE	(2X) NOITETHNOO IPAII
K 029 SS=D		FETY CODE STANDARD	ΚŒ	028	K029		5/1/12
	fire-rated doors) or extinguishing system and/or 19.3.5.4 profits approved automoption is used, the approved system doors. Occase system field-applied protect	construction (with % hour an approved automatic fire in accordance with 8.4.1 sects hazardous areas. When hatic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or live plates that do not exceed bottom of the door are			Corrective action accomplished by the facility to correct the deficient practice: The wire was removed from the kitchen storage door. Corrective action to be accomplish for those residents having potentiable affected by the same deficient practice: The Director of Facility Services ins	ned U to	
K 052 SS≃D	42 CFR 483.70(a) By observation on 3 PM the following har non-compilant, specialistichen slorage roor wire. There must be the door, NFPA 101 LIFE SAI A fire alarm system installed, lested, and with NFPA 70 Nation 72. The system has	offic findings include the the modern was held open with the no impediment to closing of the second	Κ¢	052	all doors to ensure there were not any wires holding them open. Measures put into place or systemichanges made to ensure that the deficient practice will not occur. A mag lock was installed to hold the door open properly, when needed. The Director of Facility Services will inspect all doors to ensure there are no any wires holding them open. Monitoring Process 1. The inspection of all doors will be conducted monthly for 3 months, and then quarterly by the Director of Facility Services. 2. The results of the inspections will discussed in the facility's QA meeting.	l l not	
	1		,		MINI M		1915 116 B

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDEIVSUPPLIER/GLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION (X3) DATE SURVEY O1 - MAIN BUILDING O1		
		3,45443	B. WING		03/27/2012	
•	ROVIDER OR SUPPLIER REST HEALTH AND F	REHABILITATION	681	ET ADDRESS, CITY, STATE, ZIP CODE 80 WINDY HILL DRIVE NSTON SALEM, NC 27105		
(X4) ID PREFIX I A G	(FACH DEFIGIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRE (CACH CORRECTIVE ACTION SHI GROSS-REFERENCED TO THE APP DEFICIENCY)	ONFO BE COMPTUTED	
K 052	Conlinued From pa	ge 1	K 052	K052 Corrective action accomplished the facility to correct the deficient practice:	w/5/12 by	
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/27/12 at approximately 2:00 PM the following fire alarm system component was non-compliant, specific findings include there			The annunciator panels at both nurses stations were repaired so that audible signal with loss of power, battery back-up, or loss of phone line will be heard.		
K 069 SS=D	battery back-up, or where it is likely to and audible at the in the maintenance however there was annunclator panel in NFPA 101 LIFE SA	signal with loss of power, loss of phone line at an area be heard. There was a visual main fire alarm panel located office down the service hall, only a visual signal at the located at both nurses stations. FETY CODE STANDARD	K 069	Corrective action to be accomplifor those residents having potent be affected by the same deficient practice: The annunciator panels at both austations were repaired so that nucli signal with loss of power, battery back-up, or loss of phone line will heard.	rses blc	
	42 CFR 483,70(a) By observation on 3 PM the facility's conprotected in accord Ventilation Control Commercial Cookli Specific findings in	s not met as evidenced by: 3/27/12 at approximately 2:00 bking system was not ance with NFPA 96 - and Fire Protection of ang Operations. clude; the deep fryer was eam kettle without the required	and the second s	Measures put into place or syste changes made to ensure that the deficient practice will not occur: The Director of Facility Services will inspect both the annunclator panels at both nurses stations, duri monthly fire drills, to ensure audit signal with loss of power, battery back-up, or loss of phone line will be heard. Monitoring Process	ng de	
				1. The inspection of the annuncial panels will be conducted monthly for 3 months, and then quarterly by the Director of Facility Service. 2. The results of the inspections whe discussed in facility's QA meet.	s.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL'I A. BUILDII	iple construction NG 01 - Main Building 01	(X3) DATE SUR COMPLETE	
		3,45443	B. WING _		03/27/2	2012
	(EACH DEFICIENC	REHABILITATION ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	REET ADORESS, CITY, STATE, ZIP CO 5880 WINDY HILL DRIVE WINSTON SALEM, NC 27105 PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED YO THE	SHOATO BE 10	OMPLITION (X5)
K 052	Continued From pa	age 1	K 052	. Corrective action accomplis		111/18
i	42 CFR 483,70(a) By observation on PM the following fir was not an audible battery back-up, or where it is likely to and audible at the rand audible at the rand audible at the rand audible at the Research bowever there was annunctator panel it NFPA 101 LIFE SA	3/27/12 at approximately 2:00 e alarm system component , specific findings include there signet with loss of power, loss of phone line at an area be heard. There was a visual main fire alarm panel located office down the service hall, only a visual signal at the ocated at both nurses stations, FETY CODE STANDARD re protected in accordance	K 069	the facility to correct the depractice: A required splash guard was the deep fryer Corrective action to be acces for those residents having post be affected by the same definition of the deep fryer A required splash guard was the deep fryer Measures put into place or changes made to ensure the deficient practice will not out A required splash guard was the deep fryer.	placed on omplished otential to clent placed on systemic t the cour:	
Angelia control de la control	42 CFR 483,70(a) By observation on 3 PM the facility's cooprotected in accord Ventilation Control a Commercial Cookin Specific findings inc	slude; the deep fryer was earn keltle without the required		Monitoring Process 1. The Director of Facility So inspect the required splash gudeep fryer monthly then quartensure its offectiveness. 2. The results of the inspection discussed in facility's QA me	and on the terly to ons will be	