STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345479	A. BUILDING _____ B. WING _____	C 10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEMTOWNE	**2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106**

(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 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 157		11/8/17

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

Electronically Signed | 11/02/2017

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F 157	Continued From page 1 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and medical record review, the facility failed to notify the responsible party of an injury that occurred during a transfer for 1 of 3 residents (Resident #1) reviewed for notification of condition change. Findings included: 1. Resident #1 was admitted to the facility on 12/6/11 and expired at the facility on 8/28/17. Resident #1 had diagnoses that included, in part, arthritis, non-Alzheimer's dementia and Parkinson's disease. A review of the significant change Minimum Data Set (MDS) assessment dated 6/28/17 revealed Resident #1 had impaired short term and long term memory and severely impaired decision making skills. He was totally dependent for transfers and required two persons to assist. A review of the care plan updated 8/9/17 revealed Resident #1 was at risk for falls and needed a "full body lift for transfers." A care plan intervention with a start date of 3/13/17 included, "Continue total mechanical lift for transfers." A review of an incident report dated 8/18/17 AT	F 157	Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. 1. F 157 - How corrective action will be accomplished by the facility: Resident #1 expired on 8/28/17. Nurse #2 is no longer employed by the facility. On 11/2/17, an audit with a 30 day look back was completed of all resident events to determine if other residents were affected. The IDT will review all event reports in the daily morning meeting to ensure that proper notification to responsible parties has occurred. All LPNs will be in serviced by 11/8/17 on the notification of all Resident Changes. The DON/Designee will conduct weekly audits for 4 weeks, then twice a month for 2 months and	

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F 157	Continued From page 2	F 157		

6:30 PM revealed, "Resident received bilateral lower extremity skin tear during transfer. Resident was placed in sit to stand for transfer by nurse's aide (NA). Resident received bilateral lower extremity skin tears to front of lower legs. This nurse cleansed area with normal saline, applied triple antibiotic ointment, and non-adherent dressing with tape."

A review of a physician request form dated 8/18/17 revealed, "Resident received bilateral lower extremity skin tears during transfer. Wound nurse notified."

A review of a nurse's note dated 8/19/17 at 6:55 PM revealed, "Spoke with resident's daughter about residents' skin tears. Reassured daughter that nurse's aide (NA) was educated on transfer technique, also that wound nurse was made aware. Ongoing monitoring to continue."

A review of a nurse's note correction/addendum dated 8/21/17 at 3:15 PM revealed, "Resident received bilateral lower extremity skin tears during transfer. Cleansed with normal saline, triple antibiotic ointment and island dressing applied. Resident tolerated well. Wound nurse notified, physician request form completed, oncoming nurse notified to contact family."

An interview was completed with the Assistant Director of Nursing (ADON) on 10/10/17 at 4:37 PM. She reported that Resident #1 sustained some scrapes on his legs from where his legs pushed against the cushion of the sit to stand lift.

An interview was completed with Resident #1's family member (Family Member #1) on 10/11/17 at 10:29 AM. She stated she was not notified by

report findings to the QAPI committee. If the committee feels this is a recurring problem based on the information presented, it will assign a PIP team to review this process.

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F 157	Continued From page 3	F 157		

staff when the resident sustained the skin tears to his shins. She said she did not learn about the skin tears until she came to visit the next day and observed bandages around his legs and asked the nursing staff about the injury.

An interview was completed with Nurse #2 on 10/11/17 at 11:35 AM. She stated Resident #1 required a mechanical lift with two person assist for transfers. She recalled she was at the nurse's station when NA #2 told her Resident #1 had skin tears on both of his shins from when she transferred him with the sit to stand lift. Nurse #2 said she assessed and treated the injury, emailed the wound nurse and completed an incident report. She stated she told the next shift nurse what happened and the oncoming nurse stated she would notify the resident's family member. Nurse #2 stated whenever there was a skin tear, fall or change in condition the responsible party/family member was to be notified. Nurse #2 further stated she couldn't remember if she was the nurse the family member approached and asked about how the resident obtained the skin tears.

An interview was completed with Nurse #3 on 10/11/17 at 2:40 PM. She was the nurse who came on duty after Resident #1 sustained skin tears during a transfer. She stated Nurse #2 told her that staff used a sit to stand lift instead of a mechanical lift when Resident #1 was transferred. Nurse #3 said, "It was passed on to me in report. It happened prior to my shift." Nurse #3 said she couldn't remember if Nurse #2 called and notified the family of the skin tears. Nurse #3 further reported she did not notify the family. She stated that a skin tear was something that needed to be communicated to the family and that she wasn't

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F 157	Continued From page 4 asked to call the family and "assumed everything was taken care of." An interview was completed with the ADON on 10/11/17 at 3:25 PM. She stated she would have expected the nurse to notify Resident #1's family member of skin tears he sustained in the transfer. An interview was completed with the Administrator on 10/11/17 at 3:50 PM. He said he expected the nurse to have notified the family of the skin tears Resident #1 obtained when he was transferred.	F 157		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 staff and family interviews and medical record review, the facility failed to follow the care plan to use a mechanical lift for transfers for 1 of 3 residents (Resident #1) reviewed for accidents. Findings included: 1. Resident #1 was admitted to the facility on 12/6/11 and expired at the facility on 8/28/17. Resident #1 had diagnoses that included, in part, arthritis, non-Alzheimer's dementia and Parkinson's disease.	F 282	F - 282 Comprehensive Care Plans How corrective action will be accomplished by the facility: Resident #1 expired on 8/28/17. CNA #2 was in-serviced on 11/2/17 by the Clinical Educator on the care guide tool and the need to use two employees for all mechanical lift transfers. A facility audit was completed on 11/2/17	11/8/17

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F 282	Continued From page 5 A review of the significant change Minimum Data Set (MDS) assessment dated 6/28/17 revealed Resident #1 had impaired short term and long term memory and severely impaired decision making skills. He was totally dependent for transfers and required two persons to assist. A review of the care plan updated 8/9/17 revealed Resident #1 was at risk for falls and needed a "full body lift for transfers." A care plan intervention with a start date of 3/13/17 included, "Continue total mechanical lift for transfers." A review of an incident report dated 8/18/17 revealed, "Resident received bilateral lower extremity skin tear during transfer. Resident was placed in sit to stand for transfer by nurse's aide (NA). Resident received bilateral lower extremity skin tears to front of lower legs. This nurse cleansed area with normal saline, applied triple antibiotic ointment, and non-adherent dressing with tape." An interview was completed with NA #1 on 10/10/17 at 3:58 PM. She stated that two staff were needed when either a sit to stand or mechanical lift was used for transfers. She said a resident's care plan was reviewed to determine what kind of help a resident required for transfers and included the type of lift that was used. An interview was completed with Resident #1's family member (Family Member #1) on 10/11/17 at 10:29 AM. She stated the resident had been transferred with a mechanical lift for about 18 months. Family Member #1 said that two people were supposed to help with transfers for Resident #1.	F 282	to determine if residents using a mechanical lift had their care plan/care guide followed and that the staff used two-person assist to complete the transfer. The Care plans for all residents requiring mechanical lifts have been reviewed. All resident care plans reflect which lift is to be used and two-person assist. The staff care guides are generated from the care plan and have been implemented. Care Guides are printed and each aide is to carry the care guide for their assignment. The LPNs are to conduct random audits throughout their shift to ensure that each CNA is carrying their care guide and that they are transferring residents according to said guide. The nursing department will be in-serviced by 11/8/17. The in-service will contain the importance of following the care plan/care guide when providing care to residents, and the need to carry the care guide for their assignment. The DON/designee will review the LPN audits on a weekly basis for four weeks, then twice a month for two months and report the findings to the QAPI team. If the QAPI team identifies a trend based on this information, a PIP team will be assigned to investigate this issue.	

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An interview was completed with NA #2 on 10/11/17 at 11:18 AM. She said she had worked at the facility for 11 years and was currently employed on an as needed basis. She had worked with Resident #1 in the past when he used a sit to stand lift for transfers. NA #2 stated, "When I transferred him I initially used a sit to stand lift because that's the lift he was on previously when I worked with him." NA #2 said she assumed the resident still used the sit to stand lift since that was what she used in the past. She stated she was not notified that he needed a total mechanical lift and said there was no information in his room that indicated what type of lift he needed for transfers.

An interview was completed with Nurse #2 on 10/11/17 at 11:35 AM. She stated Resident #1 required a mechanical lift with two person assist for transfers. She said the information on how much help a resident needed with transfers was located on the care plan. She recalled she was at the nurse's station when NA #2 told her Resident #1 had skin tears on both of his shins from when she transferred him with the sit to stand lift. Nurse #2 said she informed NA #2 that Resident #1 required a mechanical lift for transfers and NA #2 told her she didn't know that information. Nurse #2 said she told NA #2 she needed to look at the care plans in the computer for the care information on the resident.

An interview was completed with the MDS Nurse on 10/11/17 at 12:08 PM. She stated Resident #1 needed a total mechanical lift for transfers, not a sit to stand lift. She indicated information on transfers and lifts was on the paper care guides that were printed daily for NAs to use. She said

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F 282	Continued From page 7 the care plan reflected Resident #1 needed a "total mechanical lift" for transfers. An interview was completed with the ADON on 10/11/17 at 1:19 PM. She said she received a report that NA #2 had not worked with Resident #1 in a while and was not aware he had progressed to a mechanical lift and had instead, used a sit to stand lift when she transferred the resident. The ADON stated, "We did an investigation and NA #2 said she didn't realize he was a mechanical lift at the time she transferred him." The ADON said information on transfers was in the care plan and care guides which were located in the computer system. She stated NA #2 should have gone in to look for the care plan and/or care guide and determined what kind of transfer help he needed so she could have used the appropriate equipment. A second interview as completed with the MDS Nurse on 10/11/17 at 3:00 PM. She said information on the type of lift needed for Resident #1 (mechanical lift) was updated on the care plan as of 3/13/17. An interview was completed with the Administrator on 10/11/17 at 3:50 PM. He said he expected the staff to follow the care plan and use the correct lift to transfer Resident #1. He stated the facility met with the family after the incorrect lift was used and implemented corrections.	F 282		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that -	F 323		11/8/17

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F 323	Continued From page 8 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and medical record review, the facility failed to use two staff persons for transfers and failed to use the correct lift device according to the plan of care which resulted in skin tears to bilateral shins for 1 of 3 residents (Resident #1) reviewed for accidents. Findings included: 1. Resident #1 was admitted to the facility on 12/6/11 and expired at the facility on 8/28/17. Resident #1 had diagnoses that included, in part, arthritis, non-Alzheimer's dementia and Parkinson's disease.	F 323	F 323 - Accidents How corrective action will be accomplished by the facility: Resident #1 expired on 8/28/17. CNA #2 was in-serviced on 11/2/17 by the Clinical Educator on the care guide tool and the need to use two employees for all mechanical lift transfers. A facility audit was completed on 11/2/17 to determine if residents using a mechanical lift had their care plan/care	

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F 323	Continued From page 9 A review of the significant change Minimum Data Set (MDS) assessment dated 6/28/17 revealed Resident #1 had impaired short term and long term memory and severely impaired decision making skills. He was totally dependent for transfers and required two persons to assist. He had impairment on one side of his upper extremity and impairment on both sides of his lower extremities. A review of the care plan updated 8/9/17 revealed Resident #1 was at risk for falls and needed a "full body lift for transfers." A care plan intervention with a start date of 3/13/17 included, "Continue total mechanical lift for transfers." A review of an incident report dated 8/18/17 revealed, "Resident received bilateral lower extremity skin tear during transfer. Resident was placed in sit to stand for transfer by nurse's aide (NA). Resident received bilateral lower extremity skin tears to front of lower legs. This nurse cleansed area with normal saline, applied triple antibiotic ointment, and non-adherent dressing with tape." An interview was completed with NA #1 on 10/10/17 at 3:58 PM. She stated that two staff were needed when either a sit to stand or mechanical lift was used for transfers. She said a resident's care plan was reviewed to determine what kind of help a resident required for transfers and included the type of lift that was used. An interview was completed with the Assistant Director of Nursing (ADON) on 10/10/17 at 4:37 PM. She reported that Resident #1 sustained some scrapes on his legs from where his legs pushed against the cushion of the sit to stand lift.	F 323	guide followed and that the staff used two-person assist to complete the transfer. The Care plans for all residents requiring mechanical lifts have been reviewed. All resident care plans reflect which lift is to be used and two-person assist. The staff care guides are generated from the care plan and have been implemented. Care Guides are printed and each aide is to carry the care guide for their assignment. The LPNs are to conduct random audits throughout their shift to ensure that each CNA is carrying their care guide and that they are transferring residents according to said guide. The nursing department will be in-serviced by 11/8/17. The in-service will contain the importance of following the care plan/care guide when providing care to residents, and the need to carry the care guide for their assignment. The DON/designee will review the LPN audits on a weekly basis for four weeks, then twice a month for two months and report the findings to the QAPI team. If the QAPI team identifies a trend based on this information, a PIP team will be assigned to investigate this issue.	

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F 323	Continued From page 10	F 323		

An interview was completed with Nurse #1 on 10/10/17 at 4:35 PM. She said that information on transfer needs were listed on care guides which were printed every night for the following day. She stated the NAs picked up a care guide in the morning when they came on duty.

An interview was completed with Resident #1's family member (Family Member #1) on 10/11/17 at 10:29 AM. She stated the resident had been transferred with a mechanical lift for about 18 months. Family Member #1 said that two people were supposed to help with transfers for Resident #1.

An interview was completed with NA #2 on 10/11/17 at 11:18 AM. She said she had worked at the facility for 11 years and was currently employed on an as needed basis. She had worked with Resident #1 in the past when he used a sit to stand lift for transfers. NA #2 stated, "When I transferred him I initially used a sit to stand lift because that's the lift he was on previously when I worked with him." NA #2 said she assumed the resident still used the sit to stand lift since that was what she used in the past. She stated she was not notified that he needed a total mechanical lift and said there was no information in his room that indicated what type of lift he needed for transfers. NA #2 stated she used the sit to stand lift by herself to transfer Resident #1. She reported she "had him strapped in very secure and as I began to use the lift to transfer him, his feet lifted up off the platform." She stated Resident #1's shins ended up on top of the cushion instead of resting against the cushion and he sustained skin tears to both of his shins. NA #2 said she then opened the door

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F 323	Continued From page 11	F 323		

to the room and called for another NA to help. NA #2 further stated, "I was always under the impression that it was a one person transfer but was educated that it was a two person." NA #2 said she immediately told the nurse about the skin tears once she assisted Resident #1 into a comfortable position.

An interview was completed with Nurse #2 on 10/11/17 at 11:35 AM. She stated Resident #1 required a mechanical lift with two person assist for transfers. She said the information on how much help a resident needed with transfers was located on the care plan. She recalled she was at the nurse's station when NA #2 told her Resident #1 had skin tears on both of his shins from when she transferred him with the sit to stand lift. Nurse #2 said she informed NA #2 that Resident #1 required a mechanical lift for transfers and NA #2 told her she didn't know that information. Nurse #2 said she told NA #2 she needed to look at the care plans in the computer for the care information on the resident. Nurse #2 further stated that Resident #1 had contractures and there was "No way he could have gripped the hand rails because of the contractures in his hands and legs."

An interview was completed with the MDS Nurse on 10/11/17 at 12:08 PM. She stated Resident #1 needed a total mechanical lift for transfers, not a sit to stand lift. She indicated information on transfers and lifts was on the paper care guides that were printed daily for NAs to use. She said the care plan reflected Resident #1 needed a "total mechanical lift" for transfers.

A second interview was completed with the ADON on 10/11/17 at 1:19 PM. She said she received a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345479	A. BUILDING _____ B. WING _____	C 10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEMTOWNE	2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106

(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 323	Continued From page 12	F 323		

report that NA #2 had not worked with Resident #1 in a while and was not aware he had progressed to a mechanical lift and had instead, used a sit to stand lift when she transferred the resident. The ADON stated, "We did an investigation and NA #2 said she didn't realize he was a mechanical lift at the time she transferred him." The ADON said information on transfers was in the care plan and care guides which were located in the computer system. She stated NA #2 should have gone in to look for the care plan and/or care guide and determined what kind of transfer help he needed so she could have used the appropriate equipment.

A second interview as completed with the MDS Nurse on 10/11/17 at 3:00 PM. She said information on the type of lift needed for Resident #1 (mechanical lift) was updated on the care plan as of 3/13/17.

An interview was completed with the Administrator on 10/11/17 at 3:50 PM. He said he expected the staff to follow the care plan and use the correct lift to transfer Resident #1. He stated the facility met with the family after the incorrect lift was used and implemented corrections.