	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION F CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345573	B. WING		11/09/2022
	OVIDER OR SUPPLIER	ST RETIREMENT COMMUNITY	1250	EET ADDRESS, CITY, STATE, ZIP COL) ARBOR ROAD ISTON 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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
E 000	Initial Comments		E 000		
	survey was conducted 11/09/22. The facility with the requirement Preparedness. Event	ertification and complaint d on 11/07/22 through was found in compliance CFR 483.73, Emergency ID #U1VI11. ococcal Immunizations	F 883		12/17/22
SS=D	CFR(s): 483.80(d)(1)(§483.80(d) Influenza immunizations §483.80(d)(1) Influenza policies and procedur (i) Before offering the each resident or the r receives education re potential side effects of (ii) Each resident is of immunization October annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of was provided education and potential side effect immunization; and (B) That the resident of immunization or did n immunization due to r refusal.	2) and pneumococcal za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; fered an influenza r 1 through March 31 mmunization is medically resident has already been a time period; e resident's representative o refuse immunization; and dical record includes dicates, at a minimum, the por resident's representative on regarding the benefits			
		and procedures to ensure			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 12/07/2022

		ND HUMAN SERVICES				FOR	D: 12/07/202 MAPPROVEI
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345573	B. WING			11	/09/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				12	250 ARBOR ROAD		
ARBOR A	CRES UNITED METHOD	DIST RETIREMENT COMMUNITY		w	/INSTON SALEM, NC 27104		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 883	Continued From page	e 1	F	883			
	that-						
	(i) Before offering the						
		esident or the resident's					
	•	es education regarding the					
	benefits and potentia immunization;	i side effects of the					
		offered a pneumococcal					
	immunization, unless the immunization is						
	medically contraindicated or the resident has						
	already been immunized;						
	(iii) The resident or the resident's representative						
		o refuse immunization; and					
	(iv)The resident's me	ndicates, at a minimum, the					
	following:						
	-	or resident's representative					
		ion regarding the benefits					
	and potential side eff	ects of pneumococcal					
	immunization; and						
	(B) That the resident						
	•	nization or did not receive					
	contraindication or re	nmunization due to medical					
		Γ is not met as evidenced					
	by:						
		views and record review, the			Tag 483.80(d) Influenza and		
	•	e the residents' medical			pneumococcal immunizations		
		imococcal immunization			(1) Influenza. The facility must devel		
		lents (Resident #3 and #56) coccal immunization status.			policies and procedures to ensure that	at:	
	The findings included	i:			-Before offering the influenza immunization, each resident or the		
	• • • · · · · · · · · · · · · · · · · ·				resident's representative receives		
		y policy (revised 9/22)			education regarding the benefits and	tion	
		," read: upon admission			potential side effects of the immunization	uon	
		ument in the Immunization s history of immunization with			-Each resident is offered an influenza		
		accine, influenza vaccine,			immunization October 1 through Marc		
	and COVID-19 vacci				annually, unless the immunization is		

Facility ID: NH953504

If continuation sheet Page 2 of 4

		ND HUMAN SERVICES MEDICAID SERVICES			FORM OMB NO.	APPROVE 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345573	B. WING		11/09/2022	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1250 ARBOR ROAD		
ARBOR A	CRES UNITED METHOD	DIST RETIREMENT COMMUNITY		WINSTON SALEM, NC 27104		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 883	Continued From page	e 2	F 883	3		
				medically contraindicated or the r	esident	
	1) Resident #3 was a	admitted to the facility on		has already been immunized duri		
		oses that included a pelvic		time period	-	
	fracture and Alzheim	er's disease.		-The resident or the resident's		
				representative has the opportunit	y to	
		num Data Set (MDS), dated ent #3 was reviewed for the		refuse immunization		
		n. The pneumococcal vaccine		-The resident's medical record in		
	questions had documentation that read: the			documentation that indicates, at a	a	
		o date and had not been		minimum, the following:		
	offered.			-That the resident or resident's		
	A review of Resident	#2's modical record		representative was provided educ		
		a documentation to indicate		regarding the benefits and potent effects of influenza immunization		
		t received or refused a		-That the resident either received	d the	
	pneumococcal vacci			influenza immunization or did not		
	p			the influenza immunization due to		
		nducted with the Director of /09/2022 at 1:39 p.m. She		contraindications or refusal.		
	• • •	I record for Resident #3 and		The nursing staff failed to ensure	e the	
	revealed she had be	en unable to locate a		residents' medical record include		
	consent for the Pneu	mococcal vaccine or a		pneumococcal immunization state	us for 2	
	-	ococcal vaccination history.		of 5 residents who were reviewed	l for	
	She stated it was her			pneumococcal immunization state	us.	
		ed by the admission nurse			/2.2	
		chart within 48 hours of		We have educated staff on 11/17	/22	
	admission.			completing the immunization	,	
	2) Resident #56 was	admitted to the facility on		documentation within 48 hours of admission as per Arbor Acres Pol		
	,	noses that included atrial		Immunization Policy, reads: upon	-	
	fibrillation and heart f			admission nursing staff will docur		
				the Immunization Record the resi		
	The Admission MDS	dated 11/4/2022, for		history of immunization with the		
		viewed for the immunization		pneumococcal vaccine, influenza	vaccine,	
	section. The pneumo	ococcal vaccine questions		and COVID-19 vaccine.		
		hat read: the vaccine was not				
	up to date and had n	ot been offered.		The Director of Nursing has adde		
				admission check off list the immu		
	A review of Resident	#56's medical record		as it regards to Flu, Pneumonia a	nd	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U1VI11

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED			
	345573		B. WING	11/09/2022		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		11100/2022	
ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY			1 V			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLET	
F 883	revealed there was n whether the Resident pneumococcal vaccir An interview was con 11/09/2022 at 1:39 p. medical record for Re she had been unable Pneumococcal vaccir pneumococcal vaccir was her expectation t	o documentation to indicate t received or refused a ne. ducted with the DON on m. She reviewed the esident #56 and revealed to locate a consent for the ne or a record of his nation history. She stated it that the information be ssion nurse and entered into	F 883	 COVID-19 11/21/22 Upon admission the Admission Coordinator will have the POA com an immunization form along with the collection of documentation. This for also have education handouts attact for review regarding the benefits ar potential side effects of the immunizations. Upon admission to a Medicare bed residents or POA will complete an immunization form. This form will a have education handouts attached review regarding the benefits and potential side effects of the immunizations. Staff will document in EHR regardin vacation status. This information winder TB scrn/Immun section of re profile. Vaccines will be available for reside any time upon admission if they has received prior. The Nurse Manger will audit daily f weeks. The medical records coordin will be auditing resident simmunization thereafter to insure compliance. 	e orm will ched hd	

Facility ID: NH953504

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