DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			TE SURVEY MPLETED
		345092	B. WING			C 6/09/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		0/03/2020
THE CITA	DEL AT WINSTON SALE	М		1900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	o		
F 000	conducted on 6-2-20 was found in complia to E-0024 (b)(6), Sub	VID19 focused survey was through 6-9-20. The facility nce with CFR 483.73 related part-B-Requirements for lities. Event ID# GXEO11	F 00	0		
		VID-19 Focused Infection omplaint investigation were				
F 561 SS=E	resulting in deficiency		F 56	1		6/16/20
	promote and facilitate through support of re-	right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f)				
	activities, schedules (waking times), health					
		ident has a right to make s of his or her life in the cant to the resident.				
	with members of the	ident has a right to interact community and participate in poth inside and outside the				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ξ	TITLE		(X6) DATE
Electroni	cally Signed					06/17/2020

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.

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPI OMB NO. 093	8-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	Y	
		345092	B. WING		C 06/09/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITA	DEL AT WINSTON SALE	M		900 W 1ST STREET			
				WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COME	X5) PLETIO ATE	
F 561	Continued From page	e 1	F 561				
	facility.						
	§483.10(f)(8) The res						
	religious, and commu	ctivities, including social, unity activities that do not					
	interfere with the righ facility.	its of other residents in the					
	This REQUIREMENT is not met as evidenced by:						
	-	iew, staff interviews, resident		The facility failed to honor 4 of 5			
	representative interviews and physician		(Resident #1, #2, #3 and #4) cho				
	-	failed to honor 4 of 5		remain in the facility after testing for COVID19. All residents have	•		
		#1, #2, #3 and #4) choice to after testing positive for		potential to be affected.	lne		
	COVID19.	and testing positive for		Upon review, facility did not prov	vide		
				residents nor resident s respon			
	Findings included:			with a choice to stay in the facilit treatment. The transfer to anothe	ty for		
		's "Transfer or Discharge		was the result of facility not having	•		
		cy and procedure dated		acceptable processes in place to			
		aled the following in part;		Forsyth County Health Departme			
		permitted to stay in the		reccomendations to provide care			
	-	nsferred or discharged needs cannot be met in the		acceptable isolation barriers for with positive covid-19 test.	residents		
	facility.			II. Education was provided from - 6/15/20 to Nursing Staff and So			
	1. Resident #1 was a	dmitted to the facility on		Services Department by the Dire			
		red to another Long-Term		Nursing and Assistant Director o			
		-20 after testing positive for		to ensure the residents preferan			
		#1 also had the following		honored and notification of any u			
	aiagnosis chronic ob	structive pulmonary disease.		discharge is provided to the resident representative before a			
	The quarterly Minimu	ım Data Set (MDS) dated		transfers out of the facility not to	-		
		sident #1 was minimally		any emergency transfer to hospi			
	cognitively impaired.			emergency rooms.			
				Licensed Nurses will record the			
	-	an dated 4-21-20 revealed a		and notifications for any emerge	-		
	goal that the resident			transfer or discharge in the resid			
	opportunity to make (choices related to her		medical record. nursing staff an			

Facility ID: 923570

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	DICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	B. WING		C 06/09/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE CITADEL AT WINSTON SALEM			1900 W 1ST STREET	
			WINSTON-SALEM, NC 27104	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
and responsible party to indicated at an outside lo and/or another physician Review of Resident #1's record revealed no docur representative's response transfer to another facility The facility's medical dire 6-2-20 at 1:04pm. The m did not understand why the transferred "we have the those residents here" and involved in speaking with he did not know if any of wanted their loved one to Resident #1's legal repre- interviewed on 6-4-20 at The representative said so on 5-28-20 by the facility Resident #1 needed to be facility "because she test She also stated when she worker, she was not give resident to remain in the had to be transferred or of The facility's social worker	Atterventions associated hedical need arises, I assistance of my physician decide if treatment is boation i.e., hospital 's office. electronic medical mentation of the e of the residents y. ector was interviewed on hedical director said he the residents had been capability to care for d stated he was not in the representatives so the representatives to remain in the facility. esentative was 2:27pm by telephone. she had received a call 's social worker that e transferred to another ted positive for COVID". e spoke with the social en the choice for the facility "I was told she discharged." er was interviewed on phone. The social worker d Resident #1's legal one on 5-28-20 and were being transferred to	F 56		otice ly. De eks ure arge arge art will QAPI wed

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345092	B. WING				09/2020
NAME OF P	ROVIDER OR SUPPLIER	L	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE CITA	DEL AT WINSTON SALE	М			00 W 1ST STREET INSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	The social worker sai representatives had r to stay in the facility b the representatives the transferred or dischar choice for the residen not an option and said corporate that they had discharged." During an interview w 6-5-20 at 10:24am by Administrator stated a facility's cooperate off was made to transfer facility' because that positive residents. Sh present when the soc residents' legal repres sure how the reason f communicated to the 2. Resident #2 was au 12-28-16 and transfer 5-28-20 due to testing Resident #2 was also neoplasm of the color The quarterly Minimu 5-7-20 revealed Resid cognitively impaired. Resident #2's care pla goal that he would be make choices related collaboration with his interventions for the g arises, I have the right	d "some" of the equested for their loved one out stated she had informed he residents had to be ged. She also stated the it to stay in the facility was d, "we were told by ad to be transferred or with the Administrator on telephone, the after speaking with the fice on 5-28-20, the decision the residents to a "sister facility already had COVID he also said she was not ial worker spoke to the sentatives, so she was not for the transfers were representatives. dmitted to the facility on tred out of the facility on g positive for COVID19. o diagnosed with malignant in and diabetes. m Data Set (MDS) dated	F	561			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345092	B. WING				C / 09/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М			1900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 561	hospital and/or anoth Review of Resident # record revealed no do representative's response transfer to another fact The facility's medical 6-2-20 at 1:04pm. The did not understand with transferred "we have those residents here" involved in speaking whe did not know if any wanted their loved on Resident #2's legal re- interviewed by phone representative said he social worker of the tr telephone on 5-28-20 positive for COVID. He spoke with the social the option for Residen He stated, "I was just transferred and that the The facility's social we 6-5-20 at 9:35am by the representative by televice of the tr telephone on the social the option for the social the option for the social the option for the social the social the option for the social the social the option for the social the option f	at an outside location i.e., er physician's office. 2's electronic medical boumentation of the onse of the residents cility. director was interviewed on e medical director said he hy the residents had been the capability to care for and stated he was not with the representatives so y of the representatives the to remain in the facility. epresentative was on 6-4-20 at 3:28pm. The e was notified by the facility transfer to another facility by 0 due to the resident testing le also stated when he worker, he was not provided in #2 to remain in the facility. told he had to be here were no other options."	F	561			
	another facility due to The social worker sai representatives had r to stay in the facility b the representatives th	ts were being transferred to testing positive for COVID. d "some" of the equested for their loved one but stated she had informed he residents had to be rged. She also stated the					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345092	B. WING				C 109/2020
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE CITA	DEL AT WINSTON SALE	М			900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 561	not an option and said corporate that they had discharged." During an interview w 6-5-20 at 10:24am by Administrator stated a facility's cooperate off was made to transfer facility" because that positive residents. Sh present when the soor residents' legal repres sure how the reason to communicated to the 3. Resident #3 was at 10-4-19 and transfer 5-28-20 related to tes Resident #3 was also encephalopathy. The quarterly Minimu 5-8-20 revealed Resid cognitively impaired. Resident #3's care pla goal that she would h community and her di would be completed p	t to stay in the facility was d, "we were told by ad to be transferred or ith the Administrator on telephone, the after speaking with the fice on 5-28-20, the decision the residents to a "sister facility already had COVID e also said she was not ial worker spoke to the sentatives, so she was not for the transfers were representatives. dmitted to the facility on ed to another facility on ting positive for COVID19. diagnosed with m Data Set (MDS) dated dent #3 was moderately an dated 5-14-20 revealed a ave a safe discharge to the scharge arrangements prior to her discharge date. ociated with the goal were in the instructions to the esentative. 3's electronic medical pourentation of the onse of the residents	F	561			

Facility ID: 923570

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345092	B. WING				09/2020
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
THE CITA	DEL AT WINSTON SALE	М			0 W 1ST STREET NSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	≥ 6	F 5	61			
	6-2-20 at 1:04pm. The did not understand will transferred "we have those residents here" involved in speaking w he did not know if any wanted their loved on Resident #3's represe telephone on 6-4-20 a representative stated from the facility notify transfer. He said, "I w positive COVID test of the facility to speak to moved to another floor would be transferred (5-28-20)." The repre- informed the social w Resident #3 transferred stated "I was told eith or discharged". The re not provided a choice the facility.	he had not received a call ing him of the resident's vas not told about the or the transfer until I called o her and was told she was or due to testing positive and to another facility that day sentative said he had orker he did not want ed to another facility but her she had to be transferred epresentative stated he was a for Resident #3 to remain in					
	6-5-20 at 9:35am by t stated she had contact representative by tele explained the residen another facility due to The social worker sait representatives had r	orker was interviewed on telephone. The social worker cted Resident #3's legal ephone on 5-28-20 and its were being transferred to be testing positive for COVID. d "some" of the equested for their loved one but stated she had informed					
	the representatives th transferred or dischar						

Facility ID: 923570

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345092	B. WING				C 109/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М			900 W 1ST STREET NINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	not an option and said corporate that they had discharged." During an interview w 6-5-20 at 10:24am by Administrator stated a facility's cooperate off was made to transfer facility" because that positive residents. Sh present when the soor residents' legal repressure how the reason f communicated to the 4. Resident #4 was an 1-16-17 and was tran 5-28-20 related to tes The resident was also The quarterly Minimu 5-11-20 revealed Ress cognitively impaired. Resident #4's care pla goal that she would b make choices related collaboration with her interventions associat contact my represent decisions need to be in my level of conscio behaviors, or other m representative and m	d, "we were told by ad to be transferred or "the the Administrator on "telephone, the after speaking with the fice on 5-28-20, the decision the residents to a "sister facility already had COVID ie also said she was not cial worker spoke to the sentatives, so she was not for the transfers were representatives. dmitted to the facility on sferred to another facility on sting positive for COVID19. to diagnosed with diabetes. m Data Set (MDS) dated cident #4 was mildly an dated 5-18-20 revealed a e given the opportunity to to her care through representative. The ted with the goal were; ative when impactful made, report any changes pusness, increased edical changes to my y physician as needed. 4's electronic medical poumentation of the	F	561			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/09/2020 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345092	B. WING			_	(06/) 09/2020
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CITAI	DEL AT WINSTON SALE	И			900 W 1ST STREET VINSTON-SALEM, NC	27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	6-2-20 at 1:04pm. The did not understand wh transferred "we have a those residents here" involved in speaking w he did not know if any wanted their loved on Resident #4's represe 6-5-20 at 9:07am by t representative said sh 2:00pm on 5-28-20 by that Resident #4 need Henderson on 5-29-20 COVID19. She explai social worker; she wo remain in the facility a stated the social work had to be transferred The facility's social work 6-5-20 at 9:35am by t stated she had contact representative by tele explained the resident another facility due to The social worker said representatives had re to stay in the facility b the representatives the transferred or dischart	cility. director was interviewed on e medical director said he by the residents had been the capability to care for and stated he was not with the representatives so of the representatives e to remain in the facility. entative was interviewed on elephone. The ne was notified "around" of the facility social worker led to be transferred to 0 due to testing positive for ned she had informed the uld rather have Resident #4 and not be transferred. She er informed her the resident or discharged. orker was interviewed on elephone. The social worker cted Resident #4's legal phone on 5-28-20 and ts were being transferred to testing positive for COVID. d "some" of the equested for their loved one ut stated she had informed e residents had to be ged. She also stated the t to stay in the facility was	F	561				
	corporate that they ha discharged."	id to be transferred or						

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY PLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER:	A. BUILDING		COM	C	
		345092	B. WING		06/09/2020		
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO	DE		
	DEL AT WINSTON SALE	м		W 1ST STREET STON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE	
F 561	Continued From page	e 9	F 561				
		vith the Administrator on					
	6-5-20 at 10:24am by						
		after speaking with the fice on 5-28-20, the decision					
		the residents to a "sister					
		facility already had COVID					
		e also said she was not sial worker spoke to the					
		sentatives, so she was not					
		for the transfers were					
	communicated to the	-					
F 623	Notice Requirements CFR(s): 483.15(c)(3)	Before Transfer/Discharge	F 623			6/16/20	
SS=E	011(3): 400: 10(0)(0)	-(0)(0)					
	§483.15(c)(3) Notice						
	Before a facility trans						
	resident, the facility n (i) Notify the resident						
		he transfer or discharge and					
		ove in writing and in a					
	language and manne facility must send a c	r they understand. The					
	representative of the						
	Long-Term Care Oml	oudsman.					
	(ii) Record the reasor						
		lent's medical record in graph (c)(2) of this section;					
	and						
	(iii) Include in the not paragraph (c)(5) of th	ice the items described in is section.					
	§483.15(c)(4) Timing						
		d in paragraphs (c)(4)(ii) and					
		the notice of transfer or nder this section must be					
	- ·	t least 30 days before the					
	resident is transferred	d or discharged.					
	(ii) Notice must be ma	ade as soon as practicable					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/09/2020 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345092	B. WING		_	(06/	; 09/2020
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
THE CITA	DEL AT WINSTON SALEI	М		900 W 1ST STREET VINSTON-SALEM, NC	27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follor (i) The reason for tran (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such reques to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of	charge when- viduals in the facility would paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, l)(i)(B) of this section; hefer or discharge is ent's urgent medical needs, l)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State pudsman; y residents with intellectual	F 623				

Facility ID: 923570

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345092	B. WING				C 09/2020
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
THE CITA	DEL AT WINSTON SALEI	Μ			1900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPF DEFICIENCY)			(X5) COMPLETION DATE
F 623	developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individual established under the for Mentally III Individu §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility of the administrator of the written notification pri- to the State Survey Act State Long-Term Care the facility, and the re well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on staff and R interview and record re provide written notifica- representatives and the facility-initiated reside	lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility bients of the notice as soon ne updated information in advance of facility closure closure, the individual who is ne facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate tents, as required at § is not met as evidenced tesident Representative interview, Ombudsman review the facility failed to ation to resident he Ombudsman of nt transfers to another Long 4 of 5 residents reviewed	F	623	 The facility did not provide required notice before transfer for 4 of 5 reside (Resident #1, #2, #3 and #4). All reside have the potential to be affected. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the mov 	ents s	

Event ID: GXEO11

Facility ID: 923570

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345092	B. WING _			C 06/09/2020		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				19	00 W 1ST STREET			
	DEL AT WINSTON SALE	M		w	INSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page	9 12	F 6	523	writing and in a language and manner			
	Documentation" polic December 2016 rever each resident will be if facility and not be tran unless the resident's facility. When a reside discharged from the fip provided to the reside representative. 1.Resident #1 was act 1-10-17 and transferr Care Facility on 5-28- COVID19. Resident # diagnosis chronic obs The quarterly Minimu 4-15-20 revealed Res cognitively impaired. Resident #1's care pla goal that the resident opportunity to make of treatment through col responsible party. The with the goal were; If have the right with the and responsible party indicated at an outsid and/or other physician	acility, notice would be ent and/or legal Imitted to the facility on ed to another Long-Term 20 after testing positive for 11 also had the following structive pulmonary disease. m Data Set (MDS) dated sident #1 was minimally an dated 4-21-20 revealed a would be given the choices related to her laboration with her e interventions associated a medical need arises, I e assistance of my physician to decide if treatment is e location i.e., hospital n's office, Report any of consciousness, increased			writing and in a language and manner they understand. The facility did not send a copy of the notice to a representative of the Office the State Long-Term Care resident nor resident □s responsible party with a chi- before transfer to another facility , the transfer was a result of the facility not having processes in place to provide of and required isolation barriers for residents with positive covid-19 test. II. Education was provided from 06/10/ - 6/15/20 to Nursing Staff and Social Services Department by the Director of Nursing and Assistant Director of Nurs on ensuring the notification of any discharge is provided to the resident at resident representative upon any trans out of the facility. Licensed Nurses will record the reaso for the transfer or discharge in the resident □s medical record. Any nursing staff or social services staff will have completed education by 6/15/20. As requested by Ombudsman, Social Services Director will maintain Transfer/Discharge log and submit not of transfer log to Ombudsman monthly III. Beginning 6/10/20, an audit will be conducted weekly for twelve (12) week by the Social Service Director to ensur upon any discharge , a letter of dischar is provided to the resident and resident representative and notice of transfer w	ice care care 20 f ing fers ns g ice cs e rge t		
	Review of the facility's	l my physician as needed. s progress note from			be added to the monthly log. V. Social Service Director will report			

Facility ID: 923570

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		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · · ·	IPLETED	
						С	
		345092	B. WING		06/09/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
THE CITA	DEL AT WINSTON SALE	м		1900 W 1ST STREET WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 623	Continued From page	e 13	F 62	3			
	5-28-20 revealed Res was notified by phone	sident #1's representative e of Resident's transfer to lerson" on 5-29-20 by the		findings and resolution month minimum of three (3) months Committee. Data results will b and analyzed for the need for monitoring beyond the three r	to the QAPI be reviewed further		
	5-28-20 was reviewed representative was n	e written by Nurse #2 dated d stating Resident #1's otified of the residents n and "that it would take		subsequent POC as needed. Service Director and Administ responsible for overall compli	rator will be		
	6-2-20 at 1:04pm. Th did not understand w transferred "we have those residents here" involved in speaking he did not know if the regarding the transfe	director was interviewed on e medical director said he hy the residents had been the capability to care for ' and stated he was not with the representatives so ey had been contacted r but expected the facility resentatives prior to the					
Resident #1's legal representative was interviewed on 6-4-20 at 2:27pm by telephone. The representative said she had received a call from the facility social worker on 5-28-20 that Resident #1 needed to be transferred to another facility "because she tested positive for COVID" but stated she had not received anything in writing or a plan to have the resident return to the facility.) at 2:27pm by telephone. aid she had received a call I worker on 5-28-20 that to be transferred to another tested positive for COVID" ot received anything in					
	6-5-20 at 9:35am by stated she had conta representatives by te explained the resider another facility due to	orker was interviewed on telephone. The social worker cted Resident #1's legal lephone on 5-28-20 and ht was being transferred to b testing positive for COVID. id she had informed the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345092	B. WING			C 06/09/2020		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITA	DEL AT WINSTON SALE	М			1900 W 1ST STREET WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	representatives that ti transferred on 5-29-2 the representatives w to transfer the resider stated she had not co sent written notification During an interview w 6-5-20 at 10:24 m by Administrator stated a facility's cooperate off was made to transfer facility' because that positive residents. Shi present when the soor residents' legal representatives were in writing. Forsyth Counties Lon was interviewed by te 11:23 am. The Omburd been informed of the transferred on 5-28-2 specified, "they usual there had been a disc not received a phone anyone in the facility. 2. Resident #2 was an 12-28-16 and transfer 5-28-20 due to testing Resident #2 was also neoplasm of the color	he residents would be 0 but had not re-contacted hen the decision was made hts on 5-28-20. She also intacted the Ombudsman or on to the representatives. With the Administrator on telephone, the after speaking with the fice on 5-28-20, the decision the residents to a "sister facility already had COVID e also said she was not ial worker spoke to the sentatives but felt all the notified by telephone but not g Term Care Ombudsman elephone on 6-9-20 at dsman stated she had not 4 residents that were 0 to another facility. She ly send me an email when charge or transfer, but I have ." She also stated she had call about the transfer from dmitted to the facility on red out of the facility on g positive for COVID19. diagnosed with malignant n and diabetes. m Data Set (MDS) dated	F	623	3			

Facility ID: 923570

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CENTERS FOR MEDICARE & MI	HUMAN SERVICES				FORM APPROVED MB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED C
	345092	B. WING _			06/09/2020
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z		
THE CITADEL AT WINSTON SALEM			1900 W 1ST STREET WINSTON-SALEM, NC 27104	1	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 623 Continued From page 1	15	Fe	523		
 goal that he would be g make choices related to collaboration with his re- interventions for the goal arises, I have the right w physician and responsite treatment is indicated a hospital and/or other ph any changes in my leve increased behaviors, or my responsible party ar needed. Review of the facility's p 5-28-20 revealed Resid was notified by phone or "Pelican Health Hender facility's social worker. Another progress note w 5-28-20 was reviewed s representative was notified transfer to Henderson a about 2 hours". The facility's medical din 6-2-20 at 1:04pm. The r did not understand why transferred "we have the those residents here" and 	b his treatment through esponsible part. The al were; If a medical need with the assistance of my ble party to decide if it an outside location i.e., hysician's office, Report el of consciousness, r other medical changes to nd my physician as progress note from lent #1's representative of Resident #2's transfer to rson" on 5-29-20 by the written by Nurse #2 dated stating Resident #2's fied of the residents and "that it would take rector was interviewed on medical director said he the residents had been the capability to care for nd stated he was not th the representatives so had been contacted out expected the facility sentatives prior to the				

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/09/2020 MAPPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345092	B. WING			_		09/2020	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE CITA	DEL AT WINSTON SALEI	м			900 W 1ST STREET WINSTON-SALEM, NC	27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	interviewed by phone representative said he facilities social worker facility by telephone of resident testing positi originally told the resi- transferred until 5-29- received a call "later the resident was going to representative stated anything in writing ab- to have the resident me The facility's social wo 6-5-20 at 9:35 am by the explained the resident another facility due to The social worker said representatives that the transferred on 5-29-20 the representatives we to transfer the resident stated she had not co sent written notification During an interview we 6-5-20 at 10:24 am by Administrator stated a facility's cooperate off was made to transfer facility' because that positive residents. Sh present when the soc residents' legal represents	on 6-4-20 at 3:28pm. The e was notified by the r of the transfer to another on 5-28-20 due to the ve for COVID and was dent would not be -20 but then stated he that night" (5-28-20) the be transferred 5-28-20. The he had not received out the transfer or the plan eturn to the facility. orker was interviewed on telephone. The social worker cted Resident #2's legal lephone on 5-28-20 and ts were being transferred to testing positive for COVID. d she had informed the he residents would be 0 but had not re-contacted then the decision was made nts on 5-28-20. She also ontacted the Ombudsman or on to the representatives.	F	623					

Facility ID: 923570

If continuation sheet Page 17 of 28

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345092	B. WING				C 09/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М			900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Forsyth Counties Lon was interviewed by te 11:23am. The Ombuc been informed of the transferred on 5-28-2 specified, "they usual there had been a disc not received anything not received a phone anyone in the facility. 3. Resident #3 was au 10-4-19 and transferr 5-28-20 related to tes Resident #3 was also encephalopathy. The quarterly Minimu 5-8-20 revealed Resid cognitively impaired. Resident #3's care pla goal that she would h community and her di would be completed p The interventions ass part; Provide written of and my representative Review of the facility's Nurse #2 dated 5-28- that Resident #3's rep the transfer "to the faci that it will take about 3 The facility's medical 6-2-20 at 1:04pm. The did not understand with	In the progress note written by 20 revealed documentation or constrained by 20 revealed documentation	F	623			

Facility ID: 923570

If continuation sheet Page 18 of 28

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		SURVEY PLETED
		345092	B. WING				09/2020
NAME OF P	ROVIDER OR SUPPLIER		ł	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М			900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	those residents here" involved in speaking whe did not know if the regarding the transfer staff to notify the repri- residents transfer. Resident #3's represe telephone on 6-4-20 a representative stated from the facility notify transfer. He said, "I w positive COVID test of the facility to speak to moved to another floor would be transferred (5-28-20)." The repre- received anything in will made aware of the fa- resident return. The facility's social we 6-5-20 at 9:35am by the stated she had contact representative by tele explained the resident another facility due to The social worker sai representatives that the transferred on 5-29-2 the representatives we to transfer the resider stated she had not co sent written notification During an interview w 6-5-20 at 10:24am by Administrator stated a	and stated he was not with the representatives so y had been contacted but expected the facility esentatives prior to the entative was interviewed by at 4:02pm. The he had not received a call ing him of the resident's ras not told about the or the transfer until I called o her and was told she was or due to testing positive and to another facility that day sentative said he had not writing about the transfer or cility's plan to have the orker was interviewed on telephone. The social worker cted Resident #3's legal sphone on 5-28-20 and ts were being transferred to testing positive for COVID. d she had informed the he residents would be 0 but had not re-contacted hen the decision was made nts on 5-28-20. She also ontacted the Ombudsman or on to the representatives.	F	623			

Facility ID: 923570

If continuation sheet Page 19 of 28

CENTER STATEMENT (AND PLAN OF	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	· ,	ING _	E CONSTRUCTION	FORM OMB NC (X3) DATE COMP	D: 07/09/2020 MAPPROVED D. 0938-0391 SURVEY LETED C 09/2020
THE CITA	DEL AT WINSTON SALEI	м			1900 W 1ST STREET WINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	 was made to transfer facility" because that is positive residents. Ship present when the soci residents' legal repressive representatives were in writing. Forsyth Counties Lon was interviewed by te 11:23am. The Ombudi been informed of the transferred on 5-28-20 specified, "they usuall there had been a disc not received a phone anyone in the facility. 4. Resident #4 was and 1-16-17 and was transistication 5-28-20 related to tess The resident was also The quarterly Minimum 5-11-20 revealed Ress cognitively impaired. Resident #4's care pla goal that she would b make choices related collaboration with her interventions association contact my representation decisions need to be in my level of conscion behaviors, or other minimum sections association 	the residents to a "sister facility already had COVID the also said she was not stal worker spoke to the sentatives but felt all the notified by telephone but not of g Term Care Ombudsman elephone on 6-9-20 at dsman stated she had not 4 residents that were 0 to another facility. She ly send me an email when charge or transfer, but I have the second the transfer from dmitted to the facility on sferred to another facility on sting positive for COVID19. to diagnosed with diabetes. m Data Set (MDS) dated sident #4 was mildly an dated 5-18-20 revealed a the given the opportunity to to her care through the representative. The ted with the goal were; ative when impactful made, report any changes business, increased	F	623			

Facility ID: 923570

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
		345092	B. WING				09/2020	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
THE CITA	DEL AT WINSTON SALE	м			1900 W 1ST STREET WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Review of the facility social worker dated 5 resident's representer residents transfer to " to take place on 5-29. There was no further Resident #4's transfe The facility's medical 6-2-20 at 1:04pm. The did not understand will transferred "we have those residents here" involved in speaking whe did not know if the regarding the transfer staff to notify the repri- residents transfer. Nurse #2 was intervie 3:35pm. The nurse st supervisor for the 3:0 confirmed nursing star residents' representative transfer occurring in t also stated he could ri- representative for Resistated "each represen- stated "each represen- contacted." Resident #4's representa- tive said started st 2:00pm on 5-28-20 by that Resident #4 need Henderson on 5-29-2 COVID19. She stated	progress note written by the -28-20 revealed the d was notified of the Pelican Health Henderson" -20. documentation regarding r. director was interviewed on e medical director said he hy the residents had been the capability to care for and stated he was not with the representatives so y had been contacted but expected the facility esentatives prior to the ewed by phone on 6-4-20 at ated he was the shift Opm to 11:00pm shift. He ff were to contact the tives to inform them of the he evening of 5-28-20. He not remember if the sident #4 was contacted but ntative was supposed to be	F	623				

Facility ID: 923570

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 07/09/2020 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345092	B. WING			_		C 09/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М			1900 W 1ST STREET WINSTON-SALEM, NC	27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	and make sure she w understood what was had received a call at "Pelican Health Hend in their facility. The re- not received a phone informing her the resi on 5-28-20 nor had sl writing about the trans- resident return to the The facility's social we 6-5-20 at 9:35am by to stated she had contact representatives by tel residents were being facility due to testing social worker said she representatives that to transferred on 5-29-2 the representatives w to transfer the resider "the nursing staff wer- representative". She a contacted the Ombud notification to the repre- During an interview w 6-5-20 at 10:24am by Administrator stated a facility" because that positive residents. Sh present when the soc residents' legal represents	vas ok with the transfer and a going on" but then said she is 11:00pm on 5-28-20 from lerson" that Resident #4 was appresentative stated she had call from the facility dent was being transferred he received anything in sfer or the plan to have the facility. orker was interviewed on telephone. The social worker cted Resident #4's legal lephone and explained the transferred to another positive for COVID. The e had informed the he residents would be 0 but had not re-contacted when the decision was made ents on 5-28-20, she stated e supposed to contact each also stated she had not lisman or sent written resentatives.	F	623				

Facility ID: 923570

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345092	B. WING _		06/09/2020		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITA	DEL AT WINSTON SALEI	м		1900 W 1ST STREET WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 623 F 880	Forsyth Counties Lon was interviewed by te 11:23am. The Ombuc been informed of the transferred on 5-28-2 specified "they usually there had been a disc not received anything not received a phone anyone in the facility.	g Term Care Ombudsman elephone on 6-9-20 at isman stated she had not 5 residents that were 0 to another facility. She y send me an email when charge or transfer, but I have ." She also stated she had call about the transfer from		380		6/16/20	
SS=D	§483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and tran- diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di	ntrol blish and maintain an nd control program a safe, sanitary and nent and to help prevent the asmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at <i>v</i> ing elements: em for preventing, identifying, g, and controlling infections seases for all residents, pors, and other individuals					
	conducted according accepted national sta §483.80(a)(2) Written	pon the facility assessment to §483.70(e) and following ndards; standards, policies, and ogram, which must include,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/09/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345092	B. WING		_	(06/	C 09/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М		1900 W 1ST STREET WINSTON-SALEM, NC	27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	possible communicabi infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement tha least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste- identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will conduct	lance designed to identify ble diseases or can spread to other in possible incidents of the or infections should be assission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct to or their food, if direct the disease; and procedures to be followed rect resident contact. em for recording incidents facility's IPCP and the en by the facility. le, store, process, and to prevent the spread of	F 88				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 07/09/2020 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED		
	345092		B. WING			C 06/09/2020		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE			
				1900 W 1ST STREET				
	DEL AT WINSTON SALE			WINSTON-SALEM, NC 271	04			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION YE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 880	Continued From page	e 24	F 8	80				
	This REQUIREMENT							
	This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's Handwashing/Hand Hygiene policy and procedure, Infection Control policy and procedure and the facility's COVID19 policy and procedures, staff interviews and physician interview the facility failed to perform hand hygiene when a housekeeper entered and exited 2 of 2 resident rooms (Residents #1 and #2) who were on droplet precautions. This failure occurred during a COVID19 pandemic. Findings included: Review of the facility's Handwashing/Hand Hygiene policy and procedure dated August 2015 revealed in part; all personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections, use alcohol hand rub after contact with objects in the immediate vicinity of the resident and before and after entering isolation precaution setting. The facility's Infection Control policy and procedure, Transmission Based Precautions dated 4-24-20, was reviewed and revealed in			The facilitys contracter services staff failed to hygiene when a house exited 2 of 2 resident r #1 and #2) who were of precautions. The Corrective action accomplished for those have been affected, A potential to be affected housekeeping aide wa immediatly on infection control,handwashing,o gloves when moving fr room.the housekeeper about coming out of th without removing or ch washing her hands. All residents having th affected by the same of Residents who reside the potential to be affected changes made to ensu- practice will not recur; nursing and housekeeper	perform hand ekeeper entered and rooms (Residents on droplet will be e residents found to Il residents have the d. The as educated n doning and doffing rom room to r ws also inserviced he isolation area hanging gloves or e potential to be deficient practice All on the hallway have ected. "Systemic ure that the deficient The director of			
	room and perform ha Review of the facility' procedure dated 5-6- revealed in part; remi	before leaving the resident nd hygiene. s COVID19 policy and 20 was reviewed and and staff that handwashing is and effective preventive		Education related to ha 6/12/2020 for nursing staff and ancillary staff to the residents. Staff educated by 6/13/2020 from the schedule unti completed. This educated added to the general of	and washing on staff, environmental f providing services that have not been 0 will be removed il education is ation has been			
	The Administrator was interviewed on 6-2-20 at 10:30am. The Administrator stated the facility had 5 residents' that had tested positive for COVID19			employees. The Direc Services, Nurse Mana Administrator and/or D	tor of environmental gement,			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345092 NAME OF PROVIDER OR SUPPLIER				A. BUILDING			
						С	
		B. WING		06	6/09/2020		
			STREET ADDRESS, CITY, STATE, ZIP	CODE			
	DEL AT WINSTON SALE	M		1900 W 1ST STREET			
	DELAT WINGTON SALL	IVI		WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE	
F 880	Continued From page	e 25	F 88	0			
		rged to a sister facility. She		Managers are monitoring	hand washing		
		ising "part" of the 2nd floor		daily for one week, then v	•		
		nit" and an Isolation unit.		weeks, then monthly ther	-		
		bservation unit" was sealed		continued compliance.			
		e 2nd floor by the fire doors		The Administrator, Director			
		nitor residents who had		Services and Department			
		spital, waiting for their r new admissions needing to		observing the staff in the ensure their following our			
	be observed for signs	•		policys.			
		histrator further explained,		The Administrator and/or	Director of		
	the facility had placed			Health Services are corre	elating the data		
		m the isolation unit which		from the handwashing rev	-		
	was located at the en	nd of the hall.		presenting the analysis of Quality Assurance and Pe			
	During a continuous of	observation on 6-2-20 from		Improvement Committee			
		of the facility's "observation		three consecutive months			
		revealed housekeeper (HK)		findings are sustained, th	en quarterly		
	#1 entered room num			thereafter.			
		let precaution room as let precaution isolation" sign					
		, without changing her					
		hand hygiene and began					
		er 200 by wiping down the					
	dresser, over the bed						
		g the floor. When the HK					
		mber 200, she exited the					
	room without performing hand hygiene. HK #1						
	was then observed to walk across the hall and enter resident room number 209, where another						
	resident who was on droplet precautions resided						
	and had a "droplet precaution isolation" sign						
	posted on the door. HK #1 entered the room						
		gloves or performing hand					
	hygiene and began wiping down the dresser, over						
		the bed table, bathroom and moping the floor. Once the HK completed her work in room number					
		er gloved hand and pushed					
		it the "observation unit",					
	walked onto the resid						

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345092 B. WING				C 06/09/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	М			900 W 1ST STREET VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	380			

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		ID HUMAN SERVICES				FORM	
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUIT				. 0938-0391
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345092	B. WING		06/09/2020		
NAME OF PROVIDER OR SUPPLIER					FREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL AT WINSTON SALE	Μ			000 W 1ST STREET /INSTON-SALEM, NC 27104		
				~			(X5)
(X4) ID PREFIX	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	HOULD BE COMPL	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
F 880	Continued From page	e 27	F	F 880			
		to prevent the spread of					
	COVID19.						

Event ID: GXEO11

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