

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Salemtowne		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 Babcock Drive Winston-Salem, NC 27106	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and family member, the facility failed to follow their infection control policy regarding Clostridium difficile infection (C. difficile) [bacteria that can cause diarrhea and inflammation in the colon, can cause serious complications, and is highly contagious] for hand hygiene after resident care. Two nursing assistants used alcohol-based hand sanitizer and had not washed their hands with soap and water after caring for a resident with C. difficile. The deficient practice affected 3 of 5 staff members (Nursing Assistant (NA) #1, NA #2, and Medication Aide #1) interviewed for hand hygiene specific to C. difficile management (Resident #1).</p> <p>Findings included:</p> <p>The Infection Control Protocol for C. Difficile Policy dated 1/20/25 documented, in part, 1.c. Wash hands with soap and water. Do not use alcohol gels since it does not kill spores (bacteria of C. difficile).</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses of C. difficile and dehydration.</p> <p>Resident #1 had the following orders:</p> <p>Enteric precautions for C. Difficile dated 3/31/25.</p> <p>Vancomycin (antibiotic for C. difficile infection) 125 milligram capsule every 6 hours for 4 days starting 3/31/25 and ending 4/4/25.</p> <p>An interview was conducted on 5/19/25 at 12:05 pm with Resident #1's family member. The family member stated she observed nursing staff had used the hand sanitizer from the wall dispenser after providing care when the resident had C. difficile. There were gloves, gowns, and masks available and an enteric precaution sign on the door. She never observed staff washing their hands with soap and water. The family member commented she was aware that hand sanitizer was not effective to kill the C. difficile and had not informed anyone of her concern. The family member stated the resident's C. difficile infection resolved and he was transferred to an adult living facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with NA #1 on 5/19/25 at 1:10 pm. NA #1 stated she was assigned to Resident #1 when staff was required to follow enteric precautions for C. difficile. NA #1 stated she used personal protective equipment (PPE) for all care. NA #1 further stated she used alcohol hand sanitizer after care if there was no cleaning of stool when C. difficile was active. NA #1 commented she was not aware that alcohol hand sanitizer does not kill C. difficile. NA #1 stated there was a contact precaution sign on the resident's door to wear a gown, gloves, and mask when providing care. The NA did not recall parameters for hand washing with soap and water on the sign.</p> <p>An interview was conducted with Medication Aid (MA) #1 on 5/19/25 at 1:20 pm. MA #1 stated she was assigned to Resident #1 when he had the C. difficile infection and frequent diarrhea. MA #1 stated you could use hand sanitizer after care when a resident had C. difficile but she preferred to wash her hands with soap and water if there was stool. MA #1 stated she washed her hands with soap and water after incontinence care and always wore the mask, gown, and gloves for all care. MA #1 further stated she was not aware that alcohol hand sanitizer does not kill C. difficile. There was a contact precaution sign on the resident's door, but MA #1 did not recall parameters for hand washing with soap and water on the sign.</p> <p>An interview was conducted with NA #2 on 5/19/25 at 1:55 pm. NA #2 stated she remembered Resident #1 and that he had C. difficile infection in his stool, diarrhea, and was on enteric precautions. NA #2 stated she used a mask, gown, and gloves upon entry into the room and discarded upon leaving. Hand hygiene was hand sanitizer on the wall dispenser which was alcohol. NA #2 stated she was not aware that alcohol hand sanitizer does not kill C. difficile. She had not washed her hands with soap and water after care; she used the hand sanitizer as usual.</p> <p>An interview was conducted with the Director of Nursing (DON) on 5/19/25 at 3:35 pm. The DON stated the Infection Preventionist was not available, and she was covering. The DON stated all nursing staff were educated to wash their hands with soap and water when a resident had C. difficile after all care and this requirement was a facility policy. The DON also stated that Resident #1 had an enteric precaution sign on his door which included the requirement to hand wash with soap and water. The hand sanitizer was alcohol based which was not effective to kill C. difficile spores. There was no spread of C. difficile that she was aware of. The DON further commented that NA #1 and NA #2 were agency staff and were expected to have received education from the agency before working at the facility.</p>		