PRINTED: 11/21/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345479		B. WING _	B. WING		C 10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 157 SS=D	(INJURY/DECLINE/R CFR(s): 483.10(g)(14) (g)(14) Notification of (i) A facility must immonsult with the residuation of the consistent with his or representative(s) where the consistent injury and his physician intervention. (B) A significant chargemental, or psychosocy deterioration in health status in either life-throclinical complications. (C) A need to alter treating a need to discontinue treatment due to advect the commence a new form the facility with the commence and the facility with the commence of	Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ring the resident which as the potential for requiring is ge in the resident's physical, ial status (that is, a ental, or psychosocial reatening conditions or is at ment significantly (that is, an existing form of erse consequences, or to mof treatment); or	F1	TITLE		11/8/17

11/02/2017 **Electronically Signed**

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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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345479	B. WING		C 10/11/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106	10/11/2017	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 157	as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must resupdate the address (rephone number of the This REQUIREMENT by: Based on staff and farecord review, the face responsible party of a a transfer for 1 of 3 receivemed for notification. Findings included: 1. Resident #1 was at 12/6/11 and expired at Resident #1 had diag arthritis, non-Alzheim Parkinson's disease. A review of the signification of the second required at the second required required at the second required	ent rights under Federal or ent rights under Federal or ens as specified in paragraph ecord and periodically mailing and email) and resident representative(s). is not met as evidenced emily interviews and medical elility failed to notify the en injury that occurred during esidents (Resident #1) on of condition change. Indimitted to the facility on eat the facility on 8/28/17. Inoses that included, in part, er's dementia and ecant change Minimum Data ent dated 6/28/17 revealed eaired short term and long everely impaired decision is totally dependent for ditwo persons to assist.	F 157	Preparation and execution of this Plar Correction does not constitute admissi or agreement by the provider of the tru of the items alleged or conclusion set f in the statement of deficiencies. The P of Correction is prepared and/or execusolely 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 expired on 8/28/17. Nurse #2 is no lone employed by the facility. On 11/2/17, an audit with a 30 day look back was completed of all resident ever to determine if other residents were affected. The IDT will review all event reports in daily morning meeting to ensure that proper notification to responsible partic has occurred. All LPNs will be in service by 11/8/17 on the notification of all Resident Changes. The DON/Designe will conduct weekly audits for 4 weeks, then twice a month for 2 months and	on th orth lan ted #1 ger cents the	

Facility ID: 923440

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	` '	(X3) DATE SURVEY COMPLETED		
		345479	B. WING			C 10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106	E	10/11/2017	
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F 157	lower extremity skin Resident was placed nurse's aide (NA). Flower extremity skin This nurse cleansed applied triple antibio non-adherent dressi A review of a physic 8/18/17 revealed, "Flower extremity skin nurse notified." A review of a nurse's PM revealed, "Spok about residents' skin that nurse's aide (NA technique, also that aware. Ongoing moduring transfer. Cleatiple antibiotic ointrapplied. Resident to notified, physician reconcoming nurse notified, physician reconcoming nurse notions. An interview was concoming transfer. Cleatiple antibiotic ointrapplied. Resident to notified, physician reconcoming nurse notions. An interview was concoming nurse notions against the concoming transfer. Cleatiple antibiotic ointrapplied. Resident to notified, physician reconcoming nurse notions. An interview was concoming nurse notions against the concoming nurse on his pushed against the confidence of the properties of the properties and the	Resident received bilateral tear during transfer. d in sit to stand for transfer by Resident received bilateral tears to front of lower legs. area with normal saline, tic ointment, and	F 18	report findings to the QAPI co the committee feels this is a r problem based on the informa presented, it will assign a PIF review this process.	ecurring ation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF PI	ROVIDER OR SUPPLIER		20	TREET ADDRESS, CITY, STATE, ZIP CODE DOO SALEMTOWNE DRIVE VINSTON SALEM, NC 27106	10/11/2017		
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F 157	his shins. She said skin tears until she observed bandage the nursing staff ab. An interview was compared a mechan for transfers. She is station when NA #2 tears on both of his transferred him with said she assessed the wound nurse at report. She stated what happened and she would notify the Nurse #2 stated where the stated what happened and she would notify the nurse the family asked about how the tears. An interview was compared to the nurse the family asked about how the tears. An interview was compared to the nurse the family asked about how the tears.	dent sustained the skin tears to dishe did not learn about the came to visit the next day and is around his legs and asked bout the injury. I ompleted with Nurse #2 on the came to with the stated Resident #1 ical lift with two person assist recalled she was at the nurse's the told her Resident #1 had skin as shins from when she is the sit to stand lift. Nurse #2 and treated the injury, emailed and completed an incident is she told the next shift nurse in the oncoming nurse stated the resident's family member. The nenever there was a skin tear, andition the responsible for was to be notified. Nurse #2 couldn't remember if she was a y member approached and the resident obtained the skin of the skin stated Nurse #3 on the stated Nurse #3 on the stated Nurse #2 told as it to stand lift instead of a sin Resident #1 was transferred.	F 157				
	mechanical lift when Nurse #3 said, "It was to happened prior to couldn't remember the family of the sk reported she did not that a skin tear was the skin t						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 157	was taken care of." An interview was com 10/11/17 at 3:25 PM. expected the nurse to member of skin tears An interview was com Administrator on 10/1 expected the nurse to the skin tears Reside transferred. SERVICES BY QUAL CARE PLAN CFR(s): 483.21(b)(3)(b)(3) Comprehensive The services provide as outlined by the commust- (ii) Be provided by quaccordance with each care. This REQUIREMENT by: Based on staff and farecord review, the fact plan to use a mechan 3 residents (Resident #1 was a 12/6/11 and expired as 12/6/11 and 12/6	Ity and "assumed everything Inpleted with the ADON on She stated she would have onotify Resident #1's family he sustained in the transfer. Inpleted with the 1/17 at 3:50 PM. He said he on have notified the family of int #1 obtained when he was IFIED PERSONS/PER (iii) If Care Plans If or arranged by the facility, inprehensive care plan, If is not met as evidenced If is not met as evidenced If it is not met as evidenced If		282	F - 282 Comprehensive Care Plans How corrective action will be accomplished by the facility: Resident a 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	e	11/8/17	

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TO WILL OF T	NOVIBER OR COLL FIER							
SALEMTO	OWNE				000 SALEMTOWNE DRIVE			
				W	VINSTON SALEM, NC 27106			
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F 282	A review of the significate (MDS) assessme Resident #1 had impaterm memory and seymaking skills. He was transfers and required A review of the care processed of the care of the care processed of the care	cant change Minimum Data ant dated 6/28/17 revealed aired short term and long verely impaired decision is totally dependent for d two persons to assist. Dan updated 8/9/17 revealed sk for falls and needed a fers." A care plan art date of 3/13/17 included, anical lift for transfers." Int report dated 8/18/17 eccived bilateral lower uring transfer. Resident was for transfer by nurse's aide wed bilateral lower extremity ower legs. This nurse ormal saline, applied triple and non-adherent dressing Inpleted with NA #1 on She stated that two staff of the a sit to stand or sed for transfers. She said a vas reviewed to determine esident required for transfers of lift that was used. Inpleted with Resident #1's by Member #1) on 10/11/17 ated the resident had been chanical lift for about 18 by Ber #1 said that two people	F 2	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 requirimechanical lifts have been reviewed. A resident care plans reflect which lift is to be used and two-person assist. The strate 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 assignme. The LPNs are to conduct random audit throughout their shift to ensure that each CNA is carrying their care guide and the they are transferring residents according to said guide. The nursing department be in-serviced by 11/8/17. The in-service will contain the importance of following care plan/care guide when providing care plan/care guide when providing 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 QAPI team identifies a trend based on information, a PIP team will be assigned to investigate this issue.	ng All to aff re e nt. ts chat ng will ce the are t, the this		
	Resident #1 had impaterm memory and sey making skills. He was transfers and required. A review of the care president #1 was at rise. "Gesident #1 was at rise." "full body lift for transintervention with a state. "Continue total mechalication of the care prevealed, "Resident revealed, "Resident revealed, "Resident received in sit to stand (NA). Resident receives in tears to front of local cleansed area with not antibiotic ointment, and with tape." An interview was comediated to the composition of the composition of the cleansed area with not antibiotic ointment, and with tape." An interview was comediated the type and included the type. An interview was comfamily member (Familat 10:29 AM. She stat transferred with a memonths. Family Memonths.	aired short term and long verely impaired decision is totally dependent for did two persons to assist. A care plan art date of 3/13/17 included, anical lift for transfers." A creptal lower transfer by nurse's aide ved bilateral lower extremity ower legs. This nurse ormal saline, applied triple and non-adherent dressing Appleted with NA #1 on She stated that two staff of transfers. She said a vas reviewed to determine esident required for transfers of lift that was used. Appleted with Resident #1's ly Member #1) on 10/11/17 ated the resident had been chanical lift for about 18			two-person assist to complete the transfer. The Care plans for all residents requirismechanical lifts have been reviewed. A resident care plans reflect which lift is to be used and two-person assist. The state care guides are generated from the carplan and have been implemented. Care Guides are printed and each aide is to carry the care guide for their assignme. The LPNs are to conduct random audit throughout their shift to ensure that each CNA is carrying their care guide and the they are transferring residents according to said guide. The nursing department be in-serviced by 11/8/17. The in-service will contain the importance of following care plan/care guide when providing 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 QAPI team identifies a trend based on information, a PIP team will be assigned.	All to aff re e nt. ts ch rate ce the are		

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F 282	10/11/17 at 11:18 Al at the facility for 11 employed on an as worked with Reside used a sit to stand li "When I transferred stand lift because the previously when I wishe assumed the restand lift since that the past. She stated she needed a total mechanic for transfers. She sident was a much help a resider located on the care at the nurse's station Resident #1 had ski from when she transfers and NA #2 information. Nurse needed to look at the for the care information. An interview was con 10/11/17 at 12:00 needed a total mechanic for the care information. An interview was con 10/11/17 at 12:00 needed a total mechanic for the care information.	mpleted with NA #2 on M. She said she had worked years and was currently needed basis. She had nt #1 in the past when he ft for transfers. NA #2 stated, him I initially used a sit to at's the lift he was on orked with him." NA #2 said sident still used the sit to was what she used in the e was not notified that he nanical lift and said there was a room that indicated what d for transfers. mpleted with Nurse #2 on M. She stated Resident #1 cal lift with two person assist aid the information on how at needed with transfers was plan. She recalled she was n when NA #2 told her n tears on both of his shins sferred him with the sit to said she informed NA #2 that d a mechanical lift for told her she didn't know that #2 said she told NA #2 she e care plans in the computer tion on the resident. mpleted with the MDS Nurse 8 PM. She stated Resident #1 nanical lift for transfers, not a	F 28	32				
	An interview was co on 10/11/17 at 12:00 needed a total mech sit to stand lift. She transfers and lifts wa	tion on the resident. mpleted with the MDS Nurse 3 PM. She stated Resident #1						

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(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE	
F 282 Continued From page 7 the care plan reflected Resid "total mechanical lift" for trans An interview was completed 10/11/17 at 1:19 PM. She sa report that NA #2 had not wo #1 in a while and was not aw progressed to a mechanical I used a sit to stand lift when s resident. The ADON stated, investigation and NA #2 said was a mechanical lift at the ti him." The ADON said inform was in the care plan and care located in the computer syste #2 should have gone in to loc and/or care guide and detern transfer help he needed so s the appropriate equipment. A second interview as comple Nurse on 10/11/17 at 3:00 PN information on the type of lift #1 (mechanical lift) was upda as of 3/13/17. An interview was completed Administrator on 10/11/17 at expected the staff to follow th the correct lift to transfer Res the facility met with the family lift was used and implemented FREE OF ACCIDENT HAZARDS/SUPERVISION/D CFR(s): 483.25(d)(1)(2)(n)(1) (d) Accidents. The facility must ensure that	with the ADON on aid she received a rked with Resident are he had ift and had instead, the transferred the "We did an she didn't realize he me she transferred ation on transfers a guides which were ation. She stated NA ok for the care plan and with the MDS M. She said needed for Resident ated on the care plan with the 3:50 PM. He said he are care plan and use ident #1. He stated of after the incorrect and corrections.	F 28			11/8/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COMPLET	(X3) DATE SURVEY COMPLETED			
		345479	B. WING _		C 10/11/	10/11/2017		
	NAME OF PROVIDER OR SUPPLIER SALEMTOWNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106	10/11//	2017		
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F 323	Continued From pa	ge 8	F 3	23				
	` '	vironment remains as free rds as is possible; and						
		eceives adequate supervision ices 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 residence from bed rails prior	dent for risk of entrapment to installation.						
	` '	s and benefits of bed rails with dent representative and obtain rior to installation.						
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced						
	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 - Accidents How corrective action will be accomplished by the facility: Re expired on 8/28/17. CNA #2 was in-serviced on 11/2/17 by the CI Educator on the care guide tool need to use two employees for mechanical lift transfers. A facility audit was completed of to determine if residents using a mechanical lift had their care play	s inical and the all			

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NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI		10/11/2017	
				2000 SALEMTOWNE DRIVE			
SALEMTO	OWNE			WINSTON SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From pag	ge 9	F 32	3			
F 323	A review of the signiful Set (MDS) assessment Resident #1 had impleterm memory and set making skills. He was transfers and require had impairment on onextremity and impair lower extremities. A review of the care Resident #1 was at refull body lift for transintervention with a step "Continue total mechanter and placed in sit to stand (NA). Resident recession tears to front of cleansed area with mantibiotic ointment, a with tape." An interview was contol/10/17 at 3:58 PM	ficant change Minimum Data ent dated 6/28/17 revealed paired short term and long everely impaired decision as totally dependent for ed two persons to assist. He one side of his upper rment on both sides of his plan updated 8/9/17 revealed risk for falls and needed a	F 32	guide followed and that the stwo-person assist to complet transfer. The Care plans for all reside mechanical lifts have been reresident care plans reflect whe used and two-person ass care guides are generated freplan and have been implemed Guides are printed and each carry the care guide for their The LPNs are to conduct rand throughout their shift to ensure CNA is carrying their care guithey are transferring resident to said guide. The nursing debe in-serviced by 11/8/17. The will contain the importance of care plan/care guide when put or residents, and the need to care guide for their assignment. The DON/designee will revie audits on a weekly basis for then twice a month for two more report the findings to the QAI QAPI team identifies a trend information, a PIP team will to	nts requiring eviewed. All hich lift is to ist. The staff om the care ented. Care aide is to assignment. Indom audits according epartment will ne in-service of following the roviding care ocarry the ent. The with ELPN four weeks, nonths and PI team. If the based on this		
	resident's care plant what kind of help a rand included the type. An interview was condirector of Nursing (PM. She reported the some scrapes on his	used for transfers. She said a was reviewed to determine esident required for transfers e of lift that was used. mpleted with the Assistant ADON) on 10/10/17 at 4:37 nat Resident #1 sustained is legs from where his legs cushion of the sit to stand lift.		to investigate this issue.			

Facility ID: 923440

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345479	B. WING			C	
NAME OF PR	ROVIDER OR SUPPLIER	343413		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106	<u> </u>	10/11/2017	
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F 323	Continued From pag	e 10	F 32	23			
	10/10/17 at 4:35 PM on transfer needs we which were printed eday. She stated the in the morning when An interview was confamily member (Famat 10:29 AM. She stansferred with a memonths. Family Mer	mpleted with Nurse #1 on . She said that information ere listed on care guides every night for the following NAs picked up a care guide they came on duty. mpleted with Resident #1's sily Member #1) on 10/11/17 ated the resident had been echanical lift for about 18 mber #1 said that two people elp with transfers for Resident					
	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						

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		345479	B. WING			C 10/11/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 2000 SALEMTOWNE DRIVE WINSTON SALEM, NC 27106	DE			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 323	#2 further stated, "I vimpression that it wa was educated that it said she immediately skin tears once she a comfortable position. An interview was cor 10/11/17 at 11:35 AN required a mechanic for transfers. She samuch help a resident located on the care pat the nurse's station Resident #1 had skir from when she transstand lift. Nurse #2 s Resident #1 required transfers and NA #2 information. Nurse # needed to look at the for the care informati #2 further stated that contractures and the have gripped the har contractures in his had An interview was cor on 10/11/17 at 12:08 needed a total mechanical lift. She is transfers and lifts was that were printed dail the care plan reflecte "total mechanical lift" A second interview was conditional mechanical lift."	and for another NA to help. NA was always under the s a one person transfer but was a two person." NA #2 was told the nurse about the assisted Resident #1 into a Inpleted with Nurse #2 on I. She stated Resident #1 al lift with two person assist id the information on how a needed with transfers was when NA #2 told her a tears on both of his shins ferred him with the sit to said she informed NA #2 that I a mechanical lift for told her she didn't know that I a a mechanical lift for told her she didn't know that I a said she told NA #2 she I care plans in the computer on on the resident. Nurse I Resident #1 had I re was "No way he could I drails because of the ands and legs." Inpleted with the MDS Nurse PM. She stated Resident #1 anical lift for transfers, not a indicated information on is on the paper care guides by for NAs to use. She said and Resident #1 needed a	F 3:	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345479	B. WING			C	
NAME OF PROVIDER OR SUPPLIER SALEMTOWNE				STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIO DATE		
F 323	report that NA #2 had #1 in a while and was progressed to a mechused a sit to stand lift resident. The ADON investigation and NA was a mechanical lift him." The ADON said was in the care plant a located in the comput #2 should have gone and/or care guide and transfer help he need the appropriate equip A second interview as Nurse on 10/11/17 at information on the typ #1 (mechanical lift) was of 3/13/17. An interview was com Administrator on 10/1 expected the staff to the correct lift to transfer that was a single progression.	Inot worked with Resident and aware he had hanical lift and had instead, when she transferred the stated, "We did an #2 said she didn't realize he at the time she transferred dinformation on transfers and care guides which were her system. She stated NA in to look for the care planed determined what kind of hed so she could have used ment. She completed with the MDS 3:00 PM. She said he of lift needed for Resident has updated on the care planed her follow the care plan and use offer Resident #1. He stated her family after the incorrect	F3	23			