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 06/30/2017

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 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		7/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/24/2017

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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F 166	Continued From page 1	F 166		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review resident interview, and staff interviews: 1) the facility's grievance policy failed to include the right to file grievances anonymously, allow for the contact information of the grievance official including physical address, e-mail contact, business address, and business phone number, the contact person for grievances was not posted in the facility, and failed to address retaining grievances for review over a 15 month period. 2) The facility failed to follow their grievance policy by not recording grievances and/or complaints in the Resident/Grievance/Complaint Log filed for 1 (Resident #2) of 2 sampled residents reviewed for grievances. Findings included: The facility's grievance policy dated as revised August 2008 was reviewed. The policy read in part "Written complaints or grievances must be signed by the resident or the person filing the grievance or complaint on behalf of the resident." There was no mention in the policy the length of time grievances or complaints would be retained. The Complaints/Grievances Follow-up form, dated 11/17/2016, contains a blank area for the telephone number of the person(s) reporting.	F 166	"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. The facilities grievance policy has been updated to reflect the right to file a grievance anonymously, the contact information of the centers grievance official, the location of the grievance forms, the policy location posted by the elevator and the retention of grievances for review over a 15 month period. Resident # 2 grievance was recorded on 6/26/2017 and follow up completed on 6/29/2017 resident # 2 grievance was also recorded on the resident grievance complaint log. All residents have the potential to be affected by the deficient practice so	

F 166 Continued From page 3

The form contained no areas to enter physical address, e-mail contact, business address, and business phone number.

Resident #2 was admitted to the facility on 3/25/16 with admission diagnoses that included: diabetes, high blood pressure, Rheumatoid arthritis, contractures, amputation of the left leg, and lumbar spinal fracture.

A review of Resident #2's most recent comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/20/16 revealed the resident was coded for the following: having been cognitively intact, not having had hallucinations or delusions, required extensive assistance of one person for bed mobility and eating, and required extensive assistance of two people for toileting.

A review of Resident #2's care plan that was most recently reviewed on 5/30/17 revealed the resident was care planned for the following areas: self-care deficit, bowel incontinence, indwelling urinary catheter, required assistance with Activities of Daily Living, impaired vision, Diabetes, risk for skin impairment, risk for alteration in comfort, and risk for infection.

An interview was conducted with Resident #2's family on 6/29/17 at 2:19 PM in the presence of Resident #2. The resident's family stated she and the resident had just completed a care plan meeting with several staff members from the facility. The resident's family explained she was bathing the resident on 6/24/17 and had discovered a dressing with the date of 5/24/17. The resident's family was very concerned to find a dressing with a date from a month ago. The

F 166

therefore an additional session was presented at residents council meeting held on 7/12/2017 by social services director to explain and review the revised grievance policy. There were no additional grievances introduced during the resident council meeting. The grievance policy will be reviewed with the resident and the RP on admission and twice a year during the residents council meeting, The grievance policy is posted in prominent locations throughout the facility. The postings include the residents right to file grievances orally ,anonymously, and or written.

The contact information of the grievance official with whom the grievance can be filed, the timeframe for completing the review of the grievance, the right to obtain a written decision regarding his or her grievances, and the contact information of independent entities with whom grievances may be filed.

The complaint grievance follow - up form has been revised to include the grievance officials name,email,buisness,address and phone number. The social service director and the grievance official/Administrator re educated staff on filing grievances, completing grievances in the allotted time frame,updating on the complaint log upon receipt on 7/21/2017.The staff will be re-educated to the centers revised grievance policy & procedure with an emphasis on the residents right to file a grievance orally,written,or anonymously, the grievance officials location and contact information. Location of the grievance

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F 166	Continued From page 4 resident's family informed nursing staff the day she discovered the 5/24/17 dressing. In addition, the resident's family met with the Administrator, the Director of Nursing (DON), and the charge nurse on Monday, 6/26/17 and had expressed her concerns during that meeting. The resident's sister stated she had informed several staff members, including the administrator, of her concerns in the past and had received no response or correspondence regarding investigations about the grievances or concerns from the facility. During an interview conducted with the Administrator on 6/29/17 at 3:21 PM she stated that she did not have a record of resident concerns. The Administrator further added if residents have concerns the facility had a meeting and the concerns would be resolved. The administrator produced Grievance Log from the months of February, March, April, May, and June. There were two grievances recorded. One grievance was filed in February regarding a bedside commode not being emptied. The disposition of the grievance was not documented. The second grievance was in June and it was regarding missing money. The grievance was documented as having had a resolution. An interview conducted with the DON on 6/29/17 at 3:21 PM revealed she had not received any resident concerns or grievances from Resident #2 or his family. The DON acknowledged she had met with Resident #2's family on 6/26/17 and had recorded the family's concerns. A care plan meeting was set up for 6/29/17. The DON stated she had just attended the care plan with Resident #2, the resident's family, and other staff members. The DON further added she was	F 166	forms, and the retention of grievances for a 15 month review. This information will be reviewed annually and included in the new employee orientation program for new staff.The social service director, Social service assistant or the Administrator will interview 30 residents 2 x weekly x 4 weeks then weekly x 4 weeks to ensure prompt resolution of reported grievances. Data results will be reviewed and analyzed at the centers QAPI meeting for 3 months with a subsequent plan for correction if needed.	

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F 166	Continued From page 5 made aware of the resident's family discovering the dressing dated 5/24/17 on 6/24/17 via phone. During an interview with Nurse #10 on 6/30/17 at 1:48 PM provided the information of if she became aware of concern from a resident or a family member she would do her best to resolve the concern. If she were unable to resolve the concern she would inform her supervisor. An interview conducted with Nursing Assistant (NA) #10 on 6/30/17 at 1:53 PM revealed she would inform her supervisor of a resident concern. In regards to any paperwork that would be completed for a concern the NA clarified she believed there was a form that would have been filled out if the concern became serious. During an interview conducted with the Third Floor Unit Coordinator on 6/30/17 at 1:57 PM it was revealed she was familiar with the grievance form. The Unit Coordinator was able to produce a Complaints/Grievances Follow-Up Form from a wall pocket near the elevator. The Unit Coordinator further added if staff or a family member inform her of a concern, she usually just addressed the concern and would not complete the grievance form. During an interview conducted with the facility Social Work Director on 6/30/17 at 2:20 PM she verified there had only been two grievance recorded for the grievance logs from February, March, April, May, and June. The Social Work Director added if there was a concern expressed usually the staff take care of the problem. The Social Work Director further added she personally had received no grievances from family members or residents since February. In	F 166		

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F 166	Continued From page 6 regards to concerns that may have been expressed in resident council, the Director of Social Work added the resident council meeting is ran by the Activities department and she had received no resident concerns from the Activities regarding resident council. An interview conducted with the Administrator at 3:00 PM on 6/30/17 revealed the administrator's expectation was that a grievance form be completed with the resident or resident family's complaint cannot be resolved. Minor issues were handled immediately, if it was a bigger issue, facility staff would complete a grievance form and resolve it out.	F 166		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record reviews the facility failed to provide care in a manner to maintain the resident's dignity by not giving resident's showers on a weekly basis for resident needing assistance with activities of daily living. This was evident for 1 of 3 sampled residents reviewed for dignity. (Resident # 4) Findings Included: Resident # 4 was admitted to the facility on	F 241	"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,	7/25/17

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F 241 Continued From page 7

12/02/2015 with current diagnoses of anxiety disorder, cerebral infraction and chronic obstructive pulmonary disease.

A review of the Quarterly Minimum Data Set (MDS) for Resident #4 dated 4/21/2017 revealed Resident # 4 was cognitively intact. The resident required extensive to total dependence on staff for bed mobility, dressing, toilet use and personal hygiene.

A review of the care plan for Resident #4 dated 5/30/2017 revealed that Resident # 4 needed to utilize two staff members to provide activities of daily living.

An interview with Resident #4 on 6/29/17 at 2:30 PM revealed that on Saturday June 24, 2017, she was unsure of the time, she called her sister and asked her to please come to the nursing home to give her a bath because she was stinking. Resident # 4 revealed that she was supposed to get a shower on Tuesday, Thursday and Saturday during second shift but the Nursing Assistant (NA) never gave her a shower. Resident #4 stated that this made her feel bad to be in her room stinking. Resident # 4 also revealed that her hair had not been washed in weeks. Resident # 4 stated "I hated going out of my room with an odor." She dropped her head.

An interview with Resident #4's family member on 6/30/2017 at 8:30 AM, revealed that she received a call from Resident # 4 last Saturday requesting her to come to the facility and give Resident #4 a shower. The family member revealed that once she got to the facility Resident #4 had a body odor and her hair was very greasy and appeared to not have been washed in days. The family

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facts, and conclusions that form the basis for the deficiency.

Resident # 4 was taken to the shower immediately upon notification. This resident is receiving showers three times weekly and prn as per her request.
All residents have the potential to be affected by the deficient practice. The director of nursing, unit managers, and social service director interviewed the alert and oriented residents to determine if they are receiving weekly showers. The non interview able residents' skin was assessed for the need to be showered by the licensed nursing staff. Residents that were identified through this process were taken to the shower immediately.
Shower schedules and resident care cards were updated as needed by the unit managers.

In services were done by Director of nursing, assistant director of nursing and unit managers to The Licensed nurses and nursing staff to re-educate to the centers policy and procedures in maintaining a residents dignity with an emphasis on providing showers on a weekly basis and prn.
This in-service was completed on 7/25/2017, and will be reviewed in the new employee orientation program for licensed nurses and CNA's.
The director of nursing, unit managers, and social services director will interview 30 residents 2 x weekly for 4 weeks, then weekly x 4 weeks, to ensure compliance in receiving weekly and prn showers.

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F 241	Continued From page 8 member indicated that she reported to the staff that her sister (Resident #4) needed a shower. The staff informed her that Resident #4 had received her showers and baths during the week. The family member indicated that she did not believe the staff because of her sisters' condition and body odor. The family member stated that she had given Resident # 4 a bath and washed her hair before she left on that Saturday. During a second interview with Resident #4 on 6/30/2017 at 8:45 AM she continued to state that 2nd shift staff are not giving her showers on her shower days. An interview with NA #5 on 6/30/2017 at 9 AM, revealed that Resident #4 had reported to her on several occasions that the second shift NA did not give her showers on her shower days. Resident #4 told her that sometimes they would give her a bed bath and sometimes no bath at all. The Daily Log NA Sign off Sheet for Resident #4 was reviewed on 6/30/17 at 10:00 am. The form revealed Resident #4's shower days were Tuesday, Thursday and Saturday and did not identify that Resident #4 had refused any showers. An interview with NA #7 on 6/30/2017 at 3:30 PM, revealed that she had been working with Resident # 4 for several months. NA #7 stated that she did not realize that Resident #4 was on her shower list for over a month and she indicated that no one told her that she was to give Resident #4 a shower on 2rd shift. NA #7 stated that Resident #4's showers were on the third shift. NA #7 also stated that sometimes Resident # 4 did not tell the whole truth because Resident #4 preferred to	F 241	Data results will be reviewed and analyzed at the centers monthly Quality assurance and process improvement meeting for 3 months with a subsequent plan of correction as needed.	

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F 241	Continued From page 9 smoke over take a shower. An interview with the Administrator on 6/30/2017 at 5:15 PM revealed it was her expectation that staff treat residents with dignity and respect during all encounters with each resident.	F 241		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		7/25/17

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F 309	Continued From page 10 residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, family interview, and resident interview the facility failed to provide follow-up assessment of wound care for 1 of 3 residents (Resident #2) reviewed for wellbeing. Findings Included: Resident #2 was admitted to the facility on 3/25/16 with admission diagnoses that included: diabetes, high blood pressure, Rheumatoid arthritis, contractures, amputation of the left leg, and lumbar spinal fracture. A review of Resident #2's most recent comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/20/16 revealed the resident was coded for the following: having been cognitively intact, not having had hallucinations or delusions, required extensive assistance of one person for bed mobility and eating, and required extensive assistance of two people for toileting. A review of Resident #2's care plan that was most recently reviewed on 5/30/17 revealed the resident was care planned for the following areas: self-care deficit, bowel incontinence, indwelling urinary catheter, required assistance with Activities of Daily Living, impaired vision, Diabetes, risk for skin impairment, risk for alteration in comfort, refusing care, refusing	F 309	"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. Resident # 2 allowed the registered nurse to assess his skin on 6/30/2017.The Medical Director and Responsible Party was notified of skin check findings.New orders were received and processed.The wound Care Director was re-educated by the director of nursing on the importance of providing follow - up assessment of wound care with an emphasis of notifying the Director of nursing ,responsible party and /or medical director ,or nurse practitioner for directives each time the resident refuses care. All residents have the potential to be affected by this deficient practice.The Licensed Nurse performed a skin integrity	

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medications, and risk for infection.

An interview was conducted with the Wound Care Director on 5/29/17 at 1:48 PM revealed she was familiar with Resident #2 and had been providing wound care to the resident since his admission. The Wound Care Director added the resident had developed a blister on his back in April of 2017. A dressing was applied to the blistered area on the resident's back. Near the end of May, the resident started to refuse wound care and refused to have the applied dressing removed. On 6/24/17 the Wound Care Director stated she received a call and was informed the resident's sister was assisting the resident with care and had discovered a dressing dated 5/24/17. The Wound Care Director explained the resident allowed the nurse working on 6/24/17 to remove the dressing and the resident's skin was dry and intact.

An interview was conducted with Resident #2's family on 6/29/17 at 2:19 PM in the presence of Resident #2. The resident's family stated she and the resident had just completed a care plan meeting with several staff members from the facility. The resident's family explained she was bathing the resident on 6/24/17 and had discovered a dressing with the date of 5/24/17. The resident's family was very concerned to find a dressing with a date from a month ago. The resident's family informed nursing staff the day she discovered the 5/24/17 dressing.

A review of Resident #2's physician's orders on 6/30/17 at 10:07 AM revealed an order dated 5/10/17 that read, blisters of upper back: cleanse with soap and water pat dry and apply 6 inch by 6 inch dressing weekly on Wednesday and as

check on current resident population to assess for new areas of concern and outdated dressings,no other residents were identified during this process.
The licensed nurses were in serviced by the director of nursing and assistant director of nursing regarding notification of the responsible party,medical director or nurse practitioner each time a resident refuses care.
The nursing staff was educated 7/25/2017 on reporting any old dressings observed on residents skin and the presence of any discolored,opened areas with or without a bandage to the licensed nurse or the unit manager,assistant director of nursing,or Director of nursing for evaluation. This information will be reviewed annually and in the new employee orientation program for licensed nurses and certified nursing assistants.
The unit manager, assistant director of nursing,or the director of nursing will audit 20 residents weekly for skin integrity checks, records,treatment administrative record (TAR).
The unit manager, assistant director of nursing, or the director of nursing will perform 20 skin integrity checks two times weekly x 4 weeks,then weekly x 4 until compliance is achieved in notifying responsible party, medical director or nurse practitioner of residents refusal of care,assessing for the presence of outdated dressings intact to residents skin,and identifying the presence of any discolored or opened areas.
Data results will be reviewed and analyzed at the centers monthly quality

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	345092	A. BUILDING ______ B. WING ______	C 06/30/2017

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F 309	Continued From page 12 needed. There was an order dated 5/25/17 that read, discontinue current treatment to back per patient request. An observation of Resident #2's skin was completed during morning Activities of Daily Living (ADL) care that was conducted on 6/30/17 at 10:30 AM. The resident was observed to have two open wounds on his back. One of the wounds was on his spine and the other was on the right side of the residents' torso. The resident was also observed to have an open wound to his right leg near where the indwelling catheter strap was applied. There were no dressings observed on the resident during the morning ADL care. An interview conducted with Nurse #10 on 6/30/17 at 11:42 AM revealed Resident #2 frequently refused care. The Nursing Assistants communicated to the nurse when the resident refused care. The resident refused bathing, showers, bed baths, peri-care, and other care. The resident had a history of refusing care and after a period of time, the resident would complain care had not been provided. The resident also had a history of being noncompliant with prescribed medications. An interview conducted with resident's Nurse Practitioner (NP) on 6/30/17 at 12:12 PM revealed she was not aware of Resident #2's refusing refusal of care for skin issues. An interview conducted with Nursing Assistant (NA) #10 on 6/30/17 at 1:53 PM revealed she had been working with Resident #2 for about 4 weeks. The resident had refused any type of bathing for two weeks, then she was allowed to wash his face, and currently she was allowed to wash the resident's face and arm pits. Despite	F 309	assurance performance improvement meeting for 3 months with a subsequent plan of correction as needed.	

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F 309	Continued From page 13 encouragement from the NA, the resident did not allow any further bathing. A review of Resident #2's Nurses' Notes from 5/24/17 through 6/24/17 revealed documentation regarding the dressing applied to the resident's multiple refusals of care but there was only one mention of the dressing that had been applied to the resident's upper back and the documentation was on 6/24/17, the day the resident's family discovered the dressing dated 5/24/17. A review was completed of Resident #2's Weekly Skin Integrity Review form completed on 5/25/17, 6/1/17, 6/8/17, 6/13/17, 6/23/17, and 6/30/17. On 5/25/17 there was documentation that detailed the resident's skin was dry, there was a dressing to the resident's back, there was additional documentation written next to dressing to the back that read, resolved change to barrier cream. On 6/1/17 the skin condition continued to be documented as the skin being dry, dressing to the resident's back, barrier cream to back. On 6/8/17 the skin condition was documented as dry, dressing to the resident's back resolved, and barrier cream to back. On 6/13/17 and 6/23/17 it was documented the resident refused to have his skin integrity review completed. On 6/30/17 it was documented the resident had open areas and abrasions to his mid to lower back. All documentation was completed by the Wound Care Director. An interview conducted with the Administrator on 6/30/17 at 3:00 PM revealed her expectation was for the residents at the facility to have the highest wellbeing that they could have.	F 309		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		7/25/17

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F 312 SS=D	Continued From page 14 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident, family, staff interviews and records reviews, the facility failed to give failed to give showers as scheduled for 1 of 3 sampled residents reviewed for activities of daily living. (Resident # 4) Findings Included: Resident # 4 was admitted to the facility on 12/02/2015 with current diagnoses of anxiety disorder, cerebral infraction and chronic obstructive pulmonary disease. A review of the Quarterly Minimum Data Set (MDS) for Resident #4 dated 4/21/2017 revealed Resident # 4 was cognitively intact. The resident required extensive to total dependence on staff for bed mobility, dressing, toilet use and personal hygiene. A review of the care plan for Resident #4 dated 5/30/2017 revealed that Resident #4 was non-ambulatory and required extensive staff assistance for most of her activities of daily living. Resident #4 needed to utilize two staff members to provide activities of daily living. Assist resident with AM/PM care and record completion at least every morning and evening. Bath/Shower every Tuesday, Thursday and Saturday on day shift. An interview with Resident #4 on 6/29/17 at 2:30	F 312	"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. upon notification of not receiving scheduled shower Resident # 4 was taken immediately to the shower. This resident is receiving showers three times weekly and prn as per her request. All residents have the potential to be affected by the deficient practice. The administrative staff interviewed the alert and oriented residents to determine if they are receiving weekly showers. The non interview able residents' skin was assessed for the need to be showered by the licensed nurse. Residents that were identified through this process was taken to the shower immediately.	

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F 312	Continued From page 15 PM revealed that on Saturday June 24, 2017, she was unsure of the time, she called her sister and asked her to please come to the nursing home to give her a bath because she was stinking. Resident # 4 revealed that she was supposed to get a shower on Tuesday, Thursday and Saturday during second shift but the Nursing Assistant (NA) never gave her a shower. Resident #4 stated that this made her feel bad to be in her room stinking. Resident # 4 also revealed that her hair had not been washed in weeks. Resident # 4 stated "I hated going out of my room with an odor." She dropped her head. An interview with Resident #4's family member on 6/30/2017 at 8:30 AM, revealed that she received a call from Resident # 4 last Saturday requesting her to come to the facility and give Resident #4 a shower. The family member revealed that once she got to the facility Resident #4 had a body odor and her hair was very greasy and appeared to not have been washed in days. The family member indicated that she reported to the staff that her sister (Resident #4) needed a shower. The staff informed her that Resident #4 had received her showers and baths during the week. The family member indicated that she did not believe the staff because of her sisters' condition and body odor. The family member stated that she had given Resident # 4 a bath and washed her hair before she left on that Saturday. During a second interview with Resident #4 on 6/30/2017 at 8:45 AM she continued to state that 2nd shift staff are not giving her showers on her shower days. An interview with NA #5 on 6/30/2017 at 9 AM, revealed that Resident #4 had reported to her on	F 312	In services were done by Director of nursing, assistant director of nursing and unit managers to The Licensed nurses and nursing staff to re-educate to the centers policy and procedures in maintaining a residents dignity with an emphasis on providing showers on a weekly basis and prn. This in-service was completed on 7/25/2017, and will be reviewed in the new employee orientation program for licensed nurses and CNA's. The director of nursing, unit managers, and social services director will interview 30 residents 2 x weekly for 4 weeks, then weekly x 4 weeks, to ensure compliance in receiving weekly and prn showers. Data results will be reviewed and analyzed at the centers monthly Quality assurance and process improvement meeting for 3 months with a subsequent plan of correction as needed.	

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F 312	Continued From page 16 several occasions that the second shift NA did not give her showers on her shower days. Resident #4 told her that sometimes they would give her a bed bath and sometimes no bath at all. NA # 5 indicated that the shower book that identified when residents were to have showers was located at the nursing station. The Daily Log NA Sign off Sheets for the month of June 2017 were reviewed for Resident #4 on 6/30/17 at 10:00 AM. The form revealed Resident #4's shower days were Tuesday, Thursday and Saturday and were to be given on second shift. The form did not identify that Resident #4 had refused any showers. An interview with NA #7 on 6/30/2017 at 3:30 PM, revealed that she had been working with Resident # 4 for several months. NA #7 stated that she did not realize that Resident #4 was on her shower list for over a month and she indicated that no one told her that she was to give Resident #4 a shower on 2rd shift. NA #7 stated that Resident #4's showers were on the third shift. NA #7 also stated that sometimes Resident # 4 did not tell the whole truth because Resident #4 preferred to smoke over take a shower. An interview with the Administrator on 6/30/2017 at 5:130 PM, revealed it was her expectation that the residents receive their showers as scheduled and if they refused staff needed to report this information to Nurse.	F 312		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		7/25/17

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F 520	Continued From page 17 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		

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F 520	Continued From page 18 Based on record review, resident and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place in March 2017. This was for a deficiency that was originally cited in quality of care on a complaint survey on March 28, 2017. The deficiency was in the area of F 309. This deficiency was cited again on 6/30/17 on a complaint survey. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The tag is cross-referenced to: Findings Included: F 309 - Based on record reviews, staff interviews, family interview and resident interview the facility failed to provide follow-up assessment of wound care for 1 of 3 residents (Resident #2) reviewed for well-being. During the complaint investigation survey of March 2017 the facility was cited for quality of care, F 309. Based on record review and staff interview the facility failed to assess 1 of 2 sampled residents who had a fall resulting to a right femur fracture and a right humerus fracture (Resident #6). An interview with the Administrator was conducted on 6/30/17 at 3:26 pm. She stated that the QA committee met monthly and the members included Administrator, Director of Nursing, Admissions Coordinator Social Worker, Business Office Manager, Maintenance Director, Housekeeping Director, Activities Director, Medical Records and Dietary Manager. She stated that the Medical Director attends the meetings at least quarterly. She stated that the QA program that was put into place for resident well-being was for resident choices and included	F 520	"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. The facility has a quality assurance and assessment committee that meets monthly that include Medical Director, Administrator,Director of nursing, Nurse Managers, Therapy ,Dietary,buisness office and Maintenance Director. The facility meets to identify issues with respect to which quality assessment and assurance activities that are necessary and develop and implement appropriate plans of action to identify quality deficiencies. The wound care director failed to notify Responsible party, Medical director and or Nurse praticioner,or director of nursing each time resident #2 refused care and treatments. The wound Care Director was re-educated on the importance of providing notification and follow-up assessment with an emphasis of notifying the Responsible party, Medical director and or Nurse praticioner,or director of nursing the for directives when the	

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F 520	Continued From page 19 audits for resident preferences. A resident care guide was put into place with the residents choices for the Nursing Assistants to use when caring for the residents. She stated her expectations for the QA committee and repeat deficiencies were to bring identified deficiencies to the forefront, continuously updating as they go, to have audit tools in place. She stated QAPI is part of the process, part of the monitoring and part of the changing.	F 520	resident refuses care. All residents have the potential to be affected by this deficient practice. The director of nursing,assistant director of nursing, unit managers performed a skin integrity check on current resident population to assess for new areas of concern and outdated dressings,no other residents were identified during this process. The licensed nurses were in serviced by the director of nursing, assistant director of nursing, regarding notification of the responsible party ,Medical director or Nurse practitioner when a resident refuses care or treatments. The nursing staff was educated on 7/25/2017 on reporting any refusals of care,old dressings observed on residents skin, and the presence of any opened,discolored area with or without a bandage to the licensed nurse or the unit manager,ADON,or DON for evaluation. This information will be reviewed yearly and in the new employee orientation program for licensed nurses and CNA'S. The unit manager, assistant director of nursing, or the director of nursing will audit 20 residents weekly for skin integrity checks, records, treatment administrative record (TAR). The unit manager, assistant director of nursing, or the director of nursing will perform 20 skin integrity checks two times weekly x 4 weeks, then weekly x 4 until compliance is achieved in notifying	

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F 520	Continued From page 20	F 520	responsible party, medical director or nurse practitioner of residents refusal of care, assessing for the presence of outdated dressings intact to residents skin, and identifying the presence of any discolored or opened areas. Data results will be reviewed and analyzed at the centers monthly quality assurance performance improvement meeting for 3 months with a subsequent plan of correction as needed. Regional Director of Clinical Operations will also monitor results regarding effective Quality Assurance with emphasis on consistent monitoring of implemented procedures on 7/25/2017. The Regional Director of Clinical Services will validate areas taken to Quality assurance performance improvement committee and assure the areas of concern are being monitored as indicated with weekly and monthly communication via Administrator and DON to ensure ongoing compliance.	