STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345573	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR ACRES UNITED METHODIST RETIREMENT COMMUNITY	1250 ARBOR ROAD 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
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an Emergency Preparedness (EP) Plan. The EP plan did not include policies and procedures for volunteers during an emergency, the plan did not contain the declared waiver by the Secretary and the communication plan did not have a method for sharing the information of the EP plan with the residents, residents' families and/or representatives. The EP plan also did not include contact information and names for the resident's	E 001	Tag 001-483.73 Establishment of the Emergency Program (EP) (Emergency Preparedness) 1. Our plan did not include policies and procedures for using volunteers in an emergency or other emergency staffing strategy. 2. Our EP plan did not include the declared waiver by the Secretary discussing the facility's role for the	7/2/19

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

Electronically Signed | 06/21/2019

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E 001	Continued From page 1 physicians, volunteers and staff. Findings included: A review of the facility's Emergency Preparedness plan revealed: a. The EP plan did not include policies and procedures for using volunteers in an emergency or other emergency staffing strategy. b. The EP plan did not include the declared waiver by the Secretary discussing the facility's role for the provision of care at an alternate care site that had been identified by emergency management officials. c. The EP plan did not have complete contact information of resident physicians, volunteers and staff. d. The EP manual's communication plan revealed no documentation as to how the facility would share the emergency plan information with the facility's residents, family members and /or resident representatives. During an interview with the interim Administrator on 5-30-19 at 4:22pm, the Administrator stated the facility had some changes in personal and felt parts of the EP plan had been misplaced. The Administrator was encouraged to send any further information to the team leader. She also stated she expected the EP plan to be corrected.	E 001	provision of care at an alternate care site that had been identified by emergency management officials. 3.The EP plan did not have complete contact information of resident physicians, volunteers and staff. 4. The EP manual's communication plan revealed no documentation as to how the facility would share the emergency plan information with the facility's residents, family members and/or representatives. We have added the following information, policy and procedures to our EP plan: 1.Arbor Acres EP plan includes information to be easily accessed during an emergency, to contact all employees and volunteers. It is the policy of Arbor Acres that all volunteers are briefed and directed with assignments from the incident commander. Only volunteers who are trained to the needs of the chronic, cognitively impaired and frail population can assist with transporting residents. The HR department maintains an updated contact list of all employees and volunteer's and it is updated annually or more often if need be. Arbor Acres also encourages every employee and volunteer to keep their email address, telephone and mailing address updated through our payroll system, which is Paycom. The HR department has been designated as the responsible party to contact all employees and volunteers. 2. It is the policy of Arbor Acres to ensure	

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E 001	Continued From page 2	E 001	collaboration with state and local officials and other facilities to plan a community-wide response to assure continuity of care under an 1135 waiver. Our procedure is, If Arbor Acres is impacted by a disaster to the degree that compliance to CMS requirements is not possible, the CEO, Incident Commander, or designee will submit a request to operate an 1135 waiver to the CMS Regional Office and State Survey Agency. The submission will include: Arbor Acres mailing address CMC Certification number Arbor Acres contact name and information An explanation of why the waiver is needed The scope and impact of the emergency or disaster. 3.Arbor Acres, healthcare administration staff is responsible for the updating of the residents face sheets, which include their physicians name and phone number, as well as, the name and phone numbers of their responsible parties. This information is kept in a binder along with the wrist band and can be located in the office of the healthcare administrative assistants office. This is to be used when an evacuation is needed. Arbor Acres ensures that all staff members and volunteers will be updated at least annually. This information will include telephone numbers, emergency numbers, and the facilities plans and family arrangements during an emergency situation.	

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E 001	Continued From page 3	E 001		

4.Arbor Acres policy is to ensure all family members and/POA's of residents and physicians are notified and provided the appropriate information at the time of an emergency and/or evacuation.
Means of communication to family members, staff, residents and stakeholders include email, phone, SARA mass communication, website, staffing software ,local TV station and Wellzesta.
If the phone system and email are not available at the time of an emergency, Arbor Acres maintenance department has satellite phones that will be used.

Arbor Acres maintains emergency contact numbers in addition to primary telephone numbers for resident's responsible parties and family members. Responsible parties and family members will be notified as quickly as possible when there is a disaster /emergency situation at the facility.
Designated staff members, which include all social workers and DON, are briefed on the following elements to share with residents and family members as assigned:
Type of threat
Estimated time and severity of impact
General outlook at the current time
Expected disruptions to services and routines
What the facility administration has done and is doing right now to lesson negative outcomes

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E 001	Continued From page 4	E 001	When to expect updated status reports What the residents, responsible parties, and family members can do to help Arbor Acres will maintain a face sheet on every residents which includes their emergency contact information and their physicians name and number. These will be kept in our EMR system and also a hard copy, along with the wrist band will be kept in the office of the Administrative Assistant. They will be updated on a weekly basis. Updates to our EP manual will be an on-going process as changes or updates occur. All corrections have currently been completed and updated as of 7/2/2019	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the skin section of a minimum data set (MDS) assessment for 1 of 2 residents reviewed for skin condition (Resident #4). Findings Included: Resident #4 was admitted to the facility on 5/9/19 and diagnoses included fracture of the left femur,	F 641	Tag 0641-483.209g): Accuracy of Assessments The MDS Coordinator failed to code a surgical incision as a surgical wound for Resident #4 on her admission assessment. This was corrected immediately by the MDS Coordinator on 5/30/2019.	7/2/19

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F 641	Continued From page 5 peripheral neuropathy, osteoarthritis and muscle weakness. Review of the nursing admission assessment dated 5/9/19 for Resident #5 revealed the resident had a surgical incision. An admission MDS assessment dated 5/16/19 for Resident #4 revealed section M1040 had not been checked for surgical wounds. An interview on 5/30/19 at 2:41 pm with the MDS Nurse revealed she had completed the admission MDS dated 5/16/19 for Resident #5. She stated she wasn ' t sure if a surgical incision would be coded as a surgical wound on the assessment. The Resident Assessment Instrument (RAI) manual was reviewed with the MDS nurse and she confirmed the definition of a surgical wound did include a surgical incision. She stated Resident #5 was receiving a treatment to a surgical wound during the look-back period for the admission assessment and she should have coded "yes" for surgical wound. An interview on 5/30/19 at 4:18 pm with the Administrator revealed it was here expectation that the MDS Coordinator coded the MDS assessments accurately.	F 641	Assessment was completed to address any other residents with surgical wounds and none were found. The MDS Coordinator was counseled on 5/31/2019 on the importance of accurate coding and has been instructed to seek advice if unsure before coding. To ensure accuracy of coding, Section M will be audited by the DON or her designee , daily for 2 weeks, then weekly for 4 weeks, and then monthly for 6 months. Results of the MDS audits will be submitted to the quality assurance committee and reviewed for 6 months.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		7/2/19

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F 689	Continued From page 6 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to complete a smoking assessment on a resident prior to allowing her to smoke independently at the facility and failed to provide a fire extinguisher in the designated smoking area. This was evident for 1 of 1 resident reviewed for smoking (Resident #4). Findings Included: Resident #4 was admitted to the facility on 5/9/19 and diagnoses included fracture of the left femur, peripheral neuropathy, osteoarthritis and muscle weakness. An admission minimum data set (MDS) dated 5/16/19 for Resident #4 revealed she used tobacco products and her cognition was intact. A care plan dated 5/25/19 for Resident #4 stated the resident had chosen to continue smoking. Interventions included to observe for safe smoking techniques that included ability to hold securely, ash without loosing the tip, extinguishing appropriately and disposing of butt. An observation on 5/25/19 at 10:51 am of Resident #4 revealed she was outside on the porch smoking a cigarette. The resident was accompanied by her private sitter. The resident had a pack of cigarettes and lighter with her. The private sitter was observed lighting a cigarette for the resident. The resident was observed holding and ashing the cigarette without difficulty. The private sitter was observed to extinguish the	F 689	Tag 0689-483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices 1. Resident #4 did not have a smoking assessment completed on date of admission. It was also discovered that the fire blanket was present in the fire extinguisher holder, however the fire extinguisher was not present. The nurse on duty completed the smoking assessment immediately on 5/29/2019. A fire extinguisher was placed in the appropriate box, in the designated smoking area, on this date as well. Nursing staff was educated on 5/31/2019 on the importance of all assessments to be completed on day of admission, quarterly, annually and any time that there is a change in the resident's condition. The Staff Development Coordinator added the smoking assessment to the check off sheet, on 5/29/2019, to ensure that this important assessment is not missed with future admissions. The nurse managers have added the assessment to their weekly checklist to ensure that all assessments are being completed in a timely manner. The nurse managers will audit all admissions, readmission, quarterly, and change of condition assessments to ensure all assessments are completed on admission, readmission, quarterly and	

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F 689	Continued From page 7 cigarette for the resident. An interview on 5/25/19 at 10:51 am with Resident #4 and her private sitter revealed the resident was able to smoke independently and she kept her cigarettes and lighter in her room. The sitter stated she typically came outside with the resident when she wanted to smoke, but she could come out on her own. Review of a smoking assessment dated 5/29/19 at 11:30 am for Resident #4 stated the assessment was to be completed for residents that wished to smoke on admission, quarterly, annually, with a significant change and if an incident of unsafe smoking was observed. The summary of evaluation indicated Resident #4 could smoke independently or with set-up. An observation on 5/30/19 at 10:56 am revealed Resident #4 was outside on the porch smoking accompanied by her private sitter. The porch which was a facility designated smoking area had a smoking blanket and an appropriate receptacle for extinguishing cigarettes. There was no fire extinguisher present in the smoking area. An interview on 5/30/19 at 10:56 am with Resident #4 revealed a nurse had completed a smoking assessment with her yesterday. The resident added she didn ' t recall this being done prior to yesterday. An interview on 5/30/19 at 11:00 am with Nursing Assistant (NA) #5 revealed she provided care for Resident #4. She stated the resident did smoke and could go out and smoke on her own whenever she wanted. NA #5 added the resident usually had a private sitter with her, but she didn '	F 689	when there is a change in resident's condition. This will be an ongoing process with no end date. The maintenance department uses an audit tool to check placement and expiration date of all fire extinguishers in all locations monthly. This will be indicated by dates and initials. This is an ongoing process with no end date. The results of the audits will be reviewed by the quality assurance committee for 12 months.	

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F 689	Continued From page 8 t have to be attended by a staff member. She stated the resident kept her cigarettes in her room, but she wasn ' t sure where her lighter was kept. An interview on 5/30/19 at 11:22 am with Nurse #5 revealed she had checked the smoking porch and she did not see a fire extinguisher present. An interview on 5/30/19 at 11:24 am with the Administrator revealed the facility had done some remodeling in that area and it appeared the fire extinguisher hadn ' t been reinstalled on the smoking porch. An interview on 5/30/19 at 11:34 am with the Director of Nursing (DON) revealed the smoking assessment for Resident #5 had not been completed until 5/29/19. She stated the smoking assessment should have been done on day the resident was admitted. An interview on 5/30/19 at 4:21 pm with the Administrator revealed it was her expectation that smoking assessments would be completed on the day of admission for residents that smoked. She stated all required safety equipment should be present in designated smoking areas.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		7/2/19

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F 812	Continued From page 9 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to seal, label and date food that had been opened in 2 different kitchen areas (the main kitchen and the Brock Kitchen), remove a dented can from the cooking area, maintain clean cooking equipment and ensure the chemical sanitizer was at the required level in the 3-compartment sink. This was evident in 3 of 3 kitchen observations. Findings included: The initial tour of the main kitchen area on 5-29-19 at 10:00am with the dietary manager revealed the following: 1. Half a black ham shank, a log of bologna, sliced turkey, tortia flats, half a red onion, half a yellow onion, a pan of macaroni and cheese, a container of gravy, a bag of cheddar cheese, a bag of swiss cheese and a bag of pepper jack cheese was noted to be in the walk-in cooler open without being dated. 2. 2 bags of frozen meatballs, a bag of imitation	F 812	Tag 0812-483.60(i)(1)(2)Food Procurement, Store/Prepare/Serve-Sanitary Food items were not sealed , labeled and dated in the walk-in cooler and dry storage areas. The chemical test for the sanitizer did not pass in the 3-compartment sink. All items that were not dated and labeled were immediately destroyed. All kitchen staff were educated 6/3/19 through 6/7/19 on the proper use of chemical testing for the sanitizer level of the 3-compartment sink, the importance of changing the water after each meal and ensuring foods are sealed, labeled and dated when stored. The Registered Dietician was promoted to the Director of Dining Healthcare. New checklists were developed for daily cleaning, weekly cleaning, and daily tasks to include sanitizer requirements for the 3-compartment sink.	

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F 812	Continued From page 10 lobster, chicken breasts and a pan of crab cakes was noted to be in the walk-in freezer open and not dated. 3. The dry storage room was noted to have a bar of white chocolate and a bag of coconut flakes open, not sealed and not dated. 4. The cooking area had a large rack of canned goods that were ready to be used and it was noted there was a 6 pound can of pizza sauce that was dented. 5. During the observation of the kitchen equipment it was noted the convection oven had a brown sticky and slippery substance on the doors, windows and frame of the oven as well as a white substance down the left side of the oven. Both the brown and white substances were noted to have dripped onto the floor below the convection oven. During an interview with the dietary manager on 5-29-19 at 10:30am, the manager stated he had "just started" working at the facility and had provided training with the kitchen staff "about a month ago" the importance of dating items when they are opened. The manager stated he did not know why the items found had not been dated or why there was a dented can in the cooking area "staff will usually put the dented cans in my office." The manager also stated he could not recall the last time the convection oven had been cleaned on the outside but stated "someone must have spilt something and needs to clean it up." The initial tour of the Brock Kitchen area with the dietician on 5-30-19 at 11:45am revealed the following:	F 812	Audits of the storage areas and the 3-compartment sink will be conducted daily for at least 2-4 weeks by kitchen managers. The Dining Director will conduct spot checks ongoing with no end date. Results of the kitchen audits will be submitted to the quality assurance committee and reviewed for 12 months.	

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F 812	Continued From page 11	F 812		

1. The reach in freezer was noted to have a bag of waffle sticks and approximately 15 turkey burgers that were open and not dated.

During an interview with the dietician on 5-30-19 at 11:50am, the dietician stated she checked for items to be dated daily and did not know how the items in the freezer were not dated.

During a return visit to the main kitchen on 5-30-19 at 12:50pm, a chemical test was performed on the sanitized water in the rinse sink with a dietary manager. The sanitized water was noted to have a cutting board in it. The dishwasher stated he had "just placed it in the sink after I washed it." The chemical test for the sanitized water did not pass. The dishwasher stated the water had been in the sink since he had washed the breakfast dishes. He also denied changing the sanitized water between meals "No it usually stays in there all day because it does not need to be at a certain temperature." The dietary manager had the dishwasher drain the current water and refill the sink with fresh water and sanitizer. A second chemical test was performed and was found to be within satisfactory range.

The interim Administrator was interviewed on 5-30-19 at 4:22pm. The Administrator stated she expected policies and procedures to be followed and that she would review the policy and procedures with the kitchen staff and determine what needed to change or improve.