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 02/07/2019

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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, psychiatric nurse practitioner (NP) and staff interviews the facility failed to protect the resident ' s right to be free from physical abuse for 1 of 3 residents reviewed for abuse. Resident #1 sustained facial injuries which included lacerations and a bloody nose after being struck by Resident #2 and required evaluation of his injuries in the emergency room. Findings Included: Resident #1 was admitted to the facility 10/23/17 and diagnoses included Alzheimer ' s Disease, aphasia and cognitive communication deficit. A quarterly minimum data set (MDS) dated 12/24/18 for Resident #1 identified he displayed behaviors of wandering and rejection of care for 1 to 3 days of the look-back period. He used a wheelchair for mobility and his cognition was	F 600	F - 600 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for affected resident(s): 1) Resident #1 was sent to the emergency	3/8/19

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

Electronically Signed | 03/01/2019

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F 600	Continued From page 1 moderately impaired. A care plan for Resident #1 dated 1/9/19 identified he was at risk for elopement related to dementia and wandering. Interventions included to ensure exits and stairwells were coded with alarms or monitored, ensure his room was located on the secured unit, ensure staff are aware of wandering behaviors, monitor whereabouts frequently throughout the day and provide diversional activities. Resident #2 was admitted to the facility on 1/26/18 and diagnoses includes dementia, depression, seizure disorder, diabetes and atrial fibrillation. A care plan dated 8/20/18 for Resident #2 revealed he had the potential to demonstrate physical behaviors (grabbed another resident on the arm, struck another resident in the face, struck roommate on the left side of the head and pulled on his arm). Interventions included resident sent out for psychological exam (8/20/18); analyze key times, places, circumstances, triggers and what de-escalates behaviors and document, assess and anticipate resident ' s needs; monitor and document observed behavior and attempted interventions; psychiatric consults as needed and intervene when resident becomes agitated and before agitation escalates. An annual minimum data set (MDS) dated 1/2/19 for Resident #2 indicated he had physical and verbal behaviors directed towards others for 1 to 3 days of the look-back period. He put others at risk for significant physical injury and his behaviors had improved since the last assessment. Resident #2 required limited	F 600	room for an evaluation on 1/2/19. Resident #1 returned to the facility on 1/3/19. 2) Resident #2 was sent to the emergency room for psychological evaluation on 1/2/19. Resident #2 returned to the facility and was not a candidate for inpatient psychological services. 3) Resident #1 was seen by the facility Nurse Practitioner on 1/3/19. 4) Resident #2 was seen by the facility Psychiatric Nurse Practitioner on 1/3/19. 5) On 1/2/19, police were notified of incident. No charges were filed for Resident #2. Interventions for residents identified as having the potential to be affected: 1) On 1/3/19, Resident #2 had a stop sign placed across the entrance of his room door to deter residents from entering his room. Resident #2 is in a private room. 2) By 3/8/19, an updated behavior/wandering assessment will be completed on current facility residents by the Unit Manager(s). If indicated, the Minimum Data Set (MDS) Nurse will update behavioral care plan(s) to reflect resident□s current behaviors and behavioral interventions. 3) By 3/8/19, Recreational Therapist and/or Activities will review activity care	

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F 600	Continued From page 2 one-person assistance with bed mobility / transfers, supervision with locomotion on and off the unit, used a wheelchair for mobility and his cognition was intact. Review of a behavior note dated 1/2/19 at 4:52 pm for Resident #2 revealed at approximately 3:50 pm a nurse observed Resident #1 lying on the floor in Resident #2 ' s room. Resident #1 had blood coming from his nose, a hematoma to his right eyebrow area and some shortness of breath as he yelled out for help. Resident #2 was sitting in his wheelchair beside Resident #1. Resident #2 stated he hit Resident #1 because he was in his room and hit him in the eye. The nurse examined both of Resident #2 ' s eyes and no redness or swelling was observed. The nurse explained to Resident #2 that Resident #1 was not aware of his actions and in the future, he needed to use his call button to call for assistance. The Director of Nursing and Assistant Director of Nursing spoke with Resident #2 and he told them he hit Resident #1. The physician for both Resident #1 and Resident #2 was notified of the incident. Resident #1 was sent to the emergency room for evaluation and Resident #2 was sent to the hospital for psychiatric evaluation. Review of the facility investigation for the incident that occurred on 1/2/19 revealed Resident #1 wandered into Resident #2 ' s room which was on the opposite hall of where he resided. Resident #1 was hit by Resident #2 when he wandered into his room. Resident #1 had dementia, ambulated independently and wandered on the locked unit. Resident #2 was alert and oriented. Resident #2 alleged that Resident #1 hit him, so he hit him back. He stated he hit with a closed fist and laughed. Resident #1 had a hematoma, a small	F 600	plan for identified resident(s) with behaviors/wandering. Care plans will be updated as indicated. 4) Between 1/4/19 and 1/23/19, an in-service was given by the Director of Nursing (DON), Staff Development Coordinator (SDC) or Nursing Supervisor to Nursing Staff regarding abuse, resident to resident altercations, how to handle and prevent altercations and how-to follow-up if resident to resident altercations occurs. 5) Additional behavioral management and dementia education will be provided to Nursing Staff. The education is entitled Compassion Touch- Dementia and Behavioral Training □ A CMS Initiative. This education will be given by AGEucate Training Institute at the facility on 03/19/19. Systemic Change: 1) On 2/16/19, the facility established Hall Monitors every shift (1st, 2nd and 3rd) for the Locked Unit - 5th floor. The Hall Monitor will assist with reviewing unit cameras, monitoring the halls for wandering/behavioral residents and intervening when issues occur. 2) Upon admission to the facility, residents will have a behavior assessment completed by the Unit Manager or Licensed Nurse to determine behavioral symptoms. As indicated, the MDS Nurse will update the resident care plan to establish behavioral interventions.	

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F 600	Continued From page 3 laceration on his right eyebrow, a small bruise below his nose and bleeding from his nose. Resident #2 had no redness, bruising or opened areas. The residents were separated. Resident #1 received treatment in house and both residents were sent to the emergency room for evaluation. The local police were notified, and no charges were filed. The allegation of abuse was substantiated. Corrective actions included Resident #1 and Resident #2 have been separated since the incident. Police were notified and interviewed both residents. Resident #1 and Resident #2 were sent to the emergency room for evaluation. Resident #2 was evaluated by psychiatric services at the hospital and seen by the facility psychiatric NP for medication management. Resident #2 resides in a private room and a stop sign was placed across the doorway to deter other residents from entering his room. Review of the police report dated 1/2/19 at 4:23 pm revealed the incident was a non-aggravated simple assault. Resident #1 ' s family did not want to press charges. Review of the hospital record dated 1/2/19 for Resident #1 revealed he was seen in the emergency room for facial abrasions following an assault. He had a CT (computed tomography scan) of his head, facial bones and spine. No fractures were identified, and the resident was returned to the facility with no new orders. Review of the hospital record dated 1/2/19 for Resident #2 revealed he was seen for a psychiatric evaluation. The patient stated he was sitting in his room this afternoon when another resident came into his room, started eating some	F 600	3) Quarterly Dementia/Behavior Training will be conducted by the facility SDC with Nursing Staff. 4) Dementia/Behavioral Training upon hire for newly hired employees. Monitoring of the change to sustain system compliance ongoing: 1) Scheduled Hall Monitors will update the "Hall Monitoring" tool every shift as indicated to reflect any resident specific issues related to wandering/behaviors. Behavioral interventions will be noted on audit tool (Example...resident easily redirected). 2) Beginning 2/18/19, an interdisciplinary behavior meeting will be initiated weekly to review any residents who has exhibited any adverse behaviors for the week based on Licensed Nurse and Nurse Aide behavioral documentation. During meeting, the Director of Nursing and Unit Manager will review the "Hall Monitoring" tool completed by the facility 5th Floor Hall Monitors to establish additional behavioral interventions as needed. 3) The "Hall Monitoring" Audits and Behavior Meeting Minutes will be reported to the Quality Assurance Performance Improvement (QAPI) Committee by the DON monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the audits to make	

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F 600	Continued From page 4 of his food and sat on his bed. He stated the resident punched him in his left eye and so he punched him in the face. The patient had normal mood and affect. His speech, behavior and thought content were normal. He expressed no homicidal or suicidal ideation. Behavioral health recommended to send back to the facility with no new orders. An observation of Resident #2 on 2/6/19 at 12:40 pm revealed he resided in a private room. He was laying on his bed and was awake. He stated he was doing pretty well. Resident #2 stated he didn ' t recall having any incidents or hitting another resident. An interview on 2/6/19 at 2:12 pm with Nurse #2 revealed she was the unit manager on the secured unit where Resident #2 resided during the incident on 1/2/19. She explained the resident hadn ' t displayed any behavior issues from that time until the altercation on 1/2/19. He typically had a sweet demeanor and didn ' t interact with the other residents except when he went out to smoke. She stated the incident on 1/2/19 was unwitnessed by any staff. Nurse #2 explained they determined during the investigation that Resident #1 wandered into Resident #2 ' s room. Resident #2 reported that Resident #1 hit him first and then he slugged him in the face with a closed fist. Resident #2 did express remorse and said he was sorry. She stated Resident #1 did wander on the unit and occasionally would enter another residents room. Resident #1 couldn ' t speak, mostly smiled and had never displayed any aggressive behaviors towards other residents. Nurse #2 added she believed if Resident #1 was touching Resident #2 ' s things that could have been a trigger for him and he wouldn ' t like	F 600	recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. 4) Director of Nursing is responsible for implementing acceptable plan of correction.	

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F 600	Continued From page 5	F 600		

someone invading his space.

An interview on 2/6/19 at 2:36 pm with the DON revealed when Resident #1 wandered into Resident #2 ' s room he believed Resident #1 was invading his space and taking his food and this triggered his behavior. She added after this incident Resident #2 was sent out to the hospital for another psychiatric evaluation and they felt that he was safe to return to the facility. Resident #2 was seen by the in-house psychiatric NP and she determined the resident was safe to be moved off the secured unit as he no longer displayed elopement behaviors. The DON stated the resident hasn ' t displayed any aggressive behaviors since the incident on 1/2/19.

A phone message was left on 2/7/19 at 10:57 am for the NA that was assigned to Resident #2 on 1/2/19. No return call was received.

A phone interview was conducted on 2/7/19 at 11:51 am with Nurse #3 who was the nurse for Resident #2 during the incident on 1/2/19. She stated a staff member saw Resident #1 coming out of Resident #2 ' s room with a bloody nose and redness around his eye. Nurse #3 explained Resident #2 told her Resident #1 had entered his room and hit him in the eye. She added this seemed strange to her as Resident #2 had no visible injury to his eye and Resident #1 had never displayed any physical behaviors like that in the past. She stated she notified the DON and both residents were sent out to the hospital for evaluation. Nurse #1 added she explained to Resident #2 if something like that happened he should turn on his call light, so the staff could intervene versus taking the situation into his own hands. She stated Resident #2 stayed in his room

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F 600	Continued From page 6	F 600		

most of the day except for going out to smoke. He would occasionally refuse one of his medications but didn ' t display any aggressive behaviors routinely. Nurse #3 added she believed Resident #2 knew what he was doing when he hit Resident #1.

A phone interview on 2/7/19 at 12:30 pm with the facility psychiatric NP revealed she was very familiar with Resident #2 and had been working with him since his admission. She stated she spent a considerable amount of time with Resident #2 after the incident on 1/2/19. The resident told her Resident #1 wandered into his room and he asked him to leave. Resident #1 then got on his bed and he asked him to leave again. Resident #1 didn ' t respond to him and that was when he hit him. The NP explained Resident #2 didn ' t understand that Resident #1 had dementia and couldn ' t understand what Resident #2 was asking him to do. She added she discussed in length with Resident #2 that Resident #1 ' s dementia prevented him from understanding. She stated she didn ' t think this was a willful act on the part of Resident #2, but a misunderstanding related to him trying to protect his territory and Resident #1 not being able to understand what Resident #2 was telling him. The NP stated she didn ' t believe Resident #2 was high risk for aggression or aggressive acts in his current condition.

An interview with the DON on 2/7/19 at 3:35 pm revealed it was her expectation that residents were free from abuse while residing at the facility.