PRINTED: 03/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345092	B. WING			C 02/19/2021	
NAME OF D	ROVIDER OR SUPPLIER	0.10002		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	19/2021	
NAME OF FI	NOVIDER OR SUFFLIER						
THE CITAL	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 00	0			
	was conducted from 2 of the survey, F 641,	site complaint investigation 2/15/21-2/19/21. As a result F 677, and F 688 were ot in substantial compliance. allegations were					
	substantiated.						
F 641 SS=D	Accuracy of Assessments		F 64	1		3/11/21	
	resident's status. This REQUIREMENT by: Based on record revi facility failed to accurs set for impairment in significant weight loss reviewed for range of (Resident #1). Findings Included: Resident #1 was adm	is not met as evidenced iew and staff interview the ately code the minimum data range of motion and for 1 of 1 resident that was motion and nutrition whitted to the facility on es included dementia, heart		1. Resident #1 MDS was corrected resubmitted on 2/17/21 to indicate impairment of both hands and trans on 02/17/2021. Resident #1 will also be placed on weights to monitor for any changes weights, and if any decline is identificated dietary intertventions will be put in potential to be affected by the same deficient practice;	weekly in ed blace.		
	A quarterly Minimum 1/15/21 for Resident impairment in range of lower extremities in Stotally dependent on a daily living and her compaired. Section K of weight as 120 pounds experienced a significant	Data Set (MDS) dated #1 did not identify any of motion to her upper or ection G. The resident was staff for all her activities of ognition was severely if the MDS identified her is (lbs.) and she had cant weight loss not on a		Section G-0400 and section K0200 of the most recently completed MD all current residents, will be audited accuracy by the Therapy Director a Director of Nursing. The MDS Coordinators will make Modification needed and will be corrected and submitted by the MDS coordinators completed by 3-11-2021.	S, for for nd the ns if to be		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	 E	TITLE		(X6) DATE	

Electronically Signed 03/11/2021

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.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345092	B. WING _			C 02/19/2021	
NAME OF PI	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CO	•	02/19/2021	
				1900 W 1ST STREET			
THE CITA	DEL AT WINSTON SAL	EM		WINSTON-SALEM, NC 27104			
(V4) ID	STIMMADA	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From page	ge 1	F 6	41			
	· ·	ing the look back period.					
	12:15 pm revealed a left side. Both reside a fist like position. Sidirections when ask fingers. There were on the resident 's high An interview on 2/15. Assistant (NA) #1 recaring for Resident was totally dependent was totally dependent was totally dependent balled into a fist and fingers on her own. Review of the weight revealed her weight and her weight on 7	desident #1 on 2/15/21 at she was lying in bed on her ent's hands were balled into the was unable to follow any ted if she could open her no splints or devices present ands. 5/21 at 12:30 pm with Nursing evealed she was the NA #1. She stated the resident ent on staff for all her care. NA ent's hands were always if she was unable to open her ent record for Resident #1 on 1/12/21 was 121.1 lbs. 7/8/20 was 123.7 lbs. This did ant weight change for the 1		New Therapy evaluations weach current resident to ide contractures or decline in ramotion and was completed 3-10-21. Therapy services we to these residents identified contraindicated by other me conditions that would cause discomfort from therapy treat. The Registered dietician ar nursing will audit all weights 30, and 60 days to compare any significant weight losse gains, this audit will be compartant and any compartant of the suggestions for any needed and add any nessary intervence weight losses and weight gareview of the audits.	entify any new anges of on will be offered and unless edical the resident eatment. In and Director of so for the last eand identify is and weight poleted by ke any RD will make and identifies and weight poleted by the eany RD will make and identifies and weight poleted by the eany RD will make and identifies and weight poleted by the eany RD will make and identifies and weight poleted by the eany RD will make and identifies and identifie		
	the Registered Dieti Manager had comp quarterly MDS date MDS was coded incloss because the word November 2020 we wrong weight to calculate weight loss. The RE pay closer attention they were using to cothe MDS. A phone interview of the MDS.	ook-back period. In 2/17/21 at 12:30 pm with itian (RD) revealed the Dietary leted Section K of the d 1/15/21. She stated the correctly for significant weight eight record was missing the ight and the DM had used the culate the 6-month significant added they would need to to the date of the weights code significant weight loss on an 2/19/21 at 8:30 am with the d she had not completed the		The MDS staff will be re-e Regional MDS consultant o regarding the importance of coding the MDS correctly. 3. Measures and systemati in place to ensure that the o practice does not reoccur: Regional MDS consultant nursing and or designee wil G, and section K, a minimum Minimum data sets per wee ensure accuracy. After the 4 Director of Nursing and MD will review sections G and M	in 03/08/2021 If accurately ic changes put deficient and Director of II audit section m of 10 ek x 4 weeks to 4 weeks the S coordinators		

Facility ID: 923570

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345092	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	343032	5:		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	19/2021
NAIVIL OI 11	COVIDEIX OIX 301 1 EIEIX				900 W 1ST STREET		
THE CITAL	DEL AT WINSTON SALE	M			VINSTON-SALEM, NC 27104		
(X4) ID		ATEMENT OF DEFICIENCIES	·-		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE			
F 641	Continued From page	e 2	F	641			
		1/15/21 for Resident #1 and			completed Minimum Data Se□t		
		the name of the nurse who			assesments weekly during morning sta		
	had been coded inco	on G. She stated Section G rrectly for impairment in			up meeting to ensure the facility mainta compliance.	iins	
	•	e resident did have an her hands. The MDS Nurse			4.Indicate how the facility plans to		
	•	leted a modification to the			monitor its performance to make sure t	hat	
	MDS on 2/17/21.				solutions are sustained		
	A 1	0/40/04 1 40 00 ::!			Data obtained during the audit process		
	A phone interview on 2/19/21 at 10:20 am with the Administrator revealed she expected the MDS to be coded correctly to reflect the health				will be analyzed for patterns and trends and reported to Quality Assurance and	;	
					Performance Improvement Committee	by	
	condition of the resident.				the MDS coordinator monthly x 3 mont	-	
					At that time, the Quality Assurance and		
					Performance Improvement committee versuate the effectiveness of the	WIII	
					interventions to determine if a subsequ	ent	
					plan needs to be implemented and to		
					determine if continued auditing is necessary to maintain compliance.		
F 677	ADL Care Provided for	or Dependent Residents	F	677	,		3/11/21
SS=D	CFR(s): 483.24(a)(2)						
		ent who is unable to carry					
		living receives the necessary					
	personal and oral hyg	good nutrition, grooming, and giene:					
		is not met as evidenced					
	by:						
		ns, record review and staff ailed to provide nail care for			Nurse Aide #1 did not complete Activities of daily living to include nail c	aro	
		dent reviewed for activities			on Resident #1 while care observations		
	of daily living (Reside				were being conducted during a survey.		
	Findings Included:				Nurse Aide #1 was provided one-to-one	3	
	Findings Included:			education on 2/17/21 by the facility Director of Nursing concerning the pro-		er	
		Resident #1 was admitted to the facility on		procedure for performing complete AL			
	4/21/17 and diagnose	es included dementia, heart			care on a resident. Nurse Aide #1		
			1		I .		1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345092	B. WING			C	
NAME OF B		343092	B. WING _		TREET ARRESTS OFFI THE CORE	02/	19/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITAL	DEL AT WINSTON SALE	и			900 W 1ST STREET		
		-		V	VINSTON-SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	3	F	677			
	failure, diabetes, and	dysphagia.			provided a successful return demonstration. Resident #1 nails were		
	1/15/21 for Resident # dependent on staff for living (ADL 's) and he impaired.	Data Set (MDS) dated #1 identified she was totally r all her activities of daily er cognition was severely #19 for Resident #1 stated			trimmed by the wound care nurse on 2-17-21. The facility medical director visited the resident on 2-17-21 to ensu no open areas to hands The facility podiatrist will be seeing all residents or their visits scheduled for 3-19-21 and 3-24-21. The Director of nursing and Ac	re 1	
	she had an ADL self-care deficit related to dementia and refusal of care at times. Interventions included to check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. A care plan intervention dated 5/18/20 stated to refer to				will do an audit of all current residents determine if any nail care needs to be		
					done and to make podiatrist referrals if needed before the scheduled visits of 3-19-21 and 3-24-21.		
	podiatrist, foot care no document foot care a	nd to cut long nails.			Education was provided to nursing sincluding contracted staff from 3/3/21 - 03/12/21 by the Director of Nursing and		
	An observation of Resident #1 on 2/15/21 at 12:15 pm revealed she was lying in bed on her left side. Both resident 's hands were balled into a fist like position and visible fingernails were long; approximately 1 to 1 ½ inches above the nail bed. The second fingernail on her right hand appeared to be digging into her palm. Resident #1 was awake but was unable to answer any				Assistant Director of Nursing on the proper procedure for completing adl ca including nail care. Any nursing staff w has not completed this education by		
					03/12/21 will be removed from the schedule until education is completed. Newly hired nursing staff including contracted staff will have education by the		
	questions.	21 at 12:30 pm with Nursing			Staff Development Coordinator on prop procedure for completing adl care including nail care during their orientati	oer	
	Assistant (NA) #1 rev caring for Resident #1	ealed she was the NA I. She stated the resident			period.		
	#1 stated the resident balled into a fist and s	on staff for all her care. NA 's hands were always he was unable to open her A #1 explained she was			3. Beginning 03/03/21, care observation to ensure proper procedure for adlicate will be conducted by the Unit Managers and administrative nurses on Nurses a	e s	
	able to manually oper fingers on her left han washcloth to clean the	up some of the residents			nurses Aides performing adl care. These observations will be conducted with three (3) Nurse Aides three times weekly for twelve weeks on various shi	ifts.	

Facility ID: 923570

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345092	B. WING _			C 02/19/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	I CODE	02/13/2021	
				1900 W 1ST STREET			
THE CITA	DEL AT WINSTON SAI	LEM		WINSTON-SALEM, NC 27104			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From pa	age 4 I she did not cut the residents	F 6	Monthly for a minimum of t	three (3)		
	was responsible fo	was a diabetic and the nurse r cutting the resident 's nails.		months, the Director will re audit results to the Quality Performance Improvement	eport completed Assurance and t Committee.		
	During an observation of Resident #1 's wound care on 2/15/21 at 2:15 pm her toenails were observed to be long; approximately 2 to 2 ½ inches above the nail bed. The toenails were observed to be jagged and curled somewhat			The Quality Assurance and Improvement Committee wandits to make recommend ensure compliance is sustained determine the need for	vill review the dations to ained ongoing;		
	inward toward her	skin.		auditing beyond the three r	months.		
	An interview was conducted with Nurse #1 on 2/15/21 at 2:15 pm and discussed the resident 's nails being long and there was a physician 's order stating to keep the resident 's nails trimmed. Nurse #1 explained it was primarily the NA's responsibility to check the resident 's fingernails and the podiatrist was supposed to trim her toenails.			4.The Director of Nursing completed audit results to a Assurance and Performance Improvement Committee. Assurance and Performance Improvement Committee waudits to make recommence ensure compliance is sustained determine the need for	the Quality ce The Quality ce vill review the dations to ained ongoing;		
	Resident #1 was ly contracted into a fis	2/16/21 at 10:25 am revealed ing in bed; both hands were st like position and her d long approximately 1 to 1 ½ ail bed.		auditing beyond the three representation of Nursing will be converall compliance. Data represented and analyzed at the monthly QAPI meeting with POC as needed.	responsible for esults will be the centers		
	revealed she had just She stated the professor was to talk with the NA could cut them she would cut them Resident #1's nail cut them today. She nails earlier due to	6/21 at 10:30 am with NA #2 ust given Resident #1 a bath. tocol for cutting residents nails resident 's nurse to see if the ails and if okay 'd by the nurse n. NA #2 added she was aware s were long, and she would e stated she couldn 't cut her time issues. 6/21 at 10:45 am with Nurse					
	#2 revealed he did	not know how the facility sident 's nails, but if the NA					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345092	B. WING			C 02/19/2021	
NAME OF PR	ROVIDER OR SUPPLIER		l	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	13/2021
THE CITAL	DEL AT WINSTON SALE	M			900 W 1ST STREET		
				V	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	would cut them. Review of the medica revealed one podiatry	al record for Resident #1 visit on 1/21/21. This was the the residents right heel was no documented	F	677			
	A phone interview on Director of Nursing (Different provided Resident #1 was a dianurses would be responded to the following provided to the followi	2/17/21 at 11:40 am with the DON) revealed she was at #1. She stated nail care at by the NAs. She explained abetic and therefore the consible for her nail care. Facility has had limited adiatry visits due to the if nail care was needed, they ments to have the resident care. The DON stated she care concerns for Resident ow-up on getting her finger					
F 688 SS=D	the Administrator reve would be provided rot were dependent on the Increase/Prevent Dec CFR(s): 483.25(c)(1)- §483.25(c) Mobility.	crease in ROM/Mobility	F	688			3/12/21
	resident who enters the range of motion does range of motion unless	he facility without limited not experience reduction in as the resident's clinical es that a reduction in range					

AND DI AN OF CORRECTION INTERPRETATION NUMBERS		` ′	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED		
		345092	B. WING	B. WING		C 02/19/2021	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	10/2021
				1	900 W 1ST STREET		
THE CITAL	DEL AT WINSTON SALE	M			VINSTON-SALEM, NC 27104		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 688	Continued From page	∋ 6	F	688			
	8483 25(c)(2) A resid	ent with limited range of					
	motion receives appre						
		range of motion and/or to					
		ase in range of motion.					
		•					
	§483.25(c)(3) A resid	ent with limited mobility					
		services, equipment, and					
		n or improve mobility with					
	•	able independence unless a					
		s demonstrably unavoidable.					
		is not met as evidenced					
	by:	ns, record review and staff			1 Resident #1 was identified as having	,	
		ailed to identify and develop			bilateral contractures,resident#1 did no		
	a treatment plan for a				have any orders for therapy services a		
		as evident for 1 of 1 resident			or splints. The Facility failed to ensure		
		motion (Resident #1).			resident #1 received appropriate		
	_	,			treatment and services to increase range	ge	
	Findings Included:				of motion and/or to prevent further		
					decrease in range of motion.Therapy		
	Resident #1 was adm				services re evaluated resident#1 on		
		es included dementia, heart			2/17/21 and are treating as ordered.		
	failure, diabetes, and	dysphagia.			Resident #1 therapy services included		
	A guartarly Minim	Data Sat (MDS) datad			screen for different type of hand splint.		
		Data Set (MDS) dated #1 did not identify any			Orders have been updated to reflect		
		of motion to her upper or			current splint status as of 2-17/21.		
	lower extremities. The				New Therapy evaluations were done for	\r	
		r all her activities of daily			each current resident to identify any ne		
		on was severely impaired.			contractures or decline in ranges of		
	5 3	, ,			motion and was completed on		
	An observation of Re	sident #1 on 2/15/21 at			3-10-21.Therapy services will order spl	ints	
	12:15 pm revealed sh	ne was lying in bed on her			as indicated and residents will be offere		
	left side. Both resider	nt ' s hands were balled into			to participate in therapy services unless	3	
	•	l visible fingernails were			contraindicated by other medical		
		to 1 ½ inches above the			conditions that would cause the resider	nt	
		fingernail on her right hand ng into her palm. Resident			discomfort from therapy treatment.		

NAME OF PROVIDER OR SUPPLIER THE CITADEL AT WINSTON SALEM (A) IT WAS awake but was unable to answer any questions. She was unable to follow any directions when asked if she could open her fingers. There were no splints or devices present on the resident *1. She stated the resident was totally dependent on staff for all her care. NA #1 stated the resident of she was unable to open her fingers on her lork mould yell out. NA #1 explained she was able to manually open up some of the residents fight hand. She added if she tired to use a washoloth to clean the inside of her palm, but she was unable to the anable to the sundent of the resident #1 was totally dependent would yell out. NA #1 stated the resident fight hand. She added if she tired to use a washoloth to clean the inside of her palm, but she was unable to do anything with the residents fight hand. She added if she tired to open those fingers the resident would yell out. NA #1 stated the vesident *1 was totally dependent would yell out. NA #1 stated the resident she was not aware of any splints or devices that were used for the resident if she tired to use a washoloth to clean the inside of her palm, but she was unable to do anything with the residents fight hand. She added if she tired to open those fingers the resident would yell out. NA #1 stated she was not aware of any splints or devices present on the hands. An observation on 2/16/21 at 10:25 am revealed Resident #1 was lying in bed; both hands were contracted into a fist like position and there were not splints or devices present on the hands. Review of the most recent physicians progress note dated 1/16/21 for Resident #1 did not identify the contractures present to the residents #1 did not identify the contractures present to the residents for local providence and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee with eauditins by device the auditing begond the three months. The Director of Nursing will report open for were longing. The formation peri	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
THE CITADEL AT WINSTON SALEM (PA) 1D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) SERVED (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) SERVED (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FREETY TAG FOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) FOR SUMMARY STATEMENT OF DEFICIENCY FOR SUMMARY STATEMENT OF CORNETS OF SUMMARY STATEMENT OF SUMMARY STATEMENT OF SUMMARY SUMMARY SUMMARY OF SUMMARY SUMMARY OF A SUMMARY SUMMARY OF A			345092	B. WING				
International Continued From page 7 F 688 Continued From page 7 F 688 T 1 was awake but was unable to follow any directions when asked if she could open her fingers. There were no splints or devices present on the resident #1 stated the resident fingers on her low. NA #1 explained she was able to manually open up some of the residents was unable to open her fingers on her low. NA #1 stated the resident to a fist and she was unable to open her fingers on her low. NA #1 stated the resident to a fist and she was unable to open her fingers on her low. NA #1 stated the resident to a fist and she was unable to open her fingers on her low. No #1 stated the resident to see a washcloth to clean the inside of her palm, but she was unable to do anything with the residents she was not aware of any splints or devices that were used for the resident to she was not aware of any splints or devices that were used for the resident than dand tried to use a fingers the resident would yell out. NA #1 stated Resident #1 was lying in bed; both hands were contracted into a fist like position and there were not splints or devices that were used for the resident #1 did not identify the contractures present to the residents #1 hands. Review of the most recent physicians progress note dated 11/18/21 for Resident #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the progress note dated 1/12/32/1 for Resident #1 did not identify the contractures present to the progress note dated 1/12/32/1 for Resident #1 did not identify the contractures present to the solution #1 did not identify	NAME OF P	ROVIDER OR SUPPLIER	I	 	STREET ADDRESS, CITY, STATE, ZIP CODE		271072021	
International Continued From page 7 F 688 Continued From page 7 F 688 T 1 was awake but was unable to follow any directions when asked if she could open her fingers. There were no splints or devices present on the resident #1 stated the resident fingers on her low. NA #1 explained she was able to manually open up some of the residents was unable to open her fingers on her low. NA #1 stated the resident to a fist and she was unable to open her fingers on her low. NA #1 stated the resident to a fist and she was unable to open her fingers on her low. NA #1 stated the resident to a fist and she was unable to open her fingers on her low. No #1 stated the resident to see a washcloth to clean the inside of her palm, but she was unable to do anything with the residents she was not aware of any splints or devices that were used for the resident to she was not aware of any splints or devices that were used for the resident than dand tried to use a fingers the resident would yell out. NA #1 stated Resident #1 was lying in bed; both hands were contracted into a fist like position and there were not splints or devices that were used for the resident #1 did not identify the contractures present to the residents #1 hands. Review of the most recent physicians progress note dated 11/18/21 for Resident #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the solution #1 did not identify the contractures present to the progress note dated 1/12/32/1 for Resident #1 did not identify the contractures present to the progress note dated 1/12/32/1 for Resident #1 did not identify the contractures present to the solution #1 did not identify								
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Review of the most recent physicians progress note dated 1/16/21 for Resident #1 did not identify the contractures present to the residents ' hands. Review of the most recent nurse practitioner progress note dated 1/23/21 for Resident #1 did not identify the contractures present to the Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The Director of Nursing will be responsible for		not splints or devices	present on her hands.		Assurance and Performance			
note dated 1/16/21 for Resident #1 did not identify the contractures present to the residents ' hands. Review of the most recent nurse practitioner progress note dated 1/23/21 for Resident #1 did not identify the contractures present to the Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The Director of Nursing will be responsible for					Improvement Committee. The	Quality		
the contractures present to the residents ' hands. Review of the most recent nurse practitioner progress note dated 1/23/21 for Resident #1 did not identify the contractures present to the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The Director of Nursing will be responsible for								
Review of the most recent nurse practitioner progress note dated 1/23/21 for Resident #1 did not identify the contractures present to the ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. The Director of Nursing will be responsible for					· ·			
Review of the most recent nurse practitioner and determine the need for further progress note dated 1/23/21 for Resident #1 did not identify the contractures present to the and determine the need for further auditing beyond the three months. The Director of Nursing will be responsible for	the contractures pres		ent to the residents ' hands.					
progress note dated 1/23/21 for Resident #1 did auditing beyond the three months. The Director of Nursing will be responsible for								
not identify the contractures present to the Director of Nursing will be responsible for								
residents nands. overall compilance. Data results will be			ictures present to the					
popular to the content		residents nands.			· ·			
Review of the medical record for Resident #1 reviewed and analyzed at the centers monthly QAPI meeting with a subsequent		Pavious of the madica	I record for Posident #1					
Review of the medical record for Resident #1 monthly QAPI meeting with a subsequent revealed a rehab therapy screen dated 11/24/20 POC as needed.						aupaequeni		
identified as a post fall screening. This screening					1 OC as needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345092	B. WING_			C 02/19/2021	
	ROVIDER OR SUPPLIER			1900	EET ADDRESS, CITY, STATE, ZIP CODE W 1ST STREET STON-SALEM, NC 27104	1 02/	13/2021
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	÷8	F 6	888			
	hand contractures. A stated "no skilled servicentractures noted for therapy". A phone interview on	ng related to Resident #1 's rehab screen dated 9/15/20 vices needed at this time; no r physical or occupational 2/18/21 at 11:00 am with the					
	with Resident #1 and rehab therapy screen 9/15/20. She stated ty screened for therapy	/pically residents are needs quarterly, after a fall					
	full rehab screen for F and she must not hav any contractures; she	I. The RM indicated the last Resident #1 was on 9/15/20 re identified the resident had re added she just couldn ' t ned she did look at Resident					
	#1 yesterday (2/17/21 did have a full contract partial contracture on Resident #1 would be) and identified the resident cture on her right hand and her left hand. She stated enefit from treatment to the was unsure if the resident					
	would tolerate any pla						
	Director of Nursing (Difamiliar with Resident had some contracture started working at the The DON stated she had been evaluated becontractures. She addidentified to be developed.	, , ,					
	the Administrator reve	2/19/21 at 10:20 am with ealed she expected all ned for therapy needs at needed. She stated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	345092 B. WING _			C 		
	NAME OF PROVIDER OR SUPPLIER THE CITADEL AT WINSTON SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104	I	02/13/2021
(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)	OULD BE	(X5) COMPLETION DATE
F 688	Resident #1 's contra	e 9 actures should have been of care implemented as the	F 68			