DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		34G204	B. WING			C 12/2019	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	MITH COTTAGE			185 MARTINDALE RD			
WILSON 3	WITH COTTAGE			WINSTON SALEM, NC 27107			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS		W 00	00			
	Intake #NC 0015445 unsubstantiated; how non-compliance, W22 cited on 9/12/19.	-					
W 227	INDIVIDUAL PROGR CFR(s): 483.440(c)(4		W 22	27			
	objectives necessary as identified by the co	m plan states the specific to meet the client's needs, omprehensive assessment h (c)(3) of this section.					
	Based on record revi team failed to ensure plan (IHP) for 1 of 6 c	entified needs relative to					
	with the qualified intel professional (QIDP) r needs relative to non- interview with the QID his knees or to the gr or noncompliance at requested to participal activities, doing chore	evealed client #1 to have -compliance. Continued DP revealed client #1 falls on ound as a gesture of refusal various times such as when ate in his daily living es, walking to the mailbox, or t other times, especially					
	revealed client #1 fall monthly onto his knee	on 9/12/19 at 1:30 PM s approximately one time es or to the floor when he hores, go on outings or					
LABORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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

(X6) DATE

PRINTED: 09/25/2019

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.

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/25/2019 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G204	B. WING					C 12/2019
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				18	85 MARTINDALE RD			
WILSON S	MITH COTTAGE			W	VINSTON SALEM, NC 27107			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
W 227	Continued From page attend to his daily livir Continued interview w does not have any se help client #1 when he Subsequent interview only intervention for fa was to wrap their arm and pull him to a stan the ground. However the QIDP, all staff me 7/10/19 and instructed around client #1 to lift drops, but to offer the client #1 to stand up. Staff A on 9/12/19 cor staff helps client #1 to result of client #1 sust 7/9/19 when assisted pulled client #1 up by position. Review of records for revealed an individua dated 4/11/19 which in plan (BSP) dated 1/3: 9/12/19 revealed targ property destruction, s biting, or agitation suc speech. Continued re preventative and inter knowledge and guide assisting client #1 in t identified needs/beha client #1's IHP revealed	e 1 In the staff A revealed staff t interventions in place to e exhibits this behavior. with Staff A revealed staffs alling behavior of client #1 s around the client's arm ding position after he falls to , per Staff A and verified by mbers were retrained on d not wrap their arms him off the ground after he ir hand instead to assist Subsequent interview with firmed the change in how o stand up after a fall was a taining a bruised left arm on by a staff member who his arm to a standing client #1 on 9/12/19 habilitation plan (IHP) hcluded a behavior support 1/19. Review of the BSP on et behaviors of aggression, self- injury such as hitting or ch as yelling or repetitive eview of the BSP revealed active techniques to provide lines for staff to follow in raining surrounding the viors. Further review of ed no goal to address needs	W 2					
	#1 sustains at times b result of his noncomp review also revealed	ance and injury that client y falling on his knees as a liance. Subsequent record there was no consistent nt #1's falls over the past 6						

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/25/2019 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G204	B. WING				C / <b>12/2019</b>	
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
WILSON S	MITH COTTAGE				185 MARTINDALE RD WINSTON SALEM, NC 27107			
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 227	Continued From page months.	2	w	227	7			
W 331	Interview with the QIE client #1 needs a thor monthly "falling" conn and the addition of an to address client #1's NURSING SERVICES CFR(s): 483.460(c) The facility must prov services in accordance This STANDARD is r Based on observation interviews, the facility clients (#1) reported t arm bruises had docu assessments, all treat progression in his rec Observations at the g 12:15 PM revealed al a grocery shopping tr observations at 12:20 which included client ambulation/mobility d carrying plastic groce into the kitchen area of observations from 12: client #1 engaged in w moved throughout the falling. Ongoing obset throughout the compli #1 did not use any as	ide clients with nursing with their needs. Not met as evidenced by: n, record review and failed to ensure 1 of 6 o have sustained recent left imentation of nursing tments used, and client ord. The finding is: roup home on 9/12/19 at 16 clients had returned from ip with staff C & E. Further PM revealed all 6 clients, #1, exited the van with no ifficulties or problems ry bags of purchased items of the home. Continued :25 PM to 1:45 PM revealed various activities as he e home with no episodes of ervations on 9/12/19 aint survey revealed client sistive devices to ambulate.	w	331				
	Additional observation	n on 9/12/19 of client #1						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 09/25/2019 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		34G204	B. WING			( 09/	) 12/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WILSON S	MITH COTTAGE			185 MARTINDALE RD WINSTON SALEM, NC	27107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 331	revealed the client to short-sleeved T-shirt. bruising, swelling or a injury observed on the observations of client PM revealed client #1 from scratches, bruise he had sustained no e Review on 9/12/19 of revealed an incident/a noting staff C & M had #1's left arm. Continu notified facility manag instructed staff to imm Wake Forest Baptist H department (ED), whi Further review reveale immediately received and was seen by an E injury/medical problem Subsequent review revealed ind isabilities profession Forest Baptist Health 7/9/19. Further review client #1 revealed a d pain" and "traumatic e arm." Subsequent review	wear jersey shorts with a There was no visible rea(s) of visible physical e client. Subsequent #1 from 4:30 PM to 4:40 's arms and legs were free es or apparent injuries and episodes of falling. facility internal reports accident report dated 7/9/19 d observed bruises on client red review revealed staff ement and management hediately take client #1 to Health emergency ch occurred at 8:30 PM. ed while client #1 an x-ray at the hospital ED, ED physician, no in was found or noted. evealed client #1 was on 7/9/19 and arrived back 11:44 PM with written a to follow up with his in (PCP).	W 33	1			

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	2: 09/25/2019 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		34G204	B. WING			( 09/	C 12/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	FREET ADDRESS, CITY, STAT	E, ZIP CODE		
WILSON	SMITH COTTAGE			35 MARTINDALE RD /INSTON SALEM, NC 27	<b>'107</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
W 331	Continued From page	2 4	W 331				
	revealed a Novant He 7/14/19. Continued re revealed a diagnosis of and imaging tests for Left" and "XR Wrist 2 on 9/12/19 of client #' QIDP, revealed a follo dated 7/19/19 for clier review of client #1's 7 report revealed physic left arm swelling. Sub #1's 7/19/19 medical of done, and a venous D thrombosis was order Subsequent review of medical consult repor an ultrasound of the le 7/31/19 and results w #1's PCP that day. C results or documentat ultrasound was found Interview the QIDP co promptly receive the u rendered needed care Ongoing reviews on 9 revealed no nursing p provided regarding cli bruises. further review notes regarding client hospital visits for his le bruising. Further review	f client #1's IHP revealed a t dated 7/31/19 which noted eft arm was performed on rould be forwarded to client consequently, while no tion of client #1's 7/31/19 or provided on 9/12/19. onfirmed client #1's PCP did ultrasound results and e. 0/12/19 of client #1's IHP progress notes were found or ient #1's 7/9/19 left arm w revealed no progress t #1's 7/14/19 and 7/19/19 eft arm swelling and ew of client #1's IHP ng documentation dated					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/25/2019 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		34G204	B. WING				C 12/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WILSON S	MITH COTTAGE				185 MARTINDALE RD WINSTON SALEM, NC 27107		
(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
W 331	Interview conducted of facility nurse on 9/12/ confirmed staff had no client #1's left arm bru confirmed the facility of transport client #1 to to department (ED) for in The facility nurse furth was treated on 7/9/19 released back to the h perform or conduct ar assessment or docum until 7/31/19, for the of assessment. Subsequent interview revealed she did not r documentation regard arm bruises because immediate ED treatment nurse additionally reve treatment supersedes responsibility and the for her to do any nurs 7/9/19 ED visit. Subs revealed the facility no client #1's progression hospital treatment non medical consult. Continued interview w revealed while staff has client #1's intermittent however has deferred and issues with balan to address. Interview confirmed the facility in nursing services in action	over the phone with the 19 and verified by the QIDP, otified the nurse on 7/9/19 of itses. Continued interview nurse had informed staff to the local emergency mmediate medical attention. her revealed while client #1 at the local ED and home on 7/9/19, she did not by follow-up nursing hentation regarding client #1 juarterly nursing with the facility nurse also heed to do any nursing ling client #1's 7/9/19 left client #1 had received ent on 7/9/19. The facility ealed that ED physician a her nursing oversight refore eliminated the need ing documentation of the equent interviews also urse had not documented in regarding his 7/14/19 this 7/19/19 follow-up		331			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURV	ΈY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE	
				С		
					09/12/2	019
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
WILSON S	MITH COTTAGE			MARTINDALE RD NSTON SALEM, NC 27107		
(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 AP DEFICIENCY)	IOULD BE COM	(X5) MPLETIOI DATE
W 331		e 6 all documentation relative eatments used and client	W 331			
W 340	NURSING SERVICE CFR(s): 483.460(c)(5		W 340			
	other members of the appropriate protective measures that include	et include implementing with e interdisciplinary team, e and preventive health e, but are not limited to aff as needed in appropriate nethods.				
	Based on observatio interview, nursing ser were properly trained relative to incident/ac	not met as evidenced by: n, record review and vices failed to assure staff in written documentation, cident reports, to support alth care needs. The finding				
	12:15 PM revealed al a grocery shopping tr observations at 12:20 which included client ambulation/mobility d carrying plastic groce into the kitchen area Continued observatio PM revealed client #1 activities as he move no episodes of falling	ry bags of purchased items of the group home. ns from 12:25 PM to 1:45				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	09/25/2019 APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		X3) DATE S COMPLI	URVEY ETED
		34G204	B. WING			C 09/1	2/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
WILSON S	MITH COTTAGE			185 MARTINDALE RD WINSTON SALEM, NC 27107			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT	Ē	(X5) COMPLETION DATE
W 340	revealed the client to short-sleeved T-shirt. bruising, swelling or a injury observed on cli Subsequent observat PM to 4:40 PM reveal legs were free from se apparent injuries and episodes of falling. Review on 9/12/19 of revealed an incident/a noting Staff C & M ha #1's left arm. Continu notified facility manage instructed staff to imm Wake Forest Baptist H medical attention, whi Further review reveal received an x-ray at th by a hospital physicia injury/medical probler Subsequent review reveal released from the hose back to the group hor discharge instructions primary care physicia Ongoing interviews ou revealed, to ensure cl taken client #1 back to then to his PCP on 7/ on 7/31/19. Further in revealed client #1 fall ground as a gesture of at various times such	hs on 9/12/19 of client #1 wear jersey shorts with a There was no visible rea(s) of visible physical ent #1 during observations. ions of client #1 from 4:30 led the client's arms and cratches, bruises or he had sustained no facility internal reports accident report dated 7/9/19 d observed bruises on client red review revealed staff rement and management hediately take client #1 to Health for emergency the occurred at 8:30 PM. ed client #1 immediately he hospital, and was seen n; however, no n was found or noted. evealed client #1 was spital on 7/9/19 and arrived he at 11:44 PM with written a to follow up with the n (PCP). n 9/12/19 with the QIDP ient #1's care, they had o the hospital on 7/14/19, 19/19, and to an ultrasound terview with the QIDP is on his knees or to the of refusal or noncompliance as when requested to living activities, doing	W 340				

Facility ID: 921983

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/25/2019 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G204	B. WING					C 12/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WILSON	SMITH COTTAGE				85 MARTINDALE RD VINSTON SALEM, NC 27107			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
W 340	group home. In addit other than client #1's of any prior falls for cl provided her any writt #1's falls. Interview w 1:30 PM revealed clie time monthly onto his he does not want to d attend to his daily livin Interviews on 9/12/19 revealed staff have ve #1's intermittent unste completing written do document for client # interview with the faci not provide staff traini documentation to rep- interview also revealed deferred client #1's un issues to the PCP and Interview with the QIE services should have	hes, especially outside of the ion, the QIDP revealed 7/9/19 fall, she is unaware lient #1 and staff have not ten documentation of client with Staff C on 9/12/19 at ent #1 falls approximately 1 knees or to the floor when lo chores, go on outings or ng tasks and goals. With the facility nurse erbally informed her of client eady gait and falls instead of cumentation, as staff did 1's 7/9/19 fall. Subsequent ility nurse confirmed she did ing relative to written ort client #1's falls. Further ed the facility nurse has nsteady gait and balance d the QIDP to address. DP confirmed nursing conducted staff training on written documentation to	W	340				

Facility ID: 921983

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