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	345479	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEMTOWNE	**1550 BABCOCK 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
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		12/16/21

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

Electronically Signed | 12/03/2021

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(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under

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E 037	Continued From page 2	E 037		

arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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E 037	Continued From page 3	E 037		

(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency

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E 037	Continued From page 4 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and Administrator interview, the facility failed to provide and maintain documentation of annual staff training on the facility's Emergency Preparedness Plan. The findings were: A review of the facility's Emergency Preparedness Plan (EP) that was updated on 8/25/21 did not include no documentation of the annual training for staff on the EP plan. On 11/18/21 at 2:15 PM, the Administrator was interviewed. He stated he did not have any documentation that annual training on the EP plan was completed. The Administrator explained he thought the tabletop exercises counted as the training.	E 037	"Documentation for emergency preparedness training for new and existing staff, both upon hire and at least annually, was not produced to surveyors when requested. As a result, all residents are affected by this deficient practice. "To ensure that this deficient practice does not recur, a presentation on emergency response will be created by 12/16/21. This presentation will serve as an in-service for all new staff during new hire orientation and will be given annually to all existing staff every March annually. All existing team members will be in-serviced by the Director of Facilities or his designee on emergency preparedness by 1/31/22. "The facility will monitor our performance to ensure that solutions are sustained by maintaining in-service sign in sheets for each orientation class and for each annual training that is delivered in March for at least 1 year. The practice of maintaining logs for 1 year will be ongoing and maintained by the Human Resource Department. The records will be reviewed	

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E 037	Continued From page 5	E 037	annually by the Administrator or his designee.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/15/21 through 11/18/21. Event ID# HQOJ11. 2 of the 2 complaint allegations were not substantiated.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		12/31/21

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F 550	Continued From page 6 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident representative interview, staff interviews and record review, the facility failed to provide a dignified dining experience by standing over a resident while providing assistance with feeding for 1 of 8 residents (Resident #3) reviewed for assistance with dining. Findings included: Resident #3 was admitted to the facility on 4/29/20 with diagnoses that included, in part, dementia and gastro-esophageal reflux disease. The significant change in condition Minimum Data Set assessment dated 10/29/21 revealed Resident #3 had severely impaired cognition. She required limited assistance with eating. An activities of daily living care plan updated 8/10/21 revealed, "Provide encouragement for intake and may require limited assist at meals." On 11/15/21 at 1:07 PM Resident #3 was	F 550	"CNA #3 and CNA #4 were provided education on assisting residents with meals while sitting eye-level in order to provide a dignified experience on 11/18/2021. "Those who require assistance with eating have the potential to be affected by this deficient practice. In order to identify those residents, all residents will be assessed to see if they need assistance with eating by 12/30/2021. "To ensure that this deficient practice does not recur, all nursing personnel will be in-serviced on providing a dignified dining experience by 12/31/2021. "To monitor our performance and ensure that solutions are sustained, the Director or Nursing or her designee(s) will make rounds during breakfast, lunch, and/or dinner (at least one meal per day being monitored) and review 3 residents per	

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F 550	Continued From page 7	F 550		

observed in her bed in an upright seated position. A lunch tray was in front of her on the overbed table. At 1:13 PM Nurse Aide (NA) #3 entered the room and began feeding the resident. NA #3 stood next to the resident's bed as she provided the resident with feeding assistance. NA #3 stood above eye level of the resident for the duration of the meal while she fed Resident #3. NA #3 asked the resident if she wanted to feed herself, to which the resident replied, "No." The resident indicated she didn't want any more food. NA #3 offered to get some cake for the resident and Resident #3 agreed. At 1:16 PM NA #3 returned to the room and fed a piece of cake to Resident #3 while she stood next to the bed. NA #3 exited the resident's room at 1:19 PM.

An interview was completed with NA #3 on 11/16/21 at 1:20 PM, during which she stated Resident #3 needed assistance when she ate her meal. She said she stood up when she fed Resident #3 because she "knew she probably wouldn't eat much" and added she also had to complete her medication pass. NA #3 reported she was aware she needed to be seated when she fed a resident.

On 11/17/21 at 9:10 AM Resident #3 was observed lying in her bed. NA #4 entered the resident's room, sat the resident in an upright position in the bed and placed a clothing protector on her. NA #4 set up the breakfast tray and fed Resident #3. NA #4 stood above eye level of the resident for the duration of the meal while she fed the resident. At 9:18 AM the resident indicated she was finished eating and NA #4 removed the breakfast tray.

In an interview with NA #4 on 11/17/21 at 9:25 AM

meal to ensure residents are being assisted with dignity. The audit will follow this frequency: 5 days a week for 2 weeks, 3 days a week for 2 weeks, 1 day a week for 2 weeks, and 1 time a month for 2 months. If continued and regular non-compliance occurs, the monitoring will restart. Findings of this audit will be presented to the QAPI committee.

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F 550	Continued From page 8 she stated the resident needed to be fed her meals and she normally stood when she fed Resident #3 since there was not a chair in the room that could be placed next to the bed. She explained the facility "didn't say either way" if staff were to sit or stand when they fed a resident. An observation of Resident #3's room during the interview with NA #4 revealed there was a chair located near the foot of the resident's bed. Resident #3's representative was interviewed by phone on 11/16/21 at 11:26 AM. She thought Resident #3 would want staff to be seated when they fed her to promote a more dignified dining experience. During an interview with the Director of Nursing on 11/18/21 at 10:13 AM, she explained staff should be seated when they fed a resident and "would not expect them to be standing." She was unsure if protocol for feeding residents was included in the new hire orientation process. An interview was completed with the Clinical Education Director on 11/18/21 at 10:20 AM during which she said staff were supposed to be seated when they fed residents. She shared the information was included in the new hire orientation process but was unsure if it was included in the annual training of nursing staff. During the orientation process she instructed nursing staff they were to be seated when they fed a resident so they were at eye level and were not to stand over a resident when feeding them.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		12/31/21

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F 656	Continued From page 9 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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section.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to implement care planned Interventions for pressure reducing devices for 1 of 2 residents reviewed for positioning (Resident #43) and 1 of 2 residents reviewed for pressure ulcers (Resident #28).

The findings were:

1. Resident #43 was admitted to the facility on 9/22/15 with diagnoses of hemiplegia following cerebrovascular accident and vascular dementia.

A quarterly Minimum Data Set assessment dated 9/30/21 revealed Resident #43 had severely impaired cognition and required extensive assistance to total dependence of 1-2 people for bed mobility and transfers, was non-ambulatory and incontinent of bowel and bladder. She was at risk of pressure ulcer development and had no current pressure ulcers.

The care plan reviewed on 9/30/21 included a focus area of risk for pressure ulcers related to a history of pressure ulcers to left great toe and left heel. Interventions included heel protectors to be worn every shift while in bed.

Resident #43 ' s care guide listed heel protectors while in bed under skin precautions.

The November 2021 physician ' s orders included an order dated 5/30/17 to wear heel protectors every shift while in bed.

On 11/16/21 at 3:45 PM, Resident #43 was

•When we learned that a care planned intervention was not implemented for resident number 43 and resident number 28, the Director of Nursing educated the CNAs for resident number 43 and resident number 28 to follow the care plan for pressure reducing interventions on 11/18/2021. On this date, the Director of Nursing also educated the Nurses responsible for resident number 43 and resident number 28 on the expectation to supervise and monitor CNA adherence to care plan interventions.

•To identify other residents having the potential to be affected by the same deficient practice, the care plans for all residents with pressure ulcers were reviewed to ensure that care plans for reducing and caring for pressure ulcers were accurate. This review will be completed by 12/15/2021.

•The Director of Nursing or her designee will in-service all CNAs and Nurses by 12/31/21 on following care plans, adhering to care planned interventions, and the role of the nurses to monitor the care that is being given. This in-service will also be added to new-hire orientation for all Nurses and CNAs.

•Per the following frequency, the Director of Nursing or her designee will randomly select 3 residents that are care planned for pressure reducing interventions and

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F 656	Continued From page 11 observed in bed with no heel protectors on. On 11/17/21 at 4:00 PM, Resident #43 was observed in bed with no heel protectors on. On 11/18/21 at 1:31 PM, Resident #43 was observed in bed with no heel protectors on. Two heel protectors were observed on the windowsill of the room. On 11/18/21 at 2:28 PM, NA #1 was interviewed. She stated Resident #43 does wear heel protectors. When asked why she wasn ' t wearing them, NA #1 stated the night shift gets her out of bed in the morning and takes them off. NA #1 added she does put the heel protectors on when she is assigned to the resident. On 11/18/21 at 11:45 AM, the Director of Nursing was interviewed. She stated the nursing assistants should be applying heel protectors and the nurses are responsible for making sure the care planned interventions are implemented. 2. Resident #28 was admitted to the facility on 6/7/21 with diagnoses of vascular dementia, prostate cancer, and failure to thrive. A quarterly Minimum Data Set dated 9/2/21 revealed Resident #28 had severely impaired cognition, required extensive assistance of one person for bed mobility and eating, extensive assistance with two people for transfers and toileting. Resident #28 was always incontinent of bladder and frequently incontinent of bowel. Resident #28 was at risk for pressure ulcers and had no unhealed pressure ulcers during the look back period.	F 656	inspect to ensure that care plans are being followed: 5 days a week for 2 weeks, 3 days a week for 2 weeks, 1 day a week for 2 weeks, and 1 time a month for 2 months. If continued and regular non-compliance occurs, the monitoring will restart. Findings of this audit will be presented to the QAPI committee.	

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(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
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Resident #28 ' s care plan (date not obtained) indicated a focus problem of pressure ulcers due to failure to thrive and weight loss. Interventions included treatments as ordered and float heels while in bed.

Resident #28 ' s care guide for skin precautions listed float heels when in bed.

On 11/17/21 at 4:00 PM, Resident #28 was observed in bed with his heels flat on the mattress and not floated.

On 11/18/21 at 7:51 AM, Resident #28 was observed in bed with his heels flat on the mattress and not floated.

On 11/18/21 at 11:01 AM, an interview was conducted with NA #2. She stated she has never floated Resident #28 ' s heels because the nurse has never told her to. She stated she went into his room and checked on him but has not floated his heels.

On 11/18/21 at 11:45 AM, the Treatment Nurse was interviewed. She stated she has educated nursing assistants and nurses about Resident #28 needing to have his heels floated.

On 11/18/21 at 11:45 AM, the Director of Nursing was interviewed. She stated the nursing assistants should be floating Resident #28 ' s heels and the nurses should be making sure care planned interventions are implemented.