STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED			
					С		
		345573	B. WING		01/22/2021		
NAME OF PR	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
ARBOR A	CRES UNITED METHOD	IST RETIREMENT COMMUNITY	1250 ARBOR ROAD WINSTON SALEM, NC 27104				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF			
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	D ATE		
F 000	INITIAL COMMENTS	3	F 000				
	on 1/15/21 - 1/22/21.	investigation was conducted 4 of the 4 complaint ubstantiated. Event ID					
F 609 SS=D			F 609		2/19/21		
	• • •	se to allegations of abuse, or mistreatment, the facility					
	involving abuse, neg mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not res the administrator of t officials (including to adult protective servi for jurisdiction in long	e that all alleged violations lect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 ation is made, if the events tion involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides pterm care facilities) in the law through established					
	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her tative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken. Γ is not met as evidenced					

Electronically Signed

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.

02/08/2021

	CENTERS FOR MEDICARE & MEDICAID SERVICES		(¥2) MI II TI	PLE CONSTRUCTIO		(X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>	A. BUILDING			D
						С	
	345573		B. WING			01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	·	STREET ADDRESS, CITY, STATE, ZIP CODE		S, CITY, STATE, ZIP CODE		
ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY			1250 ARBOR ROAD				
	ARBOR ACRES UNITED METHODIST RETIREMENT COMMONITY			WINSTON SALEM, NC 27104			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		ROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	· ·	H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	MPLETIO DATE
F 609	Continued From page	e 1	F 6	09			
	Based on record rev	iew and resident and staff		Tag- F609			
	interviews, the facility	/ failed to submit an initial		-	t investigation was conducte	d	
	resident abuse allega	ation to the state agency		at the facili	ty. The facility received a tag		
	within the 2 hour time			facility failing to submit an ini	tial		
	abuse for 1 of 1 resid			ouse allegation to the state			
	-				hin the two hour time frame f		
	The findings included	1:		-	of abuse for one resident the	at	
	Review of the facility		was review	/ed.			
		Review of the facility 's Abuse, neglect or Sexual Assault, Protection of Residents policy included,			will ensure that all alleged		
	"a thorough investiga		-	nvolving abuse, neglect,			
	reports of any type of			n or mistreatment, including			
	state for further Inves			unknown source and			
				misapprop	riation of resident property, a	re	
	Resident #1 was adm			nmediately, but not later than	2		
	2/12/20 with diagnose		hours after	the allegation is made.			
	dementia, diabetes m	nellitus and chronic pain.					
	A quartarly Minimum	Data Sat (MDS)			y will Report the results of all		
	A quarterly Minimum	2/7/20 revealed Resident #1			ons to the administrator or his gnated representative and to		
	had moderately impa			als in accordance with State	·		
	required assistance v			ing to the State Survey Agen	cv.		
		iors not directed toward			orking days of the incident, ar		
	others 1-3 days durin	ng the look back period.			ed violation is verified		
				appropriate	e corrective action must be		
		nce log from June 2020 to		taken.			
	December 2020 was	reviewed.					
	A grievence substitute	d on 0/22/20 by Desident #4		Other Actio	ons laken:		
		d on 9/23/20 by Resident #1 the facility social worker		The Facility	y will update Abuse, Neglect	or	
	•	was expressing a concern			ault, Protection of Residents		
	about a staff member				move the verbiage Those		
		he would talk to Resident #1			hich have evidence of abuse	e,	
	-	ays to see what she reported			sexual assault		
		ne social worker interviewed					
	Resident #1. Resider	nt #1 expressed concerns		The Direct	or of Nursing will hold a traini	ing	
		ber and stated the staff			th Care Staff on the proper		
		was going crazy and might			for reporting abuse and negle		
	have to go to a menta	al institution and pounced on		in a timely	manner per state and federa	I	

Facility ID: NH953504

TATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
ND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:		A. BUILDING			
	245572					С	
		345573	B. WING			01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY				1250 ARBOR ROAD WINSTON SALEM, NC 271	04		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETIOI DATE	
F 609	Continued From page	- ²	Гсо	0			
1 003	15		F 60	-	vill be completed		
	her stomach one nigh	п.		regulations. Training v and documented no la			
		d on 12/31/20 by Resident to the facility ' s social		19th, 2021			
		of Nursing (DON) revealed		The Administrator will	check in weekly		
		Nurse #1 jumping all over		with the Social worker			
	her and trying to force	e a spoon in her mouth.		grievances that come	-		
	Review of the facility	reported incidents from June		help ensure that the fa	•		
		020 revealed no allegations		misinterpreted. Notes			
		e Agency for Resident #1.		record. This will take p 60 days.			
	On 1/15/21 at 8:15 A	M, Resident #1 was					
		ed most of the staff were					
		was one who yelled and she was busy and didn ' t do					
		ated she did not know her					
		o a heavyset nurse who					
		own her throat one time and					
	jumped on her. She v						
	incidents occurred bu	it did report it to the nurse.					
	On 1/15/21 at 10:14 /	AM the DON was					
		ed the facility did investigate					
		ations of abuse but didn ' t					
	report the allegations	to the State Agency					
	-	substantiate it and, per their					
	policy, they only repo substantiated.	orted allegations that were					
	worker was interview	timately 11:00 AM, the social ed. She stated she was the amily reported her concerns					
		in December. She stated					
		idents to the DON, but she					
	wasn ' t the one resp allegations of abuse	onsible for sending					

Facility ID: NH953504

If continuation sheet Page 3 of 7

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/24/202 FORM APPROVE OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345573		· · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/22/2021		
		B. WING					
NAME OF PROVIDER OR SUPPLIER ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1250 ARBOR ROAD 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 609	family submitted the g member, the social w #1. The Administrator not substantiated so t allegations to the Sta	ed when Resident #1 ' s grievances about the staff vorker interviewed Resident r added the allegations were they did not report the te Agency.	F 60				
F 610 SS=D	CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:		F 61		2/19/21		
	violations are thoroug §483.12(c)(3) Preven	t further potential abuse, or mistreatment while the					
	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her tative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken.					
	by: Based on record revi interviews, the facility allegation of staff to n thoroughly investigate reviewed for abuse (F	esident abuse was ed for 1 of 1 resident Resident #1).		Tag-F610 A complaint investigation was conduct the facility received a tag due to the f failing to ensure an allegation of staff resident abuse was thoroughly investigated for one resident that was reviewed for abuse.	facility f to		
	Resident #1 was adm			The facility will thoroughly investigate			

Event ID: MVSU11

Facility ID: NH953504

If continuation sheet Page 4 of 7

		MEDICAID SERVICES				10. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345573		B. WING			C	
		343573		STREET ADDRESS, CITY, STATE, ZIP CO		1/22/2021	
NAME OF P	JAME OF PROVIDER OR SUPPLIER			1250 ARBOR ROAD	DE		
ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY							
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 610	Continued From pag	e 4	F 61				
	2/12/20 with diagnos dementia, diabetes n	es of, in part, vascular nellitus and chronic pain.		alleged violations and have a documentation, staff intervie review and statements, to pr	ws, chart event further		
		Data Set (MDS) 2/7/20 revealed Resident #1 ired cognition. Resident #1		potential abuse, neglect, exp mistreatment while the inves progress. All of which will be	tigation is in		
	living and had behav	with her activities of daily iors not directed toward ng the look back period.		timely manner that follow sta regulations.			
	-	-		Other Actions Taken:			
	2020 to December 2	y ' s grievance log from June 020 revealed a grievance) by Resident #1 ' s family		The Director of Nursing will h for all Health Care Staff on th	-		
	regarding concerns a	about a staff member. The ved by the facility ' s social		procedure for reporting abus in a timely manner and per s	e and neglect		
	worker who informed	I the family she would visit ent #1 for three days to see		federal regulations Training completed and documented	vill be		
	what she reported. C	on 9/23/20, the social worker t #1. Resident #1 expressed		February 19th, 2021			
	concerns about one	staff member and stated the		The Administrator will check with the Social worker to disc	•		
		r she was going crazy and a mental institution and nach one night.		grievances that come throug help ensure that the facility is	h. This will		
	' On 1/15/21 at 8:15 A	C C		compliance and allegations of misinterpreted. Notes will be	do not get		
	interviewed. She stat nice to her, but there	ted most of the staff were was one who yelled and she was busy and didn ' t do		record. This will take place of 60 days.			
	as she asked. She st	a heavyset nurse that		Staff and resident interviews conducted immediately along			
		me. She was unsure when d but did report it to the		thorough investigation with a camera s review, other doc obtained upon being notified alleged allegation.	umentation		
	none found for Resid abuse. There was no	ported incidents revealed lent #1 ' s allegations of o evidence the facility ther residents regarding the		, , , , , , , , , , , , , , , , , , ,			

Facility ID: NH953504

If continuation sheet Page 5 of 7

TATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
ND PLAN OF	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	CO	COMPLETED	
			B WING			С
	ROVIDER OR SUPPLIER	345573	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		•	1/22/2021
			250 ARBOR ROAD			
ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY				VINSTON SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 610	Continued From page	2.5	F 610			
	Resident #1 's family					
	worker was interviewed interviewed Resident the Resident #1 's fa grievance. She stated 3 consecutive days; t Resident #1 stated, w concerns about staff about one staff memb asked Resident #1 to and Resident #1 did s staff member told her might have to go to a pounced on her stom visited Resident #1 th asked if Resident #1 again and Resident #1 no problems. On the she didn 't think she The SW determined F same staff member a nights and who the st concluded the allegat because Resident #1 taking care of her and staff member all three spoke with the family member responsible told the SW they reall had a good relationst	#1 in September 2020 after mily submitted the d she visited Resident #1 on he first day on 9/23/20, when asked if she had any members, she had concerns ber, sometimes. The SW describe the staff member so. Resident #1 added the r she was going crazy and mental institute and she ach one night. The SW he following day, 9/24/20 and had the same staff member f1 stated she had and had third day, Resident #1 stated had the same staff person. Resident #1 did have the ssigned to her all three taff member was. She cion was unsubstantiated was unclear about who was d she did have the same e nights. She stated she and told her the staff was Nurse #1. The family by liked Nurse #1 and they				
	additional concerns. On 1/22/21 at 11:44	AM, Nurse #1 was				
		ed she was not interviewed				

Facility ID: NH953504

If continuation sheet Page 6 of 7

		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/24/2021 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 01/22/2021	
	345573		B. WING	_			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ARBOR A	CRES UNITED METHOD	ST RETIREMENT COMMUNITY		1250 ARBOR ROAD 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 (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
	Continued From page Resident #1. On 1/22/21 at 10:23 A interviewed. She state allegations submitted interview with the Adr facility investigation c the resident and the f SW spoke with the re	e 6 AM, the Administrator was ed she was aware of the		CROSS-REFERE			DATE

Facility ID: NH953504

If continuation sheet Page 7 of 7