STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 08/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to allow a choice in receiving emergency hospital services for 1 (Resident #1) of 2 sampled residents with behavioral care plan interventions. The findings included: Resident #1 was admitted on 10/22/2015 with the diagnoses of metabolic encephalopathy, a cognitive communication deficit, and an anxiety disorder. The resident's most recent Quarterly Minimum Data Set assessment dated 7/12/2016 coded the resident as cognitively intact with no behaviors, no wandering, and no psychiatric services. Resident #1 had a care plan last reviewed and updated on 7/21/2016. One of the problems or needs listed was, "Dementia - resident has delusions at times." Interventions included to "avoid overstimulation" and to "redirect and provide gentle reality orientation prn (as needed)." Another care plan problem or need stated, "Resident has episodes of physically and verbally abusive behavior towards staff - hits, swears;	F 242	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." F242 1. Corrective action for resident found affected- Resident # 1 was seen by the social worker, unit coordinator, staff nurse and administrator on 7/28/16 to assure well being and comfort when sent to ED per Physician order. Director of Nursing and Social Service Director had further follow up with Resident #1 on 8/13/16 to assure wellbeing and give reassurance that her right to choose hospital services would be supported with emphasis on her	8/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/26/2016

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F 242	Continued From page 1 resident goes in the rooms of other residents and has taken multiple pairs of eyeglasses." Resident #1 had a care plan problem initiated on 10/26/2015 that stated, "Resident is at risk for elopement r/t (relative to): wandering, confusion, delusions, exit seeking behavior, and impaired cognition." This care plan problem was updated on 7/27/2016 and stated, "Resident has been removing her Wanderguard by cutting through the bracelet." On 7/26/2016 a nursing note written by Nurse #1 regarding Resident #1 stated, "Resident was asked by CNA (certified nursing assistant) not to remove silverware from other residents tray and that she was to use her plasticware that she was given to her on her tray; at that time resident was already using silverware that she had obtained from another resident's tray. When resident was approached and asked if she had received plastic ware on her tray she said 'yes and I do not want that s***, I will eat with what I want to eat with you b*** ', trying to redirect conversation and get understanding why she was becoming aggressive at which during this time resident stated she will do whatever and whenever she wanted to do on her own terms. During interaction it was noticed that her Wanderguard was not on her person; resident was asked if she knew where her Wanderguard bracelet was and she replied, "I flushed it down the toilet like I do everything else." Resident was asked if she had in fact flushed her Wanderguard and she replied "no I did not" then she told that she was just heard stating that she just said she had flushed her Wanderguard (the nurse was telling the resident that she, the resident, said she flushed the Wanderguard down the toilet) and she replied, 'I am incompetent,	F 242	wellbeing and in collaboration with her Guardian. 2. Corrective action for other residents having potential to be affected. Director of Nursing and Discharge Planner to review and assure residents discharged to hospital since 7/1/16 to 8/22/16 were in agreement with right too choose hospital discharge and overall wellbeing. 3.Measures/ Systemic changes to ensure deficient practice will not occur. Director of Social Service will assure during initial and quarterly care plan meetings that residents preferences regarding preferences and choice-specifically related to hospital discharge are discussed and care plan adjusted accordingly. 4.Monitoring Process-Unit Managers, Director of Nursing,MDS nurses and Assistant Director of Nursing will update and complete care plan audits weekly times 4 weeks and then monthly times two months and report results of the audit to the Administrator and Quality Assurance team at the Quality Assurance and Performance Improvement meeting times three months.	

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remember?' Resident took a handful of food and threw it in the writer's face, other staff members redirected resident where at this time (the) resident removed herself from the room and started pacing the hallways. Incident reported to Dr. (name) and he came and had discussion/visit with resident. Orders given for neuropsychologist consult and to notify resident's guardian, facility social worker and appropriate WSNR (Winston Salem Nursing and Rehabilitation) staff for intervention."

On 7/28/2016 a nursing note written by Nurse #1 regarding Resident #1 stated, "Resident very confrontational and verbally threatening staff; as well as invading staff members personal space with demanding behavior. Resident refused to cooperate with staff for medications. Telephone removed from toilet after resident placed it in toilet, stated she did do it then later denied that action. Order was received from Dr. (physician' s name) to send out for psych eval (evaluation), guardian notified, (family members) called by staff to notify of transport and no answer. When paramedics arrived resident became aggressive with them so much as to where they requested back up from the Winston - Salem Police Department. Resident refused to cooperate and get on stretcher, police enforcement was not able to coerce her to get on the stretcher so resident walked on elevator with paramedics and police officer to ground floor."

The Emergency Department provider notes dated 7/28/2016 stated, "On arrival the patient was very calm and reports she was angry that she was sent to the Emergency Department without her consent. She was told that she was being brought here to visit her son." The Emergency

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F 242	Continued From page 3	F 242		

department contacted the facility. The provider notes stated, "Facility reported that they sent the patient over for mental health evaluation, and she has been agitated recently. They report for several weeks the patient has tried to cut off her bracelet they make her wear at night for elopement precautions. Additionally, when patient gets agitated, she throws tantrums including throwing telephone in the toilet. Due to this agitation, the patient was brought to the Emergency Department for mental health evaluation." The provider notes additionally stated, "In the setting of these findings, the facility's complaints are likely dementia related agitation secondary to normal course of dementia. I have no significant concerns and patient required no restraints, physical or chemical while in the Emergency Department."

The facility psychiatric service that visits on a weekly or as needed basis visited the resident on 7/28/2016 at the facility.

Resident #1 was observed on 8/13/2016 at 9:05 AM to have a room located in a locked unit in the building.

Resident #1 was interviewed on 8/13/2016 at 9:05 AM and again at 2:35 PM regarding the circumstances surrounding her 7/28/2016 visit to the emergency department at the hospital. She stated, "I was sitting in my room when two men, who identified themselves as policeman told me to get on the gurney. I told them I didn't want to go and that I did nothing wrong. I wouldn't get on the gurney so they told me I would have to get on the gurney downstairs in front of everybody. We went downstairs and I got on the gurney downstairs. I had to go with them because it was

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F 242	Continued From page 4	F 242		

the police." Resident #1 explained that she is not allowed to have regular silverware but that she received plasticware with her meals. She stated that on the day she went to the emergency room she was sitting in her room eating with silverware when the supervisor and another woman came in the room demanding to have the silverware. The resident stated, "They would not leave me alone. She was coming at me so I threw a glass of water at her stomach. She got right up in my face trying to get the silverware."

Nurse #1 was interviewed on 8/13/2016 at 2:30 PM. She stated that she was the unit manager and was working on the locked unit on 7/28/2016, where Resident #1 resided. She said, "(Resident #1) has to use plasticware when she is eating. The CNA (certified nursing assistant) came to me and told me (Resident #1) had regular silverware. I went in her room with the unit secretary and tried to exchange the silverware for plasticware. She had a fork in her hand. I asked if I could have it and she said no. I asked again if I could have the fork and she said no. That is when she took a handful of food and threw it in my face. (Resident #1) was yelling. The unit secretary told me to leave but I didn't leave. I had food in my face and my hair. I did leave and told another nurse to go into the room with the unit secretary. The resident came out of the room cursing and pacing the hall. She went back in her room and five minutes later she was out in the hall to pace again. I told the staff to keep an eye on her. I called her guardian, the DON (Director of Nursing), the doctor, the administrator, and I got an order to send her out. She will pace when she is angry but she is usually very cordial when she is in the hallway. I stood clear of her at that point. She did come up to me and asked me for the telephone. When she

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brought it back it was wet. The EMS (emergency medical service) arrived and the police had to be called because she was uncooperative." The interventions listed by the unit manager as attempted prior to sending her to the emergency room were redirection, let her be alone, and another nurse with a good rapport tried to intervene.

The facility social worker was interviewed on 8/13/2016 at 12:45 PM. She said that the resident was sent to the emergency room for a psychiatric evaluation due to "throwing a tray of food on a staff member and cussing at the staff." The social worker stated that by the time she went up to see the resident on 7/28/2016 she was calm prior to being sent to the hospital. The social worker stated that Resident #1 usually will calm down after a little while if you give her some time. She said the facility sent residents to the emergency room if they were not able to calm down and continued to holler.

The facility Administrator was interviewed on 8/13/2016 at 1:10 PM. The Administrator explained that the resident needed to have a Wanderguard bracelet because she was a flight risk. She further explained that if the resident was able to get off the locked unit she would easily be able to get out of the facility. She explained that the resident was ordered to have plasticware to eat with because she used silverware to cut off her Wanderguard. The Adminstrator's concern was that the resident would harm herself in attempts to remove the Wanderguard with silverware. She stated that normally the facility tried to manage behaviors of the residents in house but when it came to the point where the resident could injure staff or other residents then

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F 242	Continued From page 6 he or she was sent out. She stated that she spoke with Resident #1 on 7/28/2016 and she felt Resident #1 needed to be sent to the emergency room and the resident agreed to go.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interview the facility failed to follow behavioral care planned interventions prior to requiring a resident to receive emergency hospital services for 1 (Resident # 1) of 2 sampled residents with behavioral care plan interventions. The findings included: Resident #1 was admitted on 10/22/2015 with the diagnoses of metabolic encephalopathy, a cognitive communication deficit, and an anxiety disorder. The resident's most recent Quarterly Minimum Data Set assessment dated 7/12/2016 coded the resident as cognitively intact with no behaviors, no wandering, and no psychiatric services. Resident #1 had a care plan last reviewed and updated on 7/21/2016. One of the problems or needs listed was, "Dementia - resident has delusions at times." Interventions included to "avoid overstimulation" and to "redirect and	F 282	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." 1. Corrective action for resident affected. Director of Nursing and Director of Social Service met with Resident #1 on 8/13/16 to assure psycho-social wellbeing and review of behavioral care plan/ interventions. 2. Corrective action for residents with potential to be affected. Director of Nursing in collaboration with Director of	8/31/16

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F 282	Continued From page 7 provide gentle reality orientation prn (as needed)." Another care plan problem or need stated, "Resident has episodes of physically and verbally abusive behavior towards staff - hits, swears; resident goes in the rooms of other residents and has taken multiple pairs of eyeglasses." Interventions included: "refocus conversation with resident when resident expresses anger or hostility; protect others from resident's outbursts - may need to move resident to own room until calm; approach resident during periods of calm, postpone care if agitated; encourage resident to verbalize through one to one interactions; consistently approach resident in a calm manner from front; and encourage resident to express feelings verbally rather than physically." Resident #1 had a care plan problem initiated on 10/26/2015 that stated, "Resident is at risk for elopement r/t (relative to): wandering, confusion, delusions, exit seeking behavior, and impaired cognition." This care plan problem was updated on 7/27/2016 and stated, "Resident has been removing her Wanderguard by cutting through the bracelet." This care plan problem was updated again on 8/13/2016 and it stated, "Wanderguard is still recommended, but Resident refuses to wear it and has removed it several times." Interventions included: "Approach resident positively and in calm, accepting manner; monitor and document behavior; resident will receive plastic utensils on all of her trays d/t (due to) her cutting off the Wanderguard bracelets. She has a history of exit seeking; Resident refuses the Wanderguard but plasticware still recommended for safety reasons." On 7/26/2016 a nursing note written by Nurse #1 regarding Resident #1 stated, "Resident was	F 282	Social Service and MDS will audit 5th floor residents' Behavioral Care Plans for appropriate interventions, (unit that residents with behavioral disturbances reside)- with completion date of 8/31/16. Staff Development Coordinator will in-service nursing staff on process for following/executing behavior care plan interventions. Completion date of 8/31/16. 3. Measures/Systemic changes to ensure deficient practice will not occur: Director of Social Service will assure that on initial and quarterly care plan meeting, Behavioral Care Plans with appropriate interventions are updated and communicated to staff that affect resident's direct care, Nursing Managers will assure compliance with daily monitoring. 4.Monitoring Process-Unit Managers, Director of Nursing ,MDS nurses and Assistant Director of Nursing will update and complete Behavioral care plan audits weekly times 4 weeks and then monthly times two months and report results of the audit to the Administrator and Quality Assurance team at the Quality Assurance and Performance Improvement meeting times three months.	

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asked by CNA (certified nursing assistant) not to remove silverware from other residents tray and that she was to use her plasticware that she was given to her on her tray; at that time resident was already using silverware that she had obtained from another resident's tray. When resident was approached and asked if she had received plastic ware on her tray she said 'yes and I do not want that s***, I will eat with what I want to eat with you b*** ', trying to redirect conversation and get understanding why she was becoming aggressive at which during this time resident stated she will do whatever and whenever she wanted to do on her own terms. During interaction it was noticed that her Wanderguard was not on her person; resident was asked if she knew where her Wanderguard bracelet was and she replied, "I flushed it down the toilet like I do everything else." Resident was asked if she had in fact flushed her Wanderguard and she replied "no I did not" then she told that she was just heard stating that she just said she had flushed her Wanderguard (the nurse was telling the resident that she, the resident, said she flushed the Wanderguard down the toilet) and she replied, 'I am incompetent, remember?' Resident took a handful of food and threw it in the writer's face, other staff members redirected resident where at this time (the) resident removed herself from the room and started pacing the hallways. Incident reported to Dr. (name) and he came and had discussion/visit with resident. Orders given for neuropsychologist consult and to notify resident's guardian, facility social worker and appropriate WSNR (Winston Salem Nursing and Rehabilitation) staff for intervention."

On 7/28/2016 a nursing note written by Nurse #1 regarding Resident #1 stated, "Resident very

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F 282	Continued From page 9	F 282		

confrontational and verbally threatening staff; as well as invading staff members personal space with demanding behavior. Resident refused to cooperate with staff for medications. Telephone removed from toilet after resident placed it in toilet, stated she did do it then later denied that action. Order was received from Dr. (physician's name) to send out for psych eval (evaluation), guardian notified, (family members) called by staff to notify of transport and no answer. When paramedics arrived resident became aggressive with them so much as to where they requested back up from the Winston - Salem Police Department. Resident refused to cooperate and get on stretcher, police enforcement was not able to coerce her to get on the stretcher so resident walked on elevator with paramedics and police officer to ground floor."

The Emergency Department provider notes dated 7/28/2016 stated, "On arrival the patient was very calm and reports she was angry that she was sent to the Emergency Department without her consent. She was told that she was being brought here to visit her son." The Emergency department contacted the facility. The provider notes stated, "Facility reported that they sent the patient over for mental health evaluation, and she has been agitated recently. They report for several weeks the patient has tried to cut off her bracelet they make her wear at night for elopement precautions. Additionally, when patient gets agitated, she throws tantrums including throwing telephone in the toilet. Due to this agitation, the patient was brought to the Emergency Department for mental health evaluation." The provider notes additionally stated, "In the setting of these findings, the facility's complaints are likely dementia related agitation secondary to

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normal course of dementia. I have no significant concerns and patient required no restraints, physical or chemical while in the Emergency Department "

The facility psychiatric service that visits on a weekly or as needed basis visited the resident on 7/28/2016 at the facility after her return from the emergency room.

Resident #1 was observed on 8/13/2016 at 9:05 AM to have a room located in a locked unit in the building.

Resident #1 was interviewed on 8/13/2016 at 9:05 AM and again at 2:35 PM regarding the circumstances surrounding her 7/28/2016 visit to the emergency department at the hospital. She stated, "I was sitting in my room when two men, who identified themselves as policeman told me to get on the gurney. I told them I didn't want to go and that I did nothing wrong. I wouldn't get on the gurney so they told me I would have to get on the gurney downstairs in front of everybody. We went downstairs and I got on the gurney downstairs. I had to go with them because it was the police." Resident #1 explained that she is not allowed to have regular silverware but that she received plasticware with her meals. She stated that on the day she went to the emergency room she was sitting in her room eating with silverware when the supervisor and another woman came in the room demanding to have the silverware. The resident stated, "They would not leave me alone. She was coming at me so I threw a glass of water at her stomach. She got right up in my face trying to get the silverware." The resident stated that she did not belong in the locked unit of the facility and she wanted to go home. The resident did not

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know how or why she was in the facility.

Nurse #1 was interviewed on 8/13/2016 at 2:30 PM. She stated that she was the unit manager and was working on the locked unit on 7/28/2016, where Resident #1 resided. She said, "(Resident #1) has to use plasticware when she is eating. The CNA (certified nursing assistant) came to me and told me (Resident #1) had regular silverware. I went in her room with the unit secretary and tried to exchange the silverware for plasticware. She had a fork in her hand. I asked if I could have it and she said no. I asked again if I could have the fork and she said no. That is when she took a handful of food and threw it in my face. (Resident #1) was yelling. The unit secretary told me to leave but I didn't leave. I had food in my face and my hair. I did leave and told another nurse to go into the room with the unit secretary. The resident came out of the room cursing and pacing the hall. She went back in her room and five minutes later she was out in the hall to pace again. I told the staff to keep an eye on her. I called her guardian, the DON (Director of Nursing), the doctor, the administrator, and I got an order to send her out. She will pace when she is angry but she is usually very cordial when she is in the hallway. I stood clear of her at that point. She did come up to me and asked me for the telephone. When she brought it back it was wet. The EMS (emergency medical service) arrived and the police had to be called because she was uncooperative." The interventions listed by the unit manager as attempted prior to sending her to the emergency room were redirection, let her be alone, and another nurse with a good rapport tried to intervene.

Nurse #1 provided a written outline of the events

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 08/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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on 7/28/2016 in the locked unit regarding Resident #1. In the outline, the times were noted to be approximate. At 9:00 AM Resident was noted on the outline to have silverware and refused to use plasticware. At 9:40 AM on the outline the Director of Nursing, Administrator, and the resident's physician were called. A physician's order was obtained to send Resident #1 to the emergency department. At 10:00 AM transportation to the emergency department was called. Within approximately an hour on 7/28/2016 the decision to send the resident to the emergency department was made. At 10:40 AM the facility Administrator and Social Worker arrived on the floor to speak to the resident. At 11:00 AM emergency medical services arrived. At 11:45 PM the police were called for assistance. At 12:00 PM the resident refused to get on the stretcher. At 12:20 the resident was escorted out of the building by the police, emergency personnel, and the social worker.

The facility social worker was interviewed on 8/13/2016 at 12:45 PM. She said that the resident was sent to the emergency room for a psychiatric evaluation due to "throwing a tray of food on a staff member and cussing at the staff." The social worker stated that by the time she went up to see the resident on 7/28/2016 she was calm prior to being sent to the hospital. The social worker stated that Resident #1 usually will calm down after a little while if you give her some time. She said the facility sent residents to the emergency room if they were not able to calm down and continued to holler.

The facility Administrator was interviewed on 8/13/2016 at 1:10 PM. The Administrator explained that the resident needed to have a

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	345092	A. BUILDING _____ B. WING _____	C 08/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON SALEM NURSING & REHABILITATION CENTER	**1900 W 1ST STREET WINSTON-SALEM, NC 27104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 13 Wanderguard bracelet because she was a flight risk. She further explained that if the resident was able to get off the locked unit she would easily be able to get out of the facility. She explained that the resident was ordered to have plasticware to eat with because she used silverware to cut off her Wanderguard. The Adminsitrator was concerned the resident would harm herself in attempts to remove the Wanderguard with silverware. She stated that normally the facility tried to manage behaviors of the residents in house but when it came to the point where the resident could injure staff or other residents then he or she was sent out. She stated that she spoke with Resident #1 on 7/28/2016 and she felt Resident #1 needed to be sent to the emergency room and the resident agreed to go.	F 282		