PRINTED: 05/23/2017 FORM APPROVED OMB NO. 0938-0391

| . , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---------------|---|---|---|-------|---|-------------------------------|---------------------|
| | | 345092 | B. WING _ | | | l | C 28/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 20/2011 |
| | | | | 19 | 900 W 1ST STREET | | |
| WINSTON | SALEM NURSING & RE | HABILITATION CENTER | | ٧ | VINSTON-SALEM, NC 27104 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | | | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIZ TAG | X | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 242 SS=D | 483.10(f)(1)-(3) SELF RIGHT TO MAKE CH | | F2 | 242 | | | 4/21/17 |
| | schedules (including shealth care and provide consistent with his or and plan of care and of this part. (f)(2) The resident has about aspects of his care significant to the resident has about aspects of his care significant to the resident has members of the commonment of the common of the | s a right to interact with nunity and participate in both inside and outside the ris not met as evidenced staff interviews and records ed to offer showers as sampled residents. Ent # 10 and Resident # 11). | | | "This Plan of Correction is prepared ar submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficien listed on this form exist, nor does the Center admit to any statements, finding facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative | on cy gs, s | |
| | impairments and no b Resident # 5 was cod 1 person for her hygic | ed as totally dependent with ene and bathing. The | | | proceedings the deficiency, statements facts, and conclusions that form the ba for the deficiency. | sis | |
| | | pdated 3/14/2016 indicated | | | 1. Corrective action for resident affecte | | |
| | the resident's shower Wednesdays and Frid | | | | Resident #5, #10, #11 were interviewed social services director to determine | а ву | |
| | vveunesuays and FIIC | iayo | | | shower preferences this information will | II | |
| | A review of the 400 ha | all Shower List dated | | | be up dated on residents care guide by | | |
| ADODATORY | | SUPPLIER REPRESENTATIVE'S SIGNATURE | <u> </u> | | TITLE | | (X6) DATE |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(Xb) DATE

Electronically Signed 04/20/2017

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 | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345092 | B. WING _ | | | | C 28/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 20/2017 |
| | | | | | 00 W 1ST STREET | | |
| WINSTON | SALEM NURSING & | REHABILITATION CENTER | | | NSTON-SALEM, NC 27104 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | (EACH DEFICIE | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | < | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 242 | Continued From p | age 1 | F 2 | 242 | | | |
| | 3/27/2017 indicate | d Resident # 5 shower days | | | social work, unit managers and charge | | |
| | | ednesdays and Fridays. | | | nurses to ensure residents are receiving | | |
| | _ | | | | showers as scheduled. | | |
| | | sk: ADL(Activity of Daily Living) | | | | | |
| | | Shower) Sheet (this is the | | | 2. Corrective action will be accomplished | | |
| | | the Nursing Assistants | | | for those residents having potential to I | эе | |
| | | ata entry) for Resident #5 | | | affected, resident population will be | | |
| | | als and no showers done on sdays and Fridays or any other | | | interviewed by Social Services, unit managers and charge nurses on | | |
| | | for the months of January 2017, | | | admission, quarterly assessments and | ner | |
| | February 2017 and | _ | | | resident preferences. The shower | рог | |
| | | preferences will be updated on Care | | | | | |
| | A review of the nu | rsing progress notes from | | | guides. | | |
| | 1/1/2017 to preser | nt made no mention of Resident | | | | | |
| | #5 refusing her sh | owers. | | | 3. Measures/Systemic changes to ensu | ure | |
| | | | | | deficient practice will not occur: The | | |
| | | 03/28/2017 at 9:25 AM, | | | Director of Nurses and Unit Managers | and | |
| | | d she was not given showers | | | Staff Development Coordinator will | | |
| | | shower days of Mondays, Fridays. The resident stated | | | re-educate nursing staff regarding the Residents Right to make choices with | | |
| | | eaths every day and no | | | emphasis on showers.Education will be | ے | |
| | | said the staff only gave her | | | incorporated into new employee | | |
| | | offered to give her showers for | | | orientation program for nursing staff. | | |
| | | since the facility did away with | | | 1 0 | | |
| | the shower team. | | | | 4. Monitoring Process , The Director of | | |
| | | | | | Nurses, Unit Managers, and charge | | |
| | | 03/28/2017 at 3:36 PM, | | | nurses will audit 40 residents shower | | |
| | | (NA) #1 who was assigned to | | | schedules 2 times weekly, times 4 weekly | | |
| | | I showers were not given due to | | | weekly times 4 and then monthly times | 3 | |
| | | staff at the facility most of the ed any refusals were to be | | | to ensure ongoing compliance. Data collection to be analyzed and reviewed | l ot | |
| | | rse and documented on her | | | monthly Quality Assurance meeting for | | |
| | | recall Resident # 5 as refusing | | | months with subsequent POC as need | | |
| | her showers. | | | | | | |
| | | 03/28/2017 at 4:00 PM, the | | | | | |
| | | ed it was her expectation that | | | | | |
| | | ive their showers as scheduled | | | | | |
| | and it they retused | I, the staff was to attempt again | | | | | [|

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | | TE SURVEY MPLETED |
|--------------------------|---|---|---------------------------|---|-----------|----------------------------|
| | | 345092 | B. WING | | | C 03/28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | • | 0/20/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 242 | Continued From polater and should reshift. | age 2 eport it to the Charge Nurse on | F 24 | 42 | | |
| | 11/3/2010 with the weakness, major of hemiplegia. The of (MDS) dated 1/25/had no cognitive problems. Reside dependent with 2 pathing. The residual transfer of the 40/3/27/2017 indicate as Tuesdays, Thurk A review of the 40/3/27/2017 indicate were Tuesdays, The A review of the Tasabathing (Prefers printed sheet from electronic kiosk daindicated no refusational transfer of the February 2017 and A review of the nur | rsing progress notes from | | | | |
| | #10 refusing her so In an interview on Resident # 10 stat on her scheduled so Thursdays and Sa not get showers at | nt made no mention of Resident howers or baths. 03/28/2017 at 9:40 AM, ed she was not given showers shower days of Tuesdays, turdays. She reported she did the facility on any day of the ived only bed baths. She | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | ATE SURVEY OMPLETED |
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| | | 345092 | B. WING | | | C 03/28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & RE | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COL 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | • | 03/26/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 242 | added it had been a shower. She also ind showers on her sche other day of the wee In an interview on 03 Nursing Assistant (N not given due to not facility most of the tir refusals was to be redocumented on her Resident # 10 as refulling an interview on 03 | while since she got a licated she would like to have duled shower days or any k. /28/2017 at 3:36 PM, A) #1 stated showers were having enough staff at the ne. NA #1 reported any ported to the nurse and kiosk. She did not recall | F 2 | 242 | | |
| | and if they refused, to later and should reposhift. 3. Resident # 11 wa 9/11/2015 with the distribution muscle weakness and Minimum Data Set (Note indicated Resident # impairments and no Resident #11 was concerned to the resident's care plant to the resident's care plant to the resident's showe Wednesdays and Frish A review of the 400 has 3/27/2017 indicated were Mondays, Wed | behavioral problems. ded as totally dependent with ene and bathing. The updated 12/26/2016 indicated r days as Mondays, | | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | | PLETED |
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| | | 345092 | B. WING | | | C / 28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | 1 00/ | 20/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 242 | indicated no refusals Mondays, Wednesda day of the week for the February 2017 and Mare Mare Mare Mare Mare Mare Mare Mare | e Nursing Assistants entry) for Resident #11 and no showers done on tys and Fridays or any other the months of January 2017, March 2017. Ing progress notes from made no mention of Resident twers or baths. 1/28/2017 at 9:29 AM, she was not given showers tower days of Mondays, days. The resident stated it the she got a shower any day led she had asked for mot know why she had not ters yet. 1/28/2017 at 3:36 PM, A) #1 who was assigned to mowers were not given due to the any refusals was to be and documented on her the term of the state of the she was not given the total Resident # 11 as 1/28/2017 at 4:00 PM, the tit was her expectation that their showers as scheduled the staff was to attempt again that it to the Charge Nurse on | F 2 | | | 4/24/47 |
| F 309 SS=G | 483.24, 483.25(k)(I) FOR HIGHEST WEL | PROVIDE CARE/SERVICES L BEING | F 3 | 09 | | 4/21/17 |

| STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER SALEM NURSING & RE | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | 03/20/2017 | |
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| F 309 | applies to all care an residents. Each resi facility must provide services to attain or practicable physical, well-being, consister comprehensive asses 483.25 Quality of care Quality of care is a function of a resident residents receive accordance with propractice, the comprecare plan, and the rebut not limited to the (k) Pain Management The facility must ensprovided to residents consistent with profeste comprehensive pand the residents who requires services, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehenses. This REQUIREMENT by: Based on record revision at the resident of practice is a preferences. | adamental principle that d services provided to facility dent must receive and the the necessary care and maintain the highest mental, and psychosocial at with the resident's asment and plan of care. The undamental principle that and care provided to sed on the comprehensive dent, the facility must ensure the treatment and care in fessional standards of thensive person-centered asidents' choices, including following: That the facility must ensure that the pain management is so who require such services, assional standards of practice, the person-centered care plan, the pain management is the dialysis receive such with professional standards of practice, the dialysis receive such with professional standards of the dialysis receive such with professional standards of the professional standards of the professional standards of the dialysis receive such with professional standards of the profess | F 30 | Corrective action for resident | | |
| | | ss 1 of 2 sampled residents ng to a right femur fracture | | Resident #6 was assessed by t sent to the hospital for treatmer | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245002 | B. WING_ | | | С | |
| | | 345092 | B. WING _ | | 03 | /28/2017 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| WINSTON | SALEM NURSING & RE | HARII ITATION CENTER | | 1900 W 1ST STREET | | | |
| WINSTON | SALLIN NORSING & KL | HABIETATION CENTER | | 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 309 | Continued From page | ÷ 6 | F 3 | 09 | | | |
| | 10/7/2014 with diagno | nitted to the facility on oses of Hypertension, Renal oritis. The most current | | Resident #6 was transferred to hospital emergency department 3-12-2017 for further evaluation #6 was returned to the facility o 3-13-2017.Rn will be re- educat Director of nursing services regrocedures to assess a residen | t on n. Resident n ed by arding | | |
| | revealed the resident memory problems; sh | had no short or long term | | fall.NA#1 was suspended and to for failure to report a fall. | | | |
| | extensive assistance | with 1 person for transfer. | | 2.Corrective action for residents the potential to be affected by the | ne alleged | | |
| | worksheet dated 7/6/2 requires limited to ext assistance with Activity | ties of daily Living (ADL)'s | | deficient practice will include: A was conducted on residents that in the last 30 days to ensure as was completed.Residents will be accorded by the light and proceed by th | at had a fall sessment e | | |
| | necessary to identify help prevent decline i She is alert and able | ng. Staff intervention is risk factors and solutions to n ADL's and complications. to make her needs known to in wheelchair around unit. | | assessed by the licensed nurse determine any immediate injury Residents that have had a fall w re-assessed with in 24 hours by manager/charge nurse. | vill be | | |
| | She has had one fall and injury. This places further falls, skin breat weight loss. Further faincreased pain and destaff intervention is not staff. | since last assessment with her at increased risk for kdown, dignity issues and alls may cause fractures, ecline in overall function. ecessary at this point to risk factors to prevent further | | 3.Measures/Systemic changes deficient practice will not occur: nurses will be educated by the I Nursing regarding the procedur assessing a resident after a Fal education included in new empl education orientation program. | Licensed Director of e of I, | | |
| | decreased mobility." the following interventing free of hazards, Do no | dent is at risk for falls due to The care plan documented tions: "Keep environment ot leave resident unattended Eliminate potential hazards, eminders not to try to | | 4.Monitoring Practice: Falls will reviewed during morning clinica by Nursing Administration team appropriate assessment and int Nursing Supervisor to review or weekends. Falls/Assessment dereviewed at weekly Risk Meeting be reviewed and analyzed at measurement of Supervisor Callet Proceedings of Supervisor Part of S | Il meeting to assure ervention. Il lata to be g and will onthly | | |

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| | | 345092 | B. WING _ | | | | 28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & RE | HABILITATION CENTER | ' | 19 | TREET ADDRESS, CITY, STATE, ZIP CODE 900 W 1ST STREET /INSTON-SALEM, NC 27104 | , 00 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | | (X5) COMPLETION DATE |
| F 309 | leg pain this morning stated she was not so but wants the doctor has refused going to current time, resident Resident is requesting evaluation." Review of the resider 3/12/2017 revealed with pain in right arm transfer from bed to vereport under descript subheading documer with the resident, who seems hesitant to claresident further state and she went and go up after she fell." The resident had a fracture humerus. Review of the facility note date 3/13/2017 NA #1 came in; resid clothes she wanted to she was sitting on sid with putting clothes or requested to have who Resident # 6 asked which was sitted to transfer and the wheelchair sid and wheelchair was of Resident states that I chair, she then comp | e's note at 3:21 PM Int with right arm and right at 8:00 PM. Resident # 6 Ince why it's hurting so bad to look at it. Resident # 6 the hospital at that time. At t's right arm is very swollen. g to go to the hospital for Int's incident report dated inder description "Resident after staff assistance with wheelchair." The incident ion of resident's injury inted "completed interview is usually alert and oriented irrify what happened. The d she was hollering for help thelp after NA#1 helped her is report indicated the is of a right femur and a right Is investigation summary documented "Per resident, ent showed NA#1 the o put on and resident reports ise of bed. NA #1 assisted in, and then resident ineelchair placed by the bed. ivas the wheelchair locked; | F3 | 309 | with subsequent plan of correction as needed. | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | | OATE SURVEY OMPLETED |
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| | ROVIDER OR SUPPLIER SALEM NURSING & R | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | <u> </u> | 03/28/2017 |
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| F 309 | resident out of bed the assistance of another states that resident arm pain after transfibed." Review of the discharge of another states that resident arm pain after transfibed." Review of the discharge of th | A#1 interview, she assisted of wheelchair with the er Nurse assistant. NA#1 started complaining of right ferring to wheelchair from the resident was discharged with the diagnoses of fracture of fracture to right femur. Ident # 6 at 7:35 PM on the resident as alert and the resident as a ledema. Right arm was up on the with Nurse Assistant (NA) # 2 and AM, she reported she was care of the resident on the sisted NA#1 to transfer the bed to the wheelchair. She signed opposite hall from the last her to help transfer the last her to he | F3 | 09 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER SALEM NURSING & R | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP C 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | | 3/20/2017 |
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| F 309 | her vital signs were During the interview 3/28/2017 at 4:00 P 3/12/2017 she recei supervisor who was possible fall with Re some time on 7-3 sh fall resulted in a frac on Monday morning Resident # 6, she to and she asked her h told her she fell whe because the wheels she said the chair tu Administrator said looking at staff that I before she had injur duty on 3/12/2017 ir when she was trying administrator felt tha from the floor and se went and got NA # 2 nurse to assess the expectation was for | e her pain medication since | F | 309 | | |
| F 323 SS=G | 483.25(d)(1)(2)(n)(1 HAZARDS/SUPER\ (d) Accidents. The facility must ens | | F | 323 | | 4/21/17 |
| | (1) The resident env from accident hazar | rironment remains as free ds as is possible; and ceives adequate supervision | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION | I . , | ATE SURVEY DMPLETED |
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| | | 345092 | B. WING _ | | | C 03/28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & R | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, 2 1900 W 1ST STREET WINSTON-SALEM, NC 2710 | ZIP CODE | 3072011 |
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| F 323 | (n) - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure correct maintenance of bed to the following elem (1) Assess the reside from bed rails prior to (2) Review the risks the resident or reside informed consent processes (3) Ensure that the transfer for the resident or the resident of the resi | facility must attempt to use ves prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited tents. ent for risk of entrapment or installation. and benefits of bed rails with ent representative and obtain ior to installation. bed's dimensions are esident's size and weight. T is not met as evidenced on, record reviews and staff by failed to provide a safe mpled residents, resulting and right humerus fracture. | F | 1.Corrective Action for Resident #6 was transf hospital emergency de 3-12-2017 for further ev #6 was returned to the 3-13-2017.Resident #6 the hospital for appropr will be re- educated by services regarding proca resident after a fall. Not suspended and terminal report a fall. | resident affected: ferred to the partment on valuation. Resident facility on was transferred to riate treatment.Rn Director of nursing bedures to assess A #1 was ated for failure to | |
| | worksheet dated 7/6 requires limited to ea | Area Assessment (CAA) i/2016 documented "Resident attensive one person articles of daily Living (ADL)'s | | with the potential to be resident populations ca reviewed and updated resident transfer. Metho | affected: Current ire guides were to reflect method of | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | CONSTRUCTION | | TE SURVEY MPLETED |
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| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | 190 | REET ADDRESS, CITY, STATE, ZIP CODE 00 W 1ST STREET INSTON-SALEM, NC 27104 | <u>, </u> | 0/20/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 323 | except set-up for eanecessary to identify help prevent decline. She is alert and ablestaff. She wheels see She has had one fano injury. This place further falls, skin broweight loss. Further increased pain and Staff intervention is identify and address falls from occurring. Resident # 6's care documented "the redecreased mobility." the following intervestree of hazards, Dowithout safety device Give resident verbal ambulate or transfer. On 3/12/2017 a number documented "Residleg pain this mornin stated she was not but wants the docto has refused going to current time, resident Resident is requestive valuation." Review of the resident verbal and the was not shout wants the docto has refused going to current time, resident is requestive valuation." | ting. Staff intervention is y risk factors and solutions to a in ADL's and complications. The to make her needs known to self in wheelchair around unit. It since last assessment with the sher at increased risk for eakdown, dignity issues and falls may cause fractures, decline in overall function. The risk factors to prevent further | F3 | 323 | be determined by nursing on admission quarterly and with any change of cond with emphasis placed on locking wheel chair before resident transfers. 3. Measures /systemic changes to ensure deficient practice will not occur: Nursing staff to be in-serviced on appropriate resident transfers. Method of transfer with transfers with transfers and with any change of cond with emphasis placed on locking wheel chair before resident transfers, this information will be included in the new orientation education program. 4. Monitoring Process-Director of Nurses, Unit Managers, SD will observe 20 resident transfers 2 time weekly for 4 weeks and then weekly time four and monthly times 3 to ensure compliance with transfers. Data result analyzed and reviewed at monthly Quarksurance meeting for 3 months with a subsequent plan of correction as need. | ition el ure g vill n, ition el hire OC nes mes cs ality a | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|---|-------------|-------------------------------|--|
| | | 345092 | B. WING _ | | | C 3/28/2017 | |
| NAME OF PROVIDER OR SUPPLIER WINSTON SALEM NURSING & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 323 | seems hesitant to classification of the facility note date 3/13/2017 NA #1 came in; resiculties she was sitting on swith putting clothes requested to have was dender #6 asked NA#1 replied yes. Rattempted to transfer and wheelchair was Resident states that chair, she then compthe NA#1 apologized documented "per Naresident out of bed transfer arm pain after transfed." | ge 12 no is usually alert and oriented arify what happened. The had asked NA (Nurse wheelchair was locked when arm on wheelchair and was nen it rolled back. The 1 told her she knew what she dent further stated she was dishe went and got help after after she fell." The report not had a fracture of a right o's investigation summary documented "Per resident, dent showed NA#1 the to put on and resident reports ide of bed. NA #1 assisted on, and then resident wheelchair placed by the bed. was the wheelchair locked; esident # 6 states she reself from bed to wheelchair, slipped; she fell on the floor on top of the resident. NA #1 assisted her back to plained of right arm pain, and d." Summary note also A#1 interview, she assisted on wheelchair with the er Nurse assistant. NA#1 started complaining of right ferring to wheelchair from arge summary dated the resident was discharged with the diagnoses of fracture fracture to right humerus. | F3 | 23 | | | |

| | OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345092 | B. WING | | C 03/28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & F | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | 1 00/20/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES OF THE A | D BE COMPLETION |
| F 323 | documented "Write from the hospital. To (computerized tome fracture to right fembearing status to right at orthopedics without tomorrow." On 3/15/2017 a nure documented "ace wright arm/ shoulder Review of the orthopedic without the fracture plan to the fracture. | rse's note at 5:19 PM r received call from the doctor The doctor reports that CT ography) scan results is a nur. Resident is non weight ght leg per doctor and states Il set up appointment for rse's note at 2:45 AM vrap/splint remains in place to ghighest slightly edematous." opedic consultation report vealed the following treatment d femur "Brace to knee PRN mfort, ROM (range of motion) | F 32 | 3 | |
| | 3/26/17 revealed the talkative. It was not swollen with pitting pillows. The reside accident but stopped her arm in a soft castopped talking after from a wheelchair thospital. During the interview on 3/28/2017 at 10 not assigned to tak 3/12/2017 but she are Resident # 6 from the reported she was a | sident # 6 at 7:35 PM on the resident as alert and ted the resident's right arm as edema. Right arm was up on tent started to talk about an ted. The resident talked about test unlike the old days. She ter mentioning she had a fall then she said she went to the w with Nurse Assistant (NA) # 2 the started to the resident on tent assisted NA#1 to transfer the bed to the wheelchair. She testigned opposite hall from the started to the started to the started to the property of the started to the start | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
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| | | 345092 | B. WING | | C 03/28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & RE | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | 1 00/20/2011 |
| (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 SH CROSS-REFERENCED TO THE APF DEFICIENCY) | IOULD BE COMPLETION |
| F 323 | room and she saw Remoaning a little. She in the wheelchair and complaining about he 3/28/2017 at 1:30 AM assigned to Resident stated it was in the most to her by NA #1 that it swollen. She reported who came and did an resident. The resident hospital so she gave her vital signs were some resident was transadded the resident to services) person that the transfer to the who buring the interview 2:33 PM, She reported was standing at the most her assignment and some she found out it was croom. She went to se resident. On her way ran into NA #1 coming wheeling Resident #1 resident looked up at help me I have pain of stated she reported the Aide #1. | neelchair. She went in the esident # 6 was on the bed stated they put the resident after that the resident was er right arm hurting. with Med Aide # 1 on 1, she reported she was # 1 on 3/12/2017. She orning when it was reported the resident's arm was dishe notified the supervisor assessment on the tidd not want to go to the her pain medication since table. She further added the pain and woke up around 2:00 and her leg were swollen. A ambulance was called and afferred to the hospital. She lid the EMS (Emergency the aide dropped her during eelchair. with NA # 3 on 3/28/2017 at a did that she on 3/12/2017, surses station writing down she heard a loud scream and coming from Resident # 6 's the what was wrong with the to the resident's room, she | F 32 | 23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED |
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| | | 345092 | B. WING _ | | C 03/28/2017 |
| NAME OF PROVIDER OR SUPPLIER WINSTON SALEM NURSING & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | • |
| (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 COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLETION |
| F 323 | resident was in pain the Med Aide # 1 that were swollen. She s resident had a fall so and the resident was an evaluation. During the interview 3/28/2017 at 4:00 Pl 3/12/2017 she receiv supervisor who was possible fall with Resome time on 7-3 sh fall resulted in a fraction Monday morning Resident # 6, she to and she asked her hold her she fell whe because the wheels she said the chair tu Administrator said slooking at staff that he before she had injuriduty on 3/12/2017 in when she was trying did not lock the wheels at her on the edge 2 to assist her and be assess the resident. Was for staff to lock residents with transform NA# 1 who was accombeelchair before traunavailable for interview. | pe 15 PM, she reported the after it was reported to her by at the resident hand and leg tated she suspected the she called the ambulance is sent out to the hospital for with the Administrator on M, she reported that on wed a call from the weekend letting her know about a sident # 6 that had happened iff. She was informed that the ture. She added she went in around 8am and spoke with lid her that they dropped her, ow it happened, she then in sitting in her wheelchair were not locked, and then med over on her. The she immediately started had worked with the resident w. She added NA # 1 was on 17-3 shift, the injury occurred to transfer Resident #6 and telchair. The administrator felt sident # 6 from the floor and of the bed, went and got NA # efore getting a nurse to She added her expectation the wheelchair and assist the ters to prevent accidents. Jused of not locking the ansferring Resident # 6 was view. She (NA # 1) was bloyment on 3/16/2017. | F3 | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345092 | B. WING | | C 03/28/2017 | | |
| | ROVIDER OR SUPPLIER SALEM NURSING & R | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | 1 00/20/2017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION | | |
| F 520 F 520 SS=G | COMMITTEE-MEM QUARTERLY/PLAN (g) Quality assessm (1) A facility must m and assurance com minimum of: (ii) The director of nu (iii) The Medical Direction (iii) At least three of staff, at least one of administrator, owne individual in a leade (g)(2) The quality as committee must: (i) Meet at least qua coordinate and eval identifying issues w assessment and as necessary; and (ii) Develop and imp action to correct ide (h) Disclosure of inf Secretary may not r records of such com | ez)(i)(ii)(h)(i) QAA BERS/MEET NS ment and assurance. raintain a quality assessment emittee consisting at a rursing services; ector or his/her designee; ther members of the facility's f who must be the er, a board member or other | F 52 F 52 | | 4/21/17 | | |

| CLIVILIN | O I OIL MEDIOAILE & | WEDICAID SERVICES | | | OIVID INO. 0930-039 I |
|--------------------------|---|--|---------------------|--|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | | | | С |
| | | 345092 | B. WING | | 03/28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & RI | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETION |
| F 520 | sanctions. This REQUIREMEN by: Based on record rev facility's Quality Asse Committee failed to procedures and mor the committee put in This was for one rec originally cited in Jar investigation survey March 2017 on a cor deficiency was in the continued failure of t surveys of record sh facility's inability to s Assurance Program. The Findings include This tag is cross refe F309 Quality of care staff interviews, the s sampled residents w right femur fracture a (Resident # 6). | faith attempts by the and correct quality be used as a basis for and to the used as a basis for a ris not met as evidenced wiews and staff interviews the essment and Assurance maintain implemented after these interventions that to place in January 2017. A ited deficiency that was an uary 2017 on a complaint and subsequently recited in mplaint investigation. The earea of Quality of Care. The he facility during two federal owed a pattern of the ustain an effective Quality ed: Based on record review and facility failed to assess 1 of 2 who had a fall resulting to a and right humerus fracture | F 520 | The facility has a quality assurance assessment committee that meets monthly that include Medical Director, Administrator, Director of n Nurse Managers, Therapy , Dietary, buisness office and Mainte Director. The facility meets to ident issues with respect to which quality assessment and assurance activitic are necessary and develop and implement appropriate plans of actidentify quality deficiencies. 1. Corrective action for resident #6 Resident #6 was assessed by the I sent to the hospital for treatment. Resident #6 was transferred to the hospital emergency department on 3-12-2017 for further evaluation. R #6 was returned to the facility on 3-13-2017.Rn will be re- educated Director of nursing services regard procedures to assess a resident af fall. NA #1 was suspended and tenfor failure to report a fall. | enance iify / es that ion to : RN and esident by ing ter a |
| | sampled residents w right femur fracture a (Resident # 6). During an interview w 3/28/17 at 3:00 p.m. | for failure to assess 1 of 2 who had a fall resulting to a and right humerus fracture with the Administrator on the Administrator stated an accident at the facility | | 2.Corrective action for residents the the potential to be affected by the adeficient practice will include: An arway conducted on residents that has in the last 30 days to ensure asses | alleged udit ad a fall |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCTION | | (X3) DATE : COMPI | |
|--------------------------|--|--|-------------------------|---|--|--|----------------------------|
| | | 345092 | B. WING _ | | _ | 03/2 | 28/2017 |
| | ROVIDER OR SUPPLIER SALEM NURSING & RE | EHABILITATION CENTER | | STREET ADDRESS, CITY, STA 1900 W 1ST STREET WINSTON-SALEM, NC 2 | | 1 03/2 | 20/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY) | | (X5) COMPLETION DATE |
| F 520 | training was complet the current issue was event". The Adminis Assistant (NA) #1 ha related to safe transf | e of the residents, sufficient ed. The Administrator stated is a "per instance one-time trator stated Nursing d received sufficient training er of residents during the open aware of the proper | F | was completed. Resassessed by the lice determine any immer Residents that have re-assessed with in manager/charge nutransfer for each residetermined by nursiquarterly and with a with emphasis place chair before resident 3. Measures/System deficient practice winurses will be educa Nursing regarding the assessing a resident of transfer will be defined on admission, quartichange of condition on locking wheel che transfers, this inform in the new hire orient program. 4. Monitoring Practic reviewed during mo by Nursing Administration appropriate assessing Nursing Supervisor weekends. Falls/Astreviewed at weekly be reviewed and an Quality Assurance my with subsequent planeeded. The RDO a observe QA weekly monthly times three | ensed nurse to ediate injury. It had a fall will be 24 hours by unit arse. The Method of sident will be ing on admission, any change of condition on locking wheel at transfers. In changes to ensure ill not occur: License ated by the Director he procedure of at after a Fall, Method etermined by nursing terly and with any a with emphasis place at the procedure of a service in the procedure of the p | ition I Ire ed r of od rg ced led ure on. e vill | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345092 | B. WING _ | | | C 03/28 / | 2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DE | 03/20/ | 2017 | |
| WINSTON | WINSTON SALEM NURSING & REHABILITATION CENTER | | | 1900 W 1ST STREET | | | | |
| WINSTON | SALLIN NORSING & RE | HABILITATION CENTER | | 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIA | _ | (X5) OMPLETION DATE | |
| F 520 | Continued From page | e 19 | F 5 | The Regional Director of Operations re-educated Admregarding effective Quality Asemphasis on consistent mon implemented procedures on Regional Director of Operation Regional Director of Clinical validate areas taken to QA as monitored as indicated with remarked on the communication via Administrensure ongoing compliance. | Clinical ninistrator ssurance w ittoring of 4/19/17. The ons and /or Services w re being monthly rator to | vith he | | |