STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345479	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEMTOWNE	**1550 BABCOCK DRIVE WINSTON SALEM, NC 27106**

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E 000	Initial Comments An unannounced Recertification Survey was conducted 4-10-23 through 4-20-23. The facility was not found in compliance with the requirement CFR 483.73, Emergency Preparedness, and was cited at E-0001. Event ID # 4N4E11	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] 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: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[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	E 001		5/18/23

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

Electronically Signed | 05/05/2023

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[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. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan indicating EP collaboration with local stakeholders, did not update or review arrangements with other facilities, nor update names and contact information of staff. Findings included: a) Review of the EP plan on 4/14/2023 revealed the plan did not include a process to contact and collaborate with local emergency preparedness officials in an effort to maintain an integrated response during a disaster or emergency situation. Further review revealed the plan did not contain that facility administration had met with local emergency preparedness officials and the plan did not contain contact information for the local emergency preparedness officials. b) Review of the EP plan on 4/14/2023 revealed the plan did not include current or former names	E 001	1.Corrective action for the alleged deficient practice regarding the Establishment of the Emergency Program: The emergency plan will include a process to contact and collaborate with local emergency preparedness officials in an effort to maintain an integrated response during a disaster or emergency situation. Facility administration met with the local emergency management officials in an effort to maintain an integrated response during a disaster or emergency situation. Contact information for emergency preparedness officials will be included in the emergency plan. An updated employee list with contact information, to include the senior leadership team, will be placed in the emergency plan. Resident physicians have been placed in the binder. The emergency plan will include other long-term care facilities which could be used as alternate housing in the event of evacuation.	

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E 001	Continued From page 2 and contact information of the staff, and residents' physicians, or other long-term care facilities which could be used as alternate housing in the event of evacuation. c) The EP plan did not show yearly review by the administrator. An interview with the Administrator on 4/14/2023 at 10:35 AM revealed that she was unable to locate the information in the EP binder regarding contact information for staff, residents' physicians, and other long-term care facilities and was unable to locate the information regarding how the facility contacted and collaborated with local emergency officials. The Administrator stated that the information should be located in the EP binder.	E 001	2. Corrective action taken for Establishment of the Emergency Program: Facility administration met with the Winston-Salem Forsyth County Office of Emergency Management on 5/3/2023 to discuss contact information for the local emergency preparedness officials and the procedure for contacting them during an emergency. Facility staff (NHA, Director of Facilities, and Resident Services Coordinator) are enrolled in the June 07, 2023, Triad Healthcare Preparedness Coalition for a Regional Licensed Care Facility Table Top Exercise. The NHA will review the emergency plan with the leadership team and will continue to review on an annual basis. The NHA spoke with the Fire Marshal on 5/3/2023 to discuss a review of our plan. This plan will be submitted to the Fire Marshal for review. 3. Measures/Systemic changes put in place to ensure the alleged deficient practice does not reoccur: On an annual basis, the NHA/designee will attend a Triad Healthcare Preparedness Coalition drill. This is currently scheduled for June 07, 2023. On a monthly basis, an updated list of employees and contact information will be swapped out of the emergency plan binder. When there is a change in leadership, the emergency plan will be updated. On an annual basis, the NHA/designee will meet with the Winston-Salem Forsyth County Office of Emergency Management to discuss the emergency plan and the procedure for	

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E 001	Continued From page 3	E 001	contacting them during an emergency. On an annual basis, the NHA/designee will review the emergency plan. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The emergency plan will be brought to QAPI for three months for review and then quarterly thereafter to review emergency preparedness plan indicating collaboration with local stakeholders, updated arrangements with other facilities, and to ensure names and contact information of staff is current. The resident physician list will be reviewed to ensure it is current. 5. Date compliant: 5.18.2023	
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation was conducted from 4-10-23 to 4-14-23. Additional information was gathered offsite on 4-20-23 making the exit date 4-20-23. Event ID# 4N4E11. The following intakes were investigated NC00198979, NC00193732, NC00193175. One of four complaint allegations resulted in a deficiency.	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.	F 550		5/18/23

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F 550	Continued From page 4 §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 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 record review, resident, staff interviews and student interviews, the facility failed to treat a resident in a dignified manner when a Nursing Assistant (NA) told a resident to use his brief when the resident requested assistance with	F 550	1. Corrective action for the resident affected by the alleged deficient practice: Resident #69 stated he felt dirty when the C.N.A. caring for him told him to use his brief instead of taking him to the	

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F 550	Continued From page 5 toileting to the bathroom for 1 of 2 residents reviewed for dignity (Resident #69). Resident #69 stated the NA's statement and lack of assistance made him feel dirty. The findings included: Resident #69 was admitted to the facility 3/30/22 with diagnoses that included other sequelae (medical conditions resulting from stroke) of cerebral infarct, difficulty walking, other lack of coordination, muscle weakness, reduced mobility, and unspecified lack of coordination. Review of Resident #69's Care Plan dated 4/14/22 revealed the problem of history of Urinary Tract Infection (UTI) with risk for Moisture-Associated Skin Damage (MASD) requiring extensive to total assist with toileting/incontinent care. The goal was for Resident #69's skin to remain intact. The interventions included assist Resident #69 to the toilet and provide proper hygiene upon request. The quarterly Minimum Data Set (MDS) dated 7/22/22 revealed Resident #69 was cognitively intact and was coded as requiring extensive assistance with two staff assist for both bed mobility and toileting. The resident was coded as being occasionally urinary incontinent and always bowel incontinent. The Initial Allegation Report/24-Hour Report dated 9/8/22 written by Nurse #5 (Clinical Lead) revealed an allegation that Resident #69 was neglected. The incident was alleged to have occurred on 9/6/22-9/8/22. The report further revealed the facility became aware of the incident on 9/8/22 at 1:15 PM. The allegation details	F 550	bathroom. C.N.A. caring for Resident #69 was terminated. Resident said he felt dirty. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents that require assistance with toileting have the potential to be affected. Residents will be offered toileting options and assistance. This will be completed by 5/18/2023 by DON/Designee. 3. Measures/Systemic changes put in place to ensure the alleged deficient practice does not reoccur: Nursing staff to be in serviced by DON/Designee on Resident Rights to include option of using the bathroom. Active nursing staff will have completed the in-service by 5/18/2023. PRN staff will be in serviced before starting their next shift. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/Designee will conduct random audits of residents who use the bathroom to ensure they have been offered the bathroom or taken to the bathroom when requested. DON/Designee will conduct random audits of residents who are both continent and incontinent that request use of the bathroom to ensure their rights have been respected. Audits will be done no less than 2 per day 5 times weekly x4 weeks on all units and rotating shifts to ensure residents are living in a dignified manner. Audits will then continue with 10 residents	

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F 550	Continued From page 6 stated that student NAs reported NA #1 refused to change Resident #69. The report further revealed NA #1 yelled at him that he needed to use his brief. Resident #69 stated he did not want to use his brief and NA #1 continued to scream at Resident #69 stating he needed to use his brief. NA #1 left Resident #69 without assisting him. No bruising or injuries were noted. The Initial Report/24-Hour Report had witness statements from the Instructor of NA Students, NA Student #1, and NA Student #2. a) Witness statement dated 9/8/22 written by the Instructor of NA Students stated she had several students approach her regarding incidents by NA #1 on Mill Place Hall. NA #1 was paired up with students for the week. The Instructor of NA Students reported the incidents to a nurse on Garden Court Hall because there was an agency nurse on Mill Place Hall. The Instructor of NA Students also reported the incidents to the Assistant Director of Nursing (ADON). b) Witness statement dated 9/6/22 written by Student NA #1 revealed the morning of 9/6/22, Resident #69 stated he needed to use the restroom. NA #1 screamed at Resident #69 that he was going to have to use his adult brief. Resident #69 told NA #1 that he did not want to use his brief. The witness statement further stated NA #1 told Resident #69 that she could not help him at that time, and he was going to have to go to the bathroom in his brief. NA #1 walked away. c) Witness statement dated 9/6/22 written by Student NA #2 revealed NA #1 was passing out breakfast trays when Resident #69 indicated he needed to use the bathroom. NA #1 told Resident #69 she did not have time to get him out of bed	F 550	monthly x 3 months, and then 10 residents will be audited quarterly as needed until 95% compliance is achieved. Any negative patterns will be presented to QAPI monthly for further review and recommendations. 5. Date compliant: 5.18.2023	

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until after breakfast. Resident #69 repeated his need to use the bathroom and NA #1 told him to just use his brief. The witness statement continued that Resident #69 told NA #1 that he did not want to use his brief and NA #1 continued to tell him she was not going to move him until later.

Review of the Five-Working Day Report/investigation submitted 9/13/22 revealed the facility investigated an allegation of neglect by NA #1. The report further revealed the allegation was substantiated. The attached investigative summary written by former Director of Nursing (DON) #2 stated on 9/8/22 the Instructor of NA Students approached Nurse #5 and revealed her students had expressed concerns with NA #1. The Instructor of NA Students obtained written statements from NA students (NA Student #1 and NA Student #2) that described potential resident neglect of Resident #69. The Investigative Summary's conclusion stated the facility substantiated the allegation of resident neglect regarding Resident #69 due to NA #1 telling Resident #69 to use his brief when he requested assistance to use the toilet. NA #1 was immediately suspended and formally terminated on 9/12/22.

An interview with Resident #69 on 4/12/23 at 3:14 PM revealed he recalled a nursing staff (name unknown) had told him to go to the bathroom in his brief. Resident #69 could not recall the date of the incident but stated he utilized a talking clock to keep himself informed of the time due to his visual impairment. He recalled having to use his call bell multiple times to get assistance to go to the bathroom, but no staff returned to clean him up after he had a bowel movement (BM).

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During a second interview on 4/13/23 at 11:25 AM, Resident #69 recalled that the nurse telling him to use his brief after he requested assistance to the toilet made him feel dirty.

A phone interview was attempted on 4/13/23 at 2:06 PM and again on 4:51 PM with NA #1. Messages were left and the phone calls were not returned.

An interview on 4/13/23 at 2:36 PM was conducted with Social Worker (SW) #2. She recalled that in response to the allegations of neglect of Resident #69, she conducted interviews of cognitively intact residents, asking if they had been abused physically or verbally, if they felt safe, or had any other concerns.

A phone interview on 4/13/23 at 4:51 PM Nurse #5 (Clinical Lead) revealed she became aware of an allegation of neglect on 9/8/22 by the Instructor of NA Students. She was informed by the Instructor of NA Students that NA students were uncomfortable being with NA #1. The NA students had given verbal descriptions of witnessing NA #1 tell Resident #69 to use his brief after he requested assistance to the toilet. Nurse #5 stated she had completed the 24-Hour Report, obtained NA students' contact information, and requested written witness statements. She further recalled directing the Instructor of NA Students to the former DON #2 to provide further details. Nurse #5 stated she recalled Resident #69 wore briefs as he was continent with incontinent episodes. Resident #69 was able to communicate his needs and would occasionally have the urge to have a bowel movement (BM) and would ask to use the toilet.

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Nurse #5 revealed she did not provide Resident #69 incontinent care but thought Nurse #4 had assisted Resident #69.

An interview was conducted by phone with Nurse #4 on 4/13/23 at 5:15 PM. She indicated she was assigned to Mill Place unit on day shift 9/8/23. She further stated she recalled several nursing students on the unit, and she was notified by Nurse #5 of the allegation of neglect of Resident #69. Nurse #4 revealed she had not provided Resident #69 incontinent care following the allegation and was unaware if any staff had provided incontinent care.

A phone interview was attempted on 4/14/23 at 9:57 AM with Student NA #2. The phone number had been disconnected and was no longer in service.

Interview by phone with Student NA #1 on 4/14/23 at 10:00 AM revealed she had witnessed Resident #69 request assistance to use the bathroom and was told by NA #1 she did not have time. NA Student #1 further stated NA #1 referred to Resident #69's brief as a diaper and would tell him to use his diaper. Resident #69 stated he did not want to use his brief and appeared to become visibly upset as evidenced by a grimaced look on his face. Student NA #1 revealed NA #1 denied Resident #69 assistance and walked out of the room. Resident #69 continued to request assistance to use the toilet and was ignored by NA #1. Student NA #1 indicated she notified the Instructor of NA Students of NA #1's refusal to provide Resident #69 incontinent care. Student NA #1 indicated that as a nursing student, she was unable to provide residents incontinent care without the assistance of a NA. Student NA #1

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further revealed she provided a written statement of what she had observed.

A phone interview on 4/14/23 at 2:55 PM with former DON #2 revealed she recalled a telephone call from the ADON on 4/8/22, who described details provided by the Instructor of NA Students and her students regarding the allegation of neglect by NA #1 toward Resident #69. DON #2 stated she conducted the investigation and substantiated NA #1 neglected Resident #69, who was told to go to the bathroom in his brief, which was not the policy of care for residents. DON #2 revealed she did not recall if someone assisted Resident #69 to the bathroom.

An interview with Administrator #1 on 4/14/23 at 3:59 PM revealed the staff were trained to assist a resident to the bathroom when requested, and to never tell a resident to go to the bathroom in their brief. She further revealed if the NA felt they were too busy, the call light should be left on, the resident was to be reassured that the NA was aware of the resident's needs, and that they were going to get assistance of another NA or nurse.