STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Forsyth County Department of Social Services conducted an annual and follow-up survey 01/29/20 through 01/31/20.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled Medication	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 164	Continued From page 1	D 164		

Aides (Staff B and C), who administered insulin and obtained finger stick blood sugars for residents, completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of Staff B's, medication aide, personnel record revealed:
-There was a hire date of 05/01/17.
-The Medication Clinical Skills Validation checklist was completed and dated 05/09/17.
-There was no documentation Staff B had completed training on the care of diabetic residents.

Review of the November 2019 electronic Medication Administration Record (eMARs) revealed there was documentation Staff B administered insulin on the following dates: 11/01/19, 11/04/19, 11/05/19, 11/06/19, 11/07/19, 11/09/10, 11/10/19, 11/12/19, 11/13/19, 11/14/19, 11/15/19, 11/18/19, 11/19/19, 11/24/19, 11/26/19, 11/27/19, 11/28/19, and 11/29/19.

Review of the December 2019 eMARs revealed there was documentation Staff B administered insulin on the following dates: 12/02/19, 12/03/19, 12/04/19, 12/05/19, 12/07/19, 12/08/19, 12/10/19, 12/11/19, 12/12/19, 12/13/19, 12/16/19, 12/17/19, 12/18/19, 12/19/19, 12/21/19, 12/22/19, 12/24/19, 12/25/19, 12/26/19, 12/27/19, 12/30/19 and 12/31/19.

Review of the January 2020 eMARs revealed there was documentation Staff B administered insulin on the following dates: 01/01/20, 01/02/20, 01/04/20, 01/05/20, 01/07/20, 01/08/20, 01/09/20, 01/10/20, 01/13/20, 01/14/20, 01/15/20, 01/16/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 164	Continued From page 2 01/18/20, 01/19/20, 01/21/20, 01/22/20, 01/23/20, 01/24/20, 01/27/20, and 01/28/20. Interview with Staff B on 01/30/20 at 7:32pm revealed: -She had worked as a medication aide at the facility since 2017. -When she worked, she passed medications including insulin injections. -When she first started working at the facility training was provided by a nurse. -She was unable to recall if the training included diabetic training. Interview with the Administrator on 01/30/20 revealed: -The Business Office Manager was responsible for all employee records. -She did not know Staff B had not received the required diabetic training. -Staff B was a medication aide and when Staff B worked, she checked fingerstick blood sugars and gave insulin injections to diabetic residents. Refer to the interview with the BOM on 01/30/20 at 3:30pm. 2. Review of Staff C's, medication aide, personnel record revealed: -There was a hire date of 04/28/15. -The Medication Clinical Skills Competency Validation checklist was completed and dated 05/13/15. -There was no documentation Staff C had completed training on the care of diabetic residents. Review of the November 2019 electronic Medication Administration Record (eMARs) for three residents revealed there was	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 164	Continued From page 3	D 164		

documentation Staff C administered insulin on the following dates: 11/01/19, 11/04/19, 11/05/19, 11/06/19, 11/07/19, 11/09/10, 11/10/19, 11/11/19, 11/12/19, 11/13/19, 11/18/19, 11/19/19, 11/20/19, 11/21/19, 11/22/19, 11/26/19, 11/27/19, 11/28/19 and 11/29/19.

Review of the December 2019 eMARs for three residents revealed there was documentation Staff C administered insulin on the following dates: 12/02/19, 12/03/19, 12/04/19, 12/05/19, 12/06/19, 12/07/19, 12/08/19, 12/09/19, 12/10/19, 12/11/19, 12/12/19, 12/13/19, 12/16/19, 12/17/19, 12/18/19, 12/21/19, 12/22/19, 12/24/19, 12/26/19 and 12/27/19.

Review of the January 2020 eMARs for three residents revealed there was documentation Staff C administered insulin on the following dates: 01/05/20, 01/07/20, 01/08/20, 01/09/20, 01/10/20, 01/13/20, 01/14/20, 01/15/20, 01/16/20, 01/18/20, 01/19/20, 01/20/20, 01/22/20, 01/23/20, 01/27/20, 01/28/20 and 01/29/20.

Staff C was not available for interview.

Interview with the Administrator on 01/30/20 at 6:50pm revealed:
-The Business Office Manager (BOM) was responsible for all employee records.
-She did not know Staff C had not received the required diabetic training.
-Staff C was a medication aide on the first shift.
-Staff C administered medications, checked fingerstick blood sugars and administered insulin injections to diabetic residents.

Refer to the interview with the BOM on 01/30/20 at 3:30pm.

_____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 164	Continued From page 4 Interview with the BOM on 01/30/20 at 3:30pm revealed: -She started working at the facility in November 2019. -She was responsible for ensuring staff had all the required trainings. -She had not checked staff records to ensure trainings had been completed. -She did not know staff had not completed training related to the care of diabetic residents.	D 164		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews and record reviews the facility failed to provide supervision to meet the needs of 1 of 3 sampled residents (Resident #1) who was found on the floor 21 times within eleven months causing abrasions, skin tears, and scrapes to the resident's back, arms and legs. The findings are:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 5 Review of Resident #1's current FL2 dated 01/29/19 revealed: -Diagnoses included Parkinson disease, paroxysmal atrial fibrillation, aortic stenosis, thrombocytopenia, and type II diabetes. -Level of care was assisted living. -Orientation was intermittently disoriented. -Ambulatory status was semi ambulatory using a wheelchair. -Resident #1 was occasionally incontinent of bowel. -The physician documented on the current FL2 dated 01/29/19 "Resident #1 will need assistance when she gets up at night. Resident #1 will need assistance with transfers from bed, bath, etc. at increased risks for falls." Review of Resident #1's Resident Register revealed an admission date of 02/15/19. Review of Resident #1's care plan dated 09/05/19 revealed: -Resident #1 required limited assistance with ambulation and dressing. -Resident #1 required supervision assistance with toileting and bathing. -Resident #1 was independent with eating, grooming and transferring. -There was no documentation related to supervision needs. Review of the Licensed Health Professional Support (LHPS) evaluation dated 12/03/19 revealed: -The Registered Nurse (RN) completing the LHPS documented Resident #1 ambulated with a rollator. -Staff were to assist Resident #1 with sit to stand transfers as needed, transferring out of bed and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 6	D 270		

off the commode.
-The RN documented Resident #1 had a history of multiple falls and had a documented fall on 11/30/19.

Review of the facility's "Narrative Charting" notes dated 02/17/19 at 3:00pm to 11:00pm revealed Resident #1 slipped and fell to the floor. No injuries documented.

Review of the facility's "Narrative Charting" notes dated 03/05/19 at 4:17pm revealed Resident #1 was observed on the floor hitting the back of her head on the nightstand. Resident #1 was sent to the hospital.

Review of the facility's "Narrative Charting" notes dated 03/31/19 at 9:15pm revealed Resident #1 fell and was observed on the floor. No injuries noted.

Review of the facility's "Narrative Charting" notes dated 04/03/19 at 7:00am to 3:00pm revealed staff found Resident #1 on the floor. The resident told staff she fell backwards while getting out of her chair. Resident #1 hit her bottom on the floor.

Review of the facility's "Narrative Charting" notes dated 04/07/19 at 8:30am revealed staff observed Resident #1 lying on the floor on her right side. Resident #1 complained of back pain and was sent to the hospital.

Review of the facility's "Narrative Charting" notes dated 04/09/19 at 8:30am revealed Resident #1 fell and was found on the floor. No injuries noted.

Review of the facility's "Narrative Charting" notes dated 05/21/19 at (no time documented) revealed Resident #1 fell and was found on the floor. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 7	D 270		

injuries noted and no complaints of pain.

Review of the facility's "Internal incident report" dated 08/10/19 at 7:30pm revealed staff found Resident #1 lying on the floor. Staff documented Resident #1 had visible bruising to the forehead and a skin tear to her forearm. Resident #1 refused to go to the hospital.

Review of the facility's "Internal incident report" dated 08/12/19 at 3:30pm revealed Resident #1 called for assistance because she fell to the floor. The resident told staff she was coming from the bathroom. There were no injuries documented.

Interview with a second shift MA on 01/30/20 at 7:44pm revealed:
-She was unable to recall the incident on 08/12/19 when Resident #1 fell.
-Resident #1 always fell, because she thought that she could get herself up from a sitting position.
-Sometimes Resident #1 was successful getting herself up from a sitting position, but she was not successful every time and she fell to the floor.
-She checked on Resident #1 and observed the resident every two hours.
-When she checked on Resident #1 she asked the resident if she needed anything.
-Also, when she checked on the resident she observed the resident's disposition (sitting in the common area, in bed, in the bathroom, etc.).
-She was not sure if Resident #1 was checked on more often that would eliminate falls because Resident #1 would still get up.
-No instructions had been given to check on Resident #1 more often than every two hours.

Review of a "Physician visit report" dated 08/13/19 revealed staff documented Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 8 fell twice two weeks ago. The resident was observed on the floor and had no complaints of pain. Interview with a second shift MA/PCA on 01/30/20 at 6:45pm revealed: -She sent the fax to Resident #1's physician on 08/13/19 but was unable to recall specifics of the incident. -Resident #1 "fell often." -She checked on Resident #1 every two hours. -She was not sure if she checked on Resident #1 more frequently that would eliminate the falls because Resident #1 would still get up when she left the room. -The Administrator was aware that Resident #1 had frequent falls. -No instructions had been given to check on Resident #1 more frequently. Review of a hospital discharge summary report dated 08/26/19 revealed Resident #1's reason for the visit was a fall. Review of the facility's "Internal incident report" dated 09/28/19 at 5:00am revealed Resident #1 called for staff help. Staff observed Resident #1 sitting on the floor in front of her bed. No injuries were documented. Review of the facility's "Narrative Charting" notes dated 11/13/19 (no time documented) revealed upon administering medications Resident #1 told staff she fell the previous night but did not tell staff. Will continue to monitor. Review of the facility's "Internal incident report" dated 11/26/19 at 4:30am revealed Resident #1 called for staff. Staff observed Resident #1 on the floor in her bathroom. Resident #1 complained of	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 9	D 270		

discomfort in her right leg. Resident #1 refused to go to the hospital.

Review of the facility's "Internal incident report" dated 11/30/19 at 2:30pm revealed Resident #1 was found on the floor. Staff documented the resident said her "legs were not working well." Resident #1 scrapped her back on the bed causing an abrasion on her lower back.

Review of a "Order Request/clarification" form dated 12/04/19 revealed Resident #1 fell in her bedroom and had an abrasion on her lower back from hitting against the bed.

Review of the facility's "Narrative Charting" notes dated 12/29/19 (no time documented) revealed Resident #1 had fallen in the shower. Staff observed red marks on the resident's left shoulder. No other complaints of pain will continue to monitor.

Review of the facility's "Narrative Charting" notes dated 01/05/20 at 4:35am documented Resident #1 fell and was observed on the floor. No injuries or complaints of pain.

Review of the facility's "Internal incident report" dated 01/05/20 at 11:45am revealed upon delivering the lunch meal to the Resident #1's room the resident informed staff she slid off the bed onto the foot stool beside her bed. No injuries noted.

Review of the facility's "Internal incident report" dated 01/05/20 at 2:10pm revealed Resident #1 was found on the floor. The resident complained of hip pain. Staff documented Resident #1's head did not feel right, and she wanted to go to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 10 Review of the facility's "Internal incident report" dated 01/10/20 at 12:50pm revealed Resident #1 was found on the floor trying to sit on her walker. No injuries noted. Review of the facility's falls policy revealed: -When a resident fell the Resident Care Director (RCD) or medication aides instructed the personal care aides (PCAs) and they provided appropriate care and frequent resident checks. -For forty-eight hours after any fall, the RCD or MA on each shift monitored the resident and made a brief narrative sharing each entry. -An internal incident report was completed and presented to the RCD. -The RCD informed the PCP of subsequent falls and instability and discussed any interventions for care such as pharmacy review of medications, physical therapy, etc. Observation of Resident #1 on 01/29/20 at 4:45pm revealed: -Resident #1 was sitting on a sofa in her living room. -There was a rolling walker placed near the sofa where the resident was sitting. -The walker had four wheels and had a hand controlled brake mechanism that could be used when the walker was moving. -The resident seated on the sofa and attempted to rise from a sitting position. -The resident attempted to stand and she started wobbling moving back and forth from side to side. -Resident #1 grabbed the handle of the walker and the walker rolled a little. -The resident then placed her left hand on the arm of the sofa to balance herself. -The resident stood still for several second before proceeding to move.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 11 Interview with Resident #1 on 01/29/20 at 4:35pm revealed: -She had several falls. -She had not broken or fractured herself, but she does get scrapes and bruises. -She did not know why she was falling other than sometimes "my feet just won't move." -She had Parkinson's and neuropathy. -Some days her feet hurt so bad could not stand to touch them. -Facility staff came to her room four to five times throughout the day, mostly to give her medications. -Staff came to her room before breakfast and lunch to give her medications. -Staff came to her at 4:30pm and 7:30pm to give her medications. -Some days staff came once other than to administer medications to ask if she needed anything. -When she stood up from a sitting position, she sometimes had a difficult time getting her balance, which usually resulted in a fall. -Staff had told her to call for help when she wanted to go to the bathroom, but sometimes she felt that she could make it without staff help. -Staff on the midnight shift used to come to her room every two hours but she told them to stop coming to her room because it disturbed her sleep. -The staff on the midnight shift stopped coming to her room. -Staff assisted her with showers only if she asked for help. -She had a fall last week (Friday or Saturday) on the midnight shift she fell off the bed into the chair and hurt her thumb. Her thumb was still sore. -She told the midnight medication aide (MA) on the third shift, and they agreed not to tell anyone	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 12 else. -She thought most of her falls had been at night when got out of bed to go to the bathroom. -When she fell, she usually called for staff to assist with getting her up because she was unable to get herself up off the floor. -Currently, she was participating in physical and occupational therapy two to three times per week. -It seemed the therapy was not working because she was still falling. -Her Primary Care Provider (PCP) was aware that she had falls because the PCP ordered the physical therapy and previously had ordered scans and MRI's to determine why she was falling. -The conclusion was she had falls due to Parkinson's disease. -She also believed the neuropathy contributed to her falls because her feet were always hurting. -Facility staff assisted her to the bathroom and with showers when she asked for assistance. Interview with a therapist with the contract physical and occupational therapy office on 01/30/20 at 2:00pm revealed: -Resident #1 was seen by physical (PT) and occupational (OT) therapy at least two to three times per week. -PT and OT therapy services were started in February 2019 and have continued off and on throughout the past year. -She was aware that Resident #1 still had falls. -A few weeks ago (January 2020, not sure of exact date) Resident #1 fell going to her mailbox which is located on another floor in the facility. -Due to Resident #1's diagnosis of Parkinson's disease and the neuropathy in her legs, without PT/OT the resident would fall more frequent and the injuries from the falls would be more severe. -Checking on Resident #1 more frequently may	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 13	D 270		

help, but she was not sure because when staff left the room the resident would still get up and move around.

Interview with a personal care aide (PCA) on 01/30/20 at 6:22pm revealed:
-Resident #1 was checked on every two fours.
-She was aware that Resident #1 had falls, but the resident did not have falls on the days that she worked.
-No one at the facility had told her to provide supervision assistance to Resident #1 with toileting and dressing.

Interview with a second PCA on 01/30/20 at 6:40pm revealed:
-When she worked, she checked on Resident #1 every hour.
-The Administrator had verbally said to make sure to check on Resident #1.
-The Administrator did not tell her how often to check on Resident #1, so she checked on the resident every hour.

Interview with a medication aide (MA) on 01/30/20 at 7:44pm revealed:
-Resident #1 had falls.
-The Administrator told staff to check on Resident #1 because she always fell.
-She never checked Resident #1 more frequent than every two hours.
-When she worked the second shift, she checked on Resident #1 every two hours.
-When she worked the third shift, she did not check on Resident #1 because the resident requested not to be checked on.
-There was a note posted in the nurses' station that told staff not to check on Resident #1 during the night.
-"Usually," after a fall Resident #1 called for staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 14	D 270		

to help her up off the floor.
-Resident #1 "usually" told staff that her feet just gave out and she fell.
-Resident #1 always complained about her leg giving out and being the cause of her falling.

Interview with the Resident Care Coordinator (RCC) on 01/30/20 at 6:55pm revealed:
-Resident #1 had Parkinson's disease and had good days and bad days.
-On good says Resident #1 was able to do more for herself.
-On bad days Resident #1 was not mobile and needed staff assistance.
-The falls were due to Resident #1's balance being off.
-Staff had not been instructed to check on Resident #1 more frequent then every two hours.
-She had told Resident #1 when she needed help to call for staff so she would not fall.
-There was no documentation related to when she discussed with Resident #1 that she needed to call for staff to assist her due to falls.

Interview with Resident #1's PCP on 01/31/20 at 10:26am revealed:
-She was aware that Resident #1 had falls.
-Due to Resident #1's Parkinson's disease progression was inevitable and the resident was going to fall.
-Resident #1 was ordered physical therapy to help with strength, balance and gait.
-Resident #1 recently was ordered a wheelchair to help with walking outside of her apartment.
-The facility was responsible to assess Resident #1 to determine the best services for the resident.
-The PCP was unable to instruct the facility of the service to provide to Resident #1.

Interview with the Administrator/ Resident Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 270	Continued From page 15 Director (RCD) on 01/30/20 at 12:44pm revealed: -The facility's intervention regarding Resident #1's falls has been to make sure the resident had physical therapy. -After a fall, the MAs on each shift monitored Resident #1 for forty-eight hours. -The monitoring did not increase supervision but required the MA on each shift to document the resident's vitals signs and the MA documented how they observed the resident. -She also instructed staff to remind Resident #1 to push her call button to call for staff when she wanted to get up from a sitting position. -No other interventions had been put in place. -She had not specifically discussed monitoring Resident #1 more frequently than every two hours. _____ The facility failed to provide supervision to Resident #1 who was found on the floor 21 times within eleven months requiring hospital emergency room visits with multiple bruises, scrapes, and pain to her back. The facility's failure placed the resident at risk for more falls and injuries and was detrimental to her health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/30/20 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 16, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 273	Continued From page 16 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to assure physician notification for 1 of 3 sampled residents (Resident #3), who had a history of deep vein thrombosis (DVT) and diagnosis of atrial fibrillation (AFib), related to not receiving numerous medications including a blood thinner. The findings are: Review of Resident #3's current hospital FL2 dated 12/31/19 revealed diagnoses included Type 2 diabetes mellitus, hypertension, acute deep vein thrombosis (DVT), and atrial fibrillation (AFib). Review of Resident #3's hospital discharge summary and medication orders dated 01/08/20 revealed a physician's order for warfarin 2.5mg (a blood thinner used to decrease risk for DVT, and stroke in persons with AFib) once daily. Review of Resident #3's January 2020 electronic Medication Administration Record (eMAR) revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 273	Continued From page 17	D 273		

-There was a computer-generated entry for warfarin 2.5mg daily scheduled for administration at 5:00pm daily.
-Warfarin 2.5mg was not administered daily from 01/09/20 to 01/28/20 with reason indicated "medication not available".

Interview with a medication aide (MA) on 01/30/20 at 12:50pm revealed:
-Resident #3's medications were supplied by a pharmacy other than the contracted pharmacy.
-Resident #3's medication orders had been faxed and requested from the resident's pharmacy.
-MAs were responsible for ordering medications and reporting medications not available for administration to the RCC or Administrator.
-She had not reported Resident #3's medications not available for administration to the Administrator but she thought the Administrator was aware medications were not available.
-She had not notified Resident #3's PCP for missed medications from 01/09/20 to 01/28/20 because the resident's PCP was different than the facility's contracted PCP and very difficult to communicate with.

Interview with the Administrator on 01/30/20 at 12:50pm revealed:
-Resident #3 used a pharmacy other than the contracted pharmacy to supply his medications.
-Resident #3's order for warfarin 2.5mg was faxed to the resident's pharmacy per the facility's policy for ordering medications on 01/08/20.
-The resident's pharmacy had not sent warfarin 2.5mg for administering to Resident #3.
-Resident #3 had not received warfarin 2.5mg as ordered.
-She thought Resident #3's warfarin was not sent by the outside pharmacy because there would need to be routine laboratory checks for clotting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 273	Continued From page 18	D 273		

times when the resident was started on warfarin.
-Resident #3 was seen by his outside primary care provider (PCP) on 01/24/20 since the hospital discharge (01/08/20) but there was no information regarding starting or stopping warfarin and no medication provided at or subsequent to the PCP visit.
-The Administrator had not notified Resident #3's PCP that the resident was not receiving warfarin 2.5mg.
-The Resident Care Coordinator (RCC) or medication aide supervisors were responsible to notify primary care providers (PCP) if medications were not administered as ordered.

Second interview with the Administrator on 01/30/20 at 2:30pm revealed:
-Resident #3's medications on the hospital discharge summary dated 01/08/20 were not started because she thought Resident #3 should be on the same medications as before his hospitalization unless his PCP approved the medication changes.
-Any changes for Resident #3's medications had to be approved by Resident #3's outside PCP before the PCP authorized the outside pharmacy provider to send the medications to Resident #3.
-She had faxed medication information request to the outside PCP on 01/21/20, and 01/24/20 but had not received the PCP's response or the medications.
-A lead MA ordered some of his medication from the facility's contracted pharmacy on 01/24/20, but not all the medications (including warfarin).
-She was responsible for assuring medications were administered as ordered.
-The facility policy was for the MAs to order medications and assure medications were administered.
-There was no current system in place to audit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 273	Continued From page 19	D 273		

residents' eMARs for missed medications.
-The facility policy was for the MAs to order medications and assure medications were administered, and report more than 3 missed doses of a medication to the Administrator or the RCC.

Telephone interview with a Pharmacist at the facility' contracted pharmacy on 01/30/20 at 1:55pm revealed:
-The pharmacy received a faxed medication order dated 01/08/20 ordering warfarin 2.5mg but did not provide medications for Resident #3 unless requested by the facility.
-The pharmacy did not know what medications Resident #3 had for administration since the medications were not routinely supplied by the contracted pharmacy.

Attempted telephone interview with Resident #3's pharmacy provider on 01/31/20 at 1:05pm was unsuccessful.

Interview with the Resident Care Coordinator on 01/30/20 at 5:05pm revealed:
-The MAs were responsible for ordering medications and administering medications as ordered.
-She became aware a few days ago (no specific date provided) that Resident #3's warfarin 2.5mg had not been received although ordered on multiple occasions from his outside pharmacy.
-She had informed the Administrator on at least 2 occasions that Resident #3 was not receiving warfarin 2.5 mg.
-She had not contacted Resident #3's PCP regarding warfarin not being administered from 01/09/20 to 01/28/20.
-The MAs were responsible for notifying PCPs when medications were not administered as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 273	Continued From page 20 ordered after 3 missed doses. Interview with a second shift MA on 01/30/20 at 5:20pm revealed: -She was aware Resident #3 did not have warfarin 2.5mg available for administration. -Resident #3 received his medication from a pharmacy other than the facility' contracted pharmacy and there was a problem getting new medications started every time a medication was stared for the resident. -She thought the facility policy was to notify the PCP and inform the RCD for more than 3 missed doses of a medication. -She had reported Resident #3's warfarin 2.5mg not available several times to the RCD. -She had not notified Resident #3's PCP that the resident was not receiving warfarin as ordered. Telephone interview with Resident #3's PCP nurse on 01/31/20 at 11:49am revealed: -The facility was aware of the procedure for Resident #3 to obtain medications through the PCP and the outside pharmacy provider. -The facility should use their contracted pharmacy provider to order a sufficient supply of medication to last until Resident #3 could be seen by the PCP and authorization completed to receive medications from the resident's outside pharmacy. -Resident #3 was seen by the PCP 01/24/20 at their clinic but no paper work was received with the resident regarding ordering warfarin. -The facility should contact the PCP if there was a question regarding the resident's medications. -There was no documentation the facility had contacted the PCP regarding Resident #3's warfarin 2.5mg. -Resident #3's warfarin 2.5mg was a new medication ordered at hospital discharge and was	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 273	Continued From page 21 being" held" (not dispensed) by the pharmacy but she was not sure why. -Not receiving warfarin as ordered could result in the resident having another DVT or stroke. Interview with Resident #3 on 01/30/20 at 6:30pm revealed: -He took too many medications to keep up with. -He had been in the hospital recently and medications may have changed. -He had been to his PCP a couple of weeks ago, since he was in the hospital. -He was not having any leg pain or additional swelling. Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration. _____ The facility failed to notify the primary care provider for Resident #3, who had a diagnosis of AFib and history of DVT, regarding 21 missed doses of warfarin 2.5mg placing the resident at increased risk for a DVT, or stroke. The facility's failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 1/30/2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 16, 2020.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 22 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing practitioner for 1 of 3 sampled residents (Resident #3) related not administering doses of a blood thinner, a blood pressure medication, a medication for gastro-esophageal reflux disease (GERD), and a medication for chronic obstructive pulmonary disease (COPD). The findings are: Review of Resident #3's current hospital FL2 dated 12/31/19 revealed diagnoses included Type 2 diabetes mellitus, hypertension, acute deep vein thrombosis (DVT), atrial fibrillation (AFib). 1. Review of Resident #3's hospital discharge summary and medication orders dated 01/08/20 revealed a physician's order for warfarin 2.5mg (a blood thinner used to decrease risk for DVT, and stroke in persons with AFib) once daily. Review of Resident #3's January 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for warfarin 2.5mg daily scheduled for administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 23	D 358		

at 5:00pm daily.
-Warfarin 2.5mg was not administered daily from 01/09/20 to 01/28/20 with reason indicated "medication not available".

Observation of Resident #3's medication on hand for administration on 01/30/20 at 1:00pm revealed there was no warfarin 2.5mg available for administration.

Interview with the Administrator on 01/30/20 at 12:50pm revealed:
-Resident #3 used a pharmacy other than the contracted pharmacy to supply his medications.
-Resident #3's order for warfarin 2.5mg was faxed to the resident's pharmacy per the facility's policy for ordering medications on 01/08/20.
-The resident's pharmacy had not sent warfarin 2.5mg for administering to Resident #3.
-She thought Resident #3's warfarin was not sent by the outside pharmacy because there would need to be routine laboratory checks for clotting times when the resident was started on warfarin.
-Resident #3 was seen by his primary care provider (PCP) on 01/24/20 since the hospital discharge (01/08/20) but there was no information regarding starting or stopping warfarin and no medication provided at or subsequent to the PCP visit.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/30/20 at 1:55pm revealed:
-The pharmacy did not routinely provide medications for Resident #3 because the resident received his medications from a different pharmacy.
-The facility could request the pharmacy to provide a medication for Resident #3.
-The pharmacy maintained a medication profile

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 24	D 358		

for Resident #3 and provided the facility's eMARs.
-The pharmacy did not receive the discharge summary for Resident #3's hospital discharge dated 01/08/20.
-The pharmacy received a faxed medication order from the hospital discharge dated 01/08/20 for warfarin 2.5mg but would not provide medications for Resident #3 unless requested by the facility.
-The facility had not requested warfarin 2.5mg to be supplied by the contracted pharmacy.
-The pharmacy did not know what medications Resident #3 had for administration since the medications were not routinely supplied by the contracted pharmacy.

Attempted telephone interview with Resident #3's pharmacy provider on 01/31/20 at 1:05pm was unsuccessful.

Interview with the Resident Care Coordinator (RCC) on 01/30/20 at 5:05pm revealed:
-The medication aides (MAs) were responsible to order medications and administer medications as ordered.
-She became aware a few days ago (no specific date) that Resident #3's warfarin 2.5mg had not been sent although ordered on multiple occasions from his outside pharmacy.
-The Administrator told her she had been attempting to receive the resident's warfarin from his outside pharmacy.

Interview with a second shift MA on 01/30/20 at 5:20pm revealed:
-She was aware Resident #3 did not have warfarin 2.5mg available for administration.
-Resident #3 received his medication from a pharmacy other than the facility' contracted pharmacy and there was a problem getting new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 25	D 358		

medications started every time a medication was stared for the resident.
-She thought the facility policy was to notify the PCP and inform the RCD for more than 3 missed doses of a medication.
-She had reported Resident #3's warfarin 2.5mg not available several times to the RCD.
-She had not notified Resident #3's PCP that the resident was not receiving warfarin as ordered.
-There was no warfarin on the medication cart to administer to Resident #3.

Interview with Resident #3 on 01/30/20 at 6:30pm revealed:
-He took too many medications to keep up with.
-He had been in the hospital recently and his medications may have changed.
-He used to take a medication for thinning his blood, but did not know if he was currently taking any blood thinner.

Telephone interview with Resident #3's primary care provider 's (PCP) nurse on 01/31/20 at 11:49am revealed:
-Resident #3 was seen by his PCP on 01/24/20 at their clinic, but no paper work was received with the resident regarding warfarin.
-Resident #3's warfarin 2.5mg was a new medication ordered at hospital discharge and was being "held" (not dispensed) by the pharmacy but she was not sure why.
-Not receiving warfarin as ordered could result in the resident having another DVT or stroke.

Refer to the interview with a medication aide (MA) on 01/20/20 at 12:50pm.

Refer to the interview with the Administrator on 1/30/20 at 12:53pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 26 Refer to the second interview with the Administrator on 01/30/20 at 4:30pm. Refer to the telephone interview with Resident #3's PCP's nurse on 01/31/20 at 11:45am. 2. Review of Resident #3's hospital discharge summary and medication orders dated 01/08/20 revealed a physician's order for losartan 25mg (used to treat high blood pressure) once daily. Review of Resident #3's January 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for losartan 25mg once daily scheduled for administration at 9:30am daily. -Losartan 25mg was not administered daily from 01/09/20 to 01/24/20 (16 doses) with reason indicated "medication not available". -Blood pressures documented as taken daily revealed form 01/08/20 to 01/29/20 the systolic BP range was from 91 to 157 and the diastolic BP range was from 58 to 101. Observation of Resident #3's medication on hand for administration on 01/30/20 at 1:00pm revealed there were 23 tablets remaining of 28 tablets of losartan 25mg dispensed on 01/24/20 available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/30/20 at 1:55pm revealed: -The pharmacy did not routinely provide medications for Resident #3 because the resident received his medications from a different pharmacy. -The pharmacy received a faxed medication order dated 01/08/20 for losartan 25mg but did	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 27	D 358		

not provide medications for Resident #3 unless requested by the facility.
-The facility requested losartan 25mg 01/24/20 and 28 tablets were dispensed on 01/24/20.
-The pharmacy did not know what medications Resident #3 had for administration since the medications were not routinely supplied by the contracted pharmacy.

Attempted telephone interview with Resident #3's pharmacy provider on 01/31/20 at 1:05pm was unsuccessful.

Interview with Resident #3 on 01/30/20 at 6:30pm revealed:
-He took too many medications to keep up with.
-He was doing fine since his hospital visit.

Refer to the interview with a medication aide (MA) on 01/20/20 at 12:50pm.

Refer to the interview with the Administrator on 1/30/20 at 12:53pm.

Refer to the second interview with the Administrator on 01/30/20 at 4:30pm.

Refer to the telephone interview with Resident #3's PCP's nurse on 01/31/20 at 11:45am.

3. Review of Resident #3's hospital discharge summary and medication orders dated 01/08/20 revealed a physician's order for pantoprazole 40mg (used to treat gastro-esophageal reflux disease) once daily.

Review of Resident #3's January 2020 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 28	D 358		

pantoprazole once daily scheduled for administration at 9:30am daily.
-Pantoprazole 40mg was not administered daily from 01/10/20 to 01/25/20 (15 doses) with reason indicated "medication not available".

Observation of Resident #3's medication on hand for administration on 01/30/20 at 1:00pm revealed there were 22 tablets remaining of 28 tablets of pantoprazole 40mg dispensed on 01/24/20 available for administration.

Interview with Resident #3 on 01/30/20 at 6:30pm revealed:
-He had been in the hospital recently and his medications may have changed.
-He had not been having any heartburn or reflux symptoms since he returned from the hospital.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/30/20 at 1:55pm revealed:
-The pharmacy did not routinely provide medications for Resident #3 because the resident received his medications from a different pharmacy.
-The pharmacy received a faxed medication order dated 01/08/20 for pantoprazole 40mg but did not provide medications for Resident #3 unless requested by the facility.
-The facility requested pantoprazole 40mg on 01/24/20 and 28 tablets were dispensed on 01/24/20.
-The pharmacy did not know what medications Resident #3 had for administration since the medications were not routinely supplied by the contracted pharmacy.

Attempted telephone interview with Resident #3's pharmacy provider on 01/31/20 at 1:05pm was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 29	D 358		

unsuccessful.

Refer to the interview with a medication aide (MA) on 01/20/20 at 12:50pm.

Refer to the interview with the Administrator on 1/30/20 at 12:53pm.

Refer to the second interview with the Administrator on 01/30/20 at 4:30pm.

Refer to the telephone interview with Resident #3's PCP's nurse on 01/31/20 at 11:45am.

4. Review of Resident #3's hospital discharge summary and physician's orders dated 01/08/2020 revealed a physician's order for ipratropium-albuterol 0.5-2.5mg per 3 milliliter(ml) solution take 3mls by nebulization 4 times daily. (Ipratropium-albuterol is used to treat chronic obstructive pulmonary disease) was included in the discharge medications.

Review of Resident #3's previous FL2 dated 08/22/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD).

Review of Resident #3's record revealed previous physician's orders dated 12/24/19, and 01/07/20 prescribing ipratropium-albuterol 0.5-2.5mg per 3ml solution take 3mls by nebulization 4 times daily.

Observation of Resident #3's medication on hand for administration on 01/30/20 at 1:00pm revealed there was no ipratropium-albuterol 0.5-2.5mg per 3ml solution available for administration.

Review of Resident #3's January 2020 electronic Medication Administration Record (eMAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 30	D 358		

revealed:
-There was a computer-generated entry for ipratropium-albuterol 0.5-2.5mg per 3ml solution take 3mls by nebulization 4 times daily, scheduled for administration at 9:30am, 12:30pm, 4:30pm, and 7:30pm.
-Ipratropium-albuterol 0.5-2.5mg per 3ml solution was not administered 4 times daily (80 doses) from 01/09/2020 to 01/28/20 with reason indicated "medication not available".

Interview with the Administrator on 01/30/20 at 12:50pm revealed:
-Resident #3 used a pharmacy other than the contracted pharmacy to supply his medications.
-Resident #3's order for ipratropium-albuterol 0.5-2.5mg per 3ml solution was faxed to the resident's pharmacy per the facility's policy for ordering medications on 01/08/20.
-Resident #3's pharmacy had not sent the ipratropium-albuterol 0.5-2.5mg per 3ml solution for administration but she did not know why.
-Resident #3 did not have a nebulization machine for administering his medications either.
-She had not ordered medications for Resident #3 from the facility's contracted pharmacy because she was still trying to get Resident #3's medications from his outside pharmacy.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/30/20 at 1:55pm revealed:
-The pharmacy did not routinely provide medications for Resident #3 because the resident received his medications from a different pharmacy.
-The pharmacy received a faxed medication order dated 01/08/20 for ipratropium-albuterol 0.5-2.5mg per 3ml solution but did not provide medications for Resident #3 unless requested by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 31	D 358		

the facility.
-The pharmacy had not received a request for ipratropium-albuterol 0.5-2.5mg per 3ml solution.
-The pharmacy did not know what medications Resident #3 had for administration since the medications were not routinely supplied by the contracted pharmacy.

Attempted telephone interview with Resident #3's pharmacy provider on 01/31/20 at 1:05pm was unsuccessful.

Interview with Resident #3 on 01/30/20 at 6:30pm revealed:
-He had a breathing machines and treatments in the past, but not recently.
-He got a little short of breath when physical therapy helped him walk in his room.

Telephone interview with Resident #3's primary care provider's (PCP) nurse on 01/31/20 at 11:49am revealed:
-She reviewed medications listed with the PCP as current medications.
-Resident #3's ipratropium-albuterol 0.5-2.5mg per 3ml solution was listed on medications that the resident should be receiving.
-Resident #3 could obtain a nebulization machine through his pharmacy provider if he did not have a machine.

Refer to the interview with a medication aide (MA) on 01/20/20 at 12:50pm.

Refer to the interview with the Administrator on 1/30/20 at 12:53pm.

Refer to the second interview with the Administrator on 01/30/20 at 4:30pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 32 Refer to the telephone interview with Resident #3's PCP's nurse on 01/31/20 at 11:45am. _____ Interview with a medication aide (MA) on 01/30/20 at 12:50pm revealed: -The facility policy was for all medications orders to be routinely entered into the facility's eMAR system by the contracted pharmacy. -MAs could enter orders on weekends or other special circumstances. -If entered by MAs, the orders were checked by a second MA, and then by the Administrator or Resident Care Coordinator (RCC). -Resident #3's medications were supplied by a pharmacy other than the contracted pharmacy. -She was sure Resident #3's medication orders had been faxed and requested from the resident's pharmacy. -Resident #3's outside pharmacy was difficult to communicate with and sent medications directly to the resident, not the facility. -She did not have some medications to administer to Resident #3 during morning medication passes until 01/24/20. There were still a couple of medications not available to administer to Resident #3. -MAs were responsible for ordering medications and reporting medications to the RCC or Administrator when medications were not available for administration. -The Administrator knew medications were not available because she had been trying to get medications approved and ordered by Resident #3's outside PCP. Interview with the Administrator on 1/30/20 at 12:53pm revealed: -The facility's policy for ordering new medications was as follows: medication aide (MA) working when the order was received was responsible for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 33 faxing all orders to the contracted pharmacy for entering into the eMAR system for administration; the pharmacy entered the orders on the eMAR system and sent the medication to the facility if the resident used the contracted pharmacy to supply medications. -The facility was responsible for obtaining medications for residents not using the contracted pharmacy to supply medications by faxing medication orders to the pharmacy and arranging pick-up or delivery of the medications. -She knew Resident #3 did not have medications for some time after his hospital discharge, but most of the problem came because the facility had to wait on the resident's outside pharmacy to send the medications. -Medications were sent to the resident directly causing a delay in the facility's ability to track if medications were not sent. Second interview with the Administrator on 01/30/20 at 2:30pm revealed: -Resident #3's medications on the hospital discharge summary dated 01/08/20 were not started because she thought Resident #3 should be on the same medications as before his hospitalization unless his PCP approved the medication changes. -Any changes for Resident #3's medications had to be approved by Resident #3's outside PCP before the PCP authorized the outside pharmacy provider to send the medications to Resident #3. -She had faxed medication information request to the outside PCP on 01/21/20, and 01/24/20 but had not received the PCP's response or the medications. -A lead MA ordered some of his medication from the facility's contracted pharmacy on 01/24/20 because the facility had not been able to obtain the medications from Resident #3's outside pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 34 -She was responsible for assuring medications were administered as ordered. -The facility policy was for the MAs to order medications and assure medications were administered. Telephone interview with Resident #3's primary care provider's (PCP) nurse on 01/31/20 at 11:45am revealed: -Resident #3's PCP and pharmacy provider were not the facility's contracted PCP or pharmacy. -The facility was aware of the procedure for Resident #3 to obtain medications through the PCP and the outside pharmacy provider. -The facility should use their contracted pharmacy provider to order a sufficient supply of medication to last until Resident #3 could be seen by the resident's PCP and authorization completed to receive medications from the resident's outside pharmacy.. -The resident or a representative designated by the resident should present all paperwork form hospital visits and any changes to medications recommended by providers other than the PCP when the resident was seen for follow-up at the clinic. -Resident #3 was seen by the PCP 01/24/20 at the PCP's clinic, but no paper work was received with the resident regarding the hospitalization discharge 01/08/20 and medications. -The facility was responsible to assure the PCP received medication requests with clinic visits. -The facility could contact the PCP if there was a question regarding the resident's medications by calling the PCP's nurse and leaving a message. _____ The facility failed to administer medications as ordered for Resident #3 related to not administering warfarin for 21 days placing the resident at increased risk for a reoccurring DVT,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D 358	Continued From page 35 and not administering ipratropium-albuterol 0.5-2.5mg per 3ml solution causing the resident to experience shortness of breath with physical therapy and increased risk for low oxygen saturation levels that can lead to dizziness and weakness. The facility's failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 1/30/2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 16, 2020.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate and in compliance with relevant state laws and rules related to Personal Care and Supervision, Health Care, and Medication Administration.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D912	Continued From page 36 The findings are: 1. Based on observation, interviews and record reviews the facility failed to provide supervision to meet the needs of 1 of 3 sampled residents (Resident #1) who was found on the floor 21 times within eleven months causing abrasions, skin tears, and scrapes to the resident's back, arms and legs. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on interviews, and record reviews, the facility failed to assure physician notification for 1 of 3 sampled residents (Resident #3), who had a history of deep vein thrombosis (DVT) and diagnosis of atrial fibrillation (AFib), related to not receiving numerous medications including a blood thinner. [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing practitioner for 1 of 3 sampled residents (Resident #3) related not administering doses of a blood thinner, a blood pressure medication, a medication for gastro-esophageal reflux disease (GERD), and a medication for chronic obstructive pulmonary disease (COPD). [Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D934	Continued From page 37 (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, Staff B and Staff C) had completed the mandatory annual infection control training. The findings are: 1. Review of Staff A, Medication Aide's (MA) personnel record revealed: -Staff A was hired on 09/15/16. -There was a certificate Staff A completed blood borne pathogen training on 02/05/19. -The was no documentation Staff A had completed the required annual infection control training.	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D934	Continued From page 38 Interview with Staff A on 01/31/20 at 12:15pm revealed: -He worked at the facility as a MA. -He recalled blood borne pathogen training being provided in the early part of 2019. Refer to the interview with the Business Office Manager (BOM) on 01/30/20 at 3:30pm. Refer to the interview with the Administrator on 01/30/20 at 6:50pm. Refer to the interview with the previous contract nurse on 01/31/20 at 1:24pm. 2. Review of Staff B, Medication Aide's (MA) personnel record revealed: -Staff B was rehired on 05/01/17. -There was a certificate of blood borne pathogen training dated 02/15/19. -There was no documentation Staff B had the mandatory annual infection control training. Interview with Staff B on 01/30/20 at 7:32pm revealed: -She worked as a medication aide at the facility since 2017. -She recalled, one year ago a nurse provided some type of training related to infection control. -She did not know if the training provided was the state approved infections control training. Refer to the interview with the Business Office Manager (BOM) on 01/30/20 at 3:30pm. Refer to the interview with the Administrator on 01/30/20 at 6:50pm. Refer to the interview with the previous contract	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D934	Continued From page 39 nurse on 01/31/20 at 1:24pm. 3. Review of Staff C, Medication Aide's (MA) personnel record revealed: -Staff C was hired on 04/28/15 as a MA. -There was no documentation Staff C had the mandatory annual infection control training. Staff C was not available for interview. Refer to the interview with the Business Office Manager (BOM) on 01/30/20 at 3:30pm. Refer to the interview with the Administrator on 01/30/20 at 6:50pm. Refer to the interview with the previous contract nurse on 01/31/20 at 1:24pm. _____ Interview with the Business Office Manager (BOM) on 01/30/20 at 3:30pm revealed: -She was responsible for ensuring staff had required trainings. -She started working at the facility in November 2019. -She did not know medication aides were required to have a mandatory annual infection control training. -She had not check staff records to ensure required trainings had been completed. Interview with the Administrator on 01/30/20 at 6:50pm revealed: -The BOM was responsible for ensuring staff completed required trainings. -She was aware the annual infection control training was required. -She had the previous contract nurse come to the facility in 2019 to complete the infection control training.	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D934	Continued From page 40 -She was not sure if the training provided by the nurse was the state approved infection control training. Interview with the previous contract nurse on 01/31/20 at 1:24pm revealed: -The Administrator asked her to provide infection control training. -In February 2019, she provided blood borne pathogen training to staff at the facility. -She obtained a video from the Internet regarding blood borne pathogens, which she used to train facility staff. -She did not use the state approved infection control training because she did not know the training was required.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D935	Continued From page 41 procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) who administered medications had completed the 5, 10, or 15-hour medication administration training course. The findings are: Review of Staff B's, medication aide's (MA) personnel record revealed:	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D935	Continued From page 42 -Staff B was hired on 05/01/17. -Staff B passed the written MA exam on 04/18/02. -Staff B had a medication clinical skills competency evaluation dated 05/09/17. -There was no documentation Staff B completed the 5, 10, or 15-hour medication administration training course. Review of a resident's November and December 2019 and January 2020 electronic Medication Administration Record (eMAR) revealed: -Staff B documented the administration of medications 18 days in November 2019. -Staff B documented the administration of medications 22 days in December 2019. -Staff B documented the administration of medications 20 days in January 2020 and had not completed the 5, 10, or 15-hour medication administration course. Interview with Staff B on 01/30/20 at 7:32pm revealed: -She had worked at the facility since 2017 as a MA. -When she worked as a MA, she administered medications independently. -She had not received the 5, 10, or 15-hour medication aide training. Interview with the Administrator on 01/30/20 at 6:50pm revealed: -Staff B was a MA and independently administered medications to the residents. -The Business Office Manager (BOM) was responsible for ensuring all staff completed their required trainings. -She did not know Staff B had not completed the 5, 10, or 15-hour medication aide training. Interview with the BOM on 01/30/20 at 3:30pm	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034003	A. BUILDING: _____ B. WING _____	R 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERRA SPRINGS AT HERITAGE WOODS	3812 FORESTGATES DRIVE WINSTON SALEM, NC 27103

(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) COMPLETE DATE
D935	Continued From page 43 revealed: -She worked at the facility in November 2019. -She had not checked staff records to ensure the required training was obtained. -She did not know Staff B needed the 5, 10, or 15-hour medication aide training.	D935		