MAR 26 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interviews and record reviews, the facility failed to have identified medical symptoms for 4 of 4 sampled residents with restraints and failed implement systematic approaches to reduce restraints (Residents #33,117,217 and 218). The findings include: The facility policy titled " Restraint Criteria " dated 11/23/10, read in part: before any restraint is applied, a restraint assessment must be completed which includes evaluation of balance, strength, gait, transfer and safety. The underlying causes of medical symptoms must be investigated, and interventions implemented to eliminate those causes. Alternative measures must be tried before a restraint is used. 1. Resident #33 was admitted to the facility on 1/26/10. Resident #33 current diagnoses included dementia, hemiparesis, hypertension diabetes and chronic obstructive pulmonary disease. The Minimum Data Set dated 10/1/11, indicated that Resident #33 had short and long term memory and decision making problems. Resident #33 required assistance with all activities of daily living	F 221	**F 221** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** 1. Physicians orders were obtained to discontinue the belt restraint on resident #33. A personal chair alarm was added to alert staff of resident's attempts to get up without assistance. ½ tray continues to assist resident with resting her non dominant weak arm. 2. Physicians orders were obtained to discontinue the lap buddy on resident #117. 3. Occupational Therapy and the D.O.N assessed the least possible restraint necessary to maintain the safety of resident #217. Physicians input and order obtained. 4. Physicians orders were obtained to discontinue the lap buddy on resident #281. A personal chair alarm was added to alert staff of resident's attempts to get up without assistance.	3/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peter N. Mabry — TITLE: ADMINISTRATOR — (X6) DATE: 3/22/12

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.

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F 221	Continued From page 1 and was coded as non ambulatory with a trunk restraint. Last recorded fall noted on 5/1/11. Review of the last fall risk assessment dated 2/4/08, revealed that Resident #33 was non-ambulatory. Review of the physician ' s order dated 6/6/11, revealed a self release belt while up in wheelchair secondary to falls. In addition, on 1/17/12, apply lap table to wheelchair when up out of bed due to decreased safety awareness related to dementia and history of falls. Review of the pre-restraining evaluation dated 5/6/11, revealed that Resident #33 was non-ambulatory, leaned forward and to left side while sitting and was able to recovery her seating position. A self release belt was applied, but resident was unable to release on command. Review of the reduction assessment form dated 6/6/11, 7/6/11, 8/6/11 and 9/19/11, revealed in the comment section that Resident #33 continue to use a self release seat belt that she was unable to release on command. On 1/21/12 a new order for lap tray was implemented. The medical symptom was poor safety awareness. Director of nursing who indicated responsibility for the assessment revealed there was no documentation available of Resident #33 observed releasing the belt or what the assessment process included to implement the restraint or lap tray. Additional review of the facility fall log from 5/1/11 through 3/1/12, revealed Resident #33 had not had any falls. Review of the revised care plan dated 7/27/11, identified the problem as Resident #33 had potential for injury related to history of falling, use	F 221	**Corrective action to be accomplished for those residents having the potential to be affected by the same deficient practice.** 1. All residents were assessed for interventions that would be considered a restraint. Any interventions that are considered restraints were assessed by therapy and nursing to determine the least restrictive device, only after all other alternative approaches have failed. 2. Same as #1 3. All current residents were assessed with the therapy department and nursing to determine that the least restrictive restraint was necessary. 4. Same as #1. **Measures put in place or systemic changes made to ensure that the deficient practice will not occur:** 1. A physical restraint can only be ordered after all other non-restraining interventions have been tried and deemed unsuccessful in keeping resident safe. The least restrictive restraint must be used first and only in collaboration with the therapy department, nursing department and physician. Families that are persistent in using restraints when not warranted will be educated on the use of restraints based on medical symptom. Quarterly restraint reduction assessments will be performed by therapy and Nursing on all residents with restraints. 2. Same as #1 3. Same as #1 4. Same as #1	

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F 221	Continued From page 2 of trunk of restraint and risk for injury from use of restraint (self release seat belt). The goals included resident will not injure self or others over the next 90 days. The approaches included make sure self release seat belt is in place when resident is up in wheelchair, check and reposition frequently, reassess quarterly for possible reduction of effectiveness, call bell in reach, falling star program, assist resident in out of room activities and mats to floor. Review of the restraint CAA(care area assessment) dated 10/1/11, revealed that Resident #33 was ordered as self release seat belt die to frequent falls. She would attempt to transfer and ambulate without asking for assistance due to dementia. She needed frequent cueing and monitoring for safety. Family was in agreement that a self release restraint would be best for her. She does not resist having it in place. Per staff, she can remove it at times but did not remove it upon request. She uses the tray to rest her left arm. Review of occupational notes dated 8/18/11 through 8/30/11, revealed that Resident #33 was seen for wheelchair positioning. She demonstrated good wheelchair positioning with appropriate positioning devices for 4-6 hours without discomfort or reports of any falls. Review of the physical therapy note dated 9/15/11, revealed that Resident #33 was seen in therapy to addressed deficits with gait and transfers. Resident #33 was able to perform gait with rolling walker 40 to 80 feet with minimal assistance and later presented with cessation of progress and was discharged to nursing services.	F 221	**Monitoring Process** All physical restraints will be monitored using the restraint reduction assessment in collaboration with the therapy department and nursing management quarterly or if change in condition of resident warrants the reduction. Assessments will be reviewed in the QA committee meetings.	

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F 221	Continued From page 3 There was no further assessment from therapy department to address the use of the self release restraint or the inclusion of the lap tray. During an observation on 2/29/12 at 7:29AM, Resident #33 was seated in front of her bedroom with lap tray in place. There was a chair cushion in place and she sat in an upright position without difficulty. There were no repetitive movements or leaning in any directions, both feet were place solid on the floor. During an interveiw on 2/29/12 at 7:32AM, nurse#1 stated that Resident #33 used the lap tray for meals and the tray was removed after meals. She added that resident was able to sit in an upright position without tray and only leans to leftside when she was tired or falls sleep in chair. Resident had not had any falls in months. Resident was unable to remove any type of device independently and she was non-ambulatory, could not recall resident attempting to get up unassisted. DON(director of nursing) handled assessments of restraints. During an interview on 2/29/12 at 7:35AM, NA #1 indicated that Resident#33 used the lap tray all the time, resident would attempt to stand or slid forward in chair. She added that the resident was able to reposition self in chair even when she slid forward. She was unaware of any falls. She indicated that when she slides forward was after she had fallen alseep in the chair. Resident was unable to remove any type of device. During an observation on 2/29/12 at 7:52AM, Resident#33 was seated in the main dining room	F 221		

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F 221	Continued From page 4 at the table with lap tray in place. Resident#33 tray was positioned under the table and she was eating her meal from the main dining room table. She only required meal set only. Resident#33 was reaching over tray trying to get to her meal that was placed on the main table. Food was spilling all over the main table and the tray. Staff was assisting other residents. During an interview on 2/29/12 at 8:00AM, NA #2 and NA #3 indicated that they generally work the main dining room. NA #2 indicated that the residents in the main dining room generally needed set-up assistance only. She added that the residents wore the lap buddy/trays because they were a fall risk and mobile within the facility. She indicated that the lap buddy or trays was not removed during dining due to the potential for the resident to lean forward or reach for something in the dining area unexpected. NA #3 stated that there have been no falls in the dining room because they did have the lap buddy's or trays in place and that the residents were fall risks. NA#3 stated that anytime a resident had a device like lap buddy or trays while in the dining room, staff would find a table that was at good height that the chair could fit under was used. During an observation on 2/29/12 at 10:45am to 11:05AM, Resident #33 seated in hall in from of her room in lap tray, no leaning in any directions or attempts to remove or stand. During an interview on 2/29/12 at 2:39PM, therapy director stated that therapy department did not do any of the assessment or determination for restraints. It was all done by the DON(director of nursing).	F 221		

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F 221	Continued From page 5 During an interview on 2/29/12 at 2:49PM, the DON(director of nursing) stated that she was responsible for the evaluations/assessments of restraints. She indicated that after review of the record that Resident #33 did not have a medical reason for the use of restraint. She further stated that the therapy department was not generally included in the evaluation/assessment process for restraints and that process included use of the pre-restraint form on a quarterly basis. She added that she did not have a system in place that included what the assessment process entailed or documentation of the observations for the continuation or reduction of a restraint. She further stated " residents should not be restrained at family request and sometimes she gave into family request knowing that was not right " .She further stated that care plans should be updated to reflect the frequency of removal of restraints. She added that none of the identified residents had any recent or recurrent falls. The restraints were either applied per family request or poor safety awareness, there was no medical indicators or physician input in the decision for the use of restraint. During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities.The residents should have a clinical reason for the use of restraint. 2. Resident #117 was admitted to the facility on 3/16/07. Resident #117 cumulative diagnoses included hypertension, pulmonary fibrosis and	F 221		

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F 221	Continued From page 6 dementia. The Minimum Data Set(MDS) dated 1/4/12, indicated that Resident #117 had short and long term memory and decision making problems. She required total assistance with all areas of daily living. She was non-ambulatory and not coded for any behaviors associated with falls. Review of physician order 8/21/11 and dated 9/19/11, revealed that occupational and physical therapy was discontinued and Resident #117 was referred to restorative for splint management, resident to tolerate knee splint x 4hrs to decrease further contracture. In addition, Resident #117 should be positioned in wheelchair with medium profile anti-thrust cushion and stop drop foot rest to wheelchair positioning to decrease falls. Review of physician order dated 2/27/12, revealed that lap buddy while in wheelchair to increase dignity due to eating feces and decrease sanitary problems. Review of pre-restraining evaluation dated 2/27/12, revealed that Resident #117 was non-ambulatory and dependent upon staff for mobility. Reason for use of lap buddy was for dignity, family request and sanitary reasons, alternatives used was long pants. Director of nursing who indicated responsibility for the assessment revealed there was no documentation available of Resident #117 observed releasing the lap buddy or what the assessment process included to implement the lap buddy or other alternative devices attempted. Additional review of the facility fall log from 5/1/11 through 3/1/12, revealed Resident #117 had not had any falls.	F 221		

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F 221	Continued From page 7 Review of care plan dated 2/27/12, identified the problems as; Resident #117 was at risk for injury due to need for a chair that prevents rising-lap buddy to aid in positioning and to prevent from eating feces and family request. The goals included Resident #117 would no longer require the use of the device in 90 days, experience no decline in activities of daily living over the next 90 days and no injuries due to the use of the device in 90 days. The approaches included teache family about the use of the device, assist and change position every 30 minutes to 2 hours, check device daily to make sure it is was in good condition, remove device during supervised activities. During an observation on 2/29/12 at 7:38AM, resident was seated in main dining room without lap buddy. She sat in an upright position without difficulty or repetitive movements with her legs crossed. There was no attempt to stand unassisted. During an observation on 2/29/12 at 7:47AM, Resident #117 was brought from bedroom back to main dining area by NA#4. NA#4 stated that the Resident#117 had a lap buddy on since November of last year and at one time the lap buddy was removed and family requested that it be put back on resident. The resident did not have any falls and was unable to remove it independently. During an observation on 2/29/12 at 8:10AM, Resident #117 sitting in front of nursing station window with her legs crossed in an upright position. She did not demonstrate any difficulty with repetitive movements or need for	F 221		

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F 221	Continued From page 8 repositioning from staff. She sat quietly. She responded appropriately to staff basic questions. Lap buddy was in place and Resident #117 never attempted to remove or stand unassisted. During an observation on 2/29/12 at 8:57AM, resident was being fed by NA#4 with lap buddy in place. During an interview on 2/29/12 at 2:39PM, therapy director stated that therapy department did not do any of the assessment or determination for restraints. It was all done by the DON(director of nursing). During an interview on 2/29/12 at 2:49PM, the DON(director of nursing) stated that she was responsible for the evaluations/assessments of restraints. She indicated that after review of the record that Resident #117 did not have a medical reason for the use of restraint. She further stated that the therapy department was not generally included in the evaluation/assessment process for restraints and that process included use of the pre-restraint form on a quarterly basis. She added that she did not have a system in place that included what the assessment process entailed or documentation of the observations for the continuation or reduction of a restraint. She further stated " residents should not be restrained at family request and sometimes she gave into family request knowing that was not right " .She further stated that care plans should be updated to reflect the frequency of removal of restraints. She added that none of the identified residents had any recent or recurrent falls. The restraints were either applied per family request or poor safety awareness, there was no medical	F 221		

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F 221	Continued From page 9 indicators or physician input in the decision for the use of restraint. During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities.The residents should have a clinical reason for the use of restraint. During an observation on 3/1/12 at 8:53AM, resident seated at table with lap buddy in place, NA#1 assisting and resident with meal. 3. Resident #217 admitted to facility on 4/25/11. The cumulative diagnoses included hypertension, mild dementia, chronic obstructive pulmonary disease, osteoprosis and anxiety. The Minimum Data Set(MDS) dated 8/7/11, indicated that Resident #217 had some short and long term memory and decision making problems. She required one person assistance with activities of daily living and transfers. She was coded with a trunk restraints and no falls. Reviewed the fall log from 8/7/11 to 3/1/12, Resident #217 had 1 fall in September 2011. Review of phsyician order dated 6/14/11, revealed lap buddy to wheelchair due to numerous falls. Review of care plan dated 11/8/11, identified the problem as Resident #217 needed 2 person assistance, at risk factors for falls and injury, recent fall with hip fx and repeated falls with peri-prostatic fx. On 6/14/11 use of trunk restraint. The goals included Resident #217 would not fall and have no injuries in next 90 days. The	F 221		

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F 221	Continued From page 10 approaches included keeping the call light within reach at all times(HOH), keep bed in low position, remind at each contact to not to transfer without assisance, make sure foot wear had non-skid bottoms. Last documented fall was 9/5/11, while reaching for something and fell forward superficial bruise to knee. 2: Resident #217 required the use of a lap buddy due significant impaired cognition and poor decision making. The goal would be Resident #217 would have no adverse effect of restraint use AEB(as evidence by) no skin breakdown or dcreased ROM(range of motion). The approachaes included to make sure restraint was applied correctly, monitor that resident doesnt not slouch and slide down in chair, check freqently and give ROM exercise, provide opportunity for socilaization and sensory stimulation, reveiew restraint as needed for reduction or elimination, lap buddy in place as ordered. Review of the restraint reduction assessment form dated 7/3/11,8/14/11, 9/9/11,12/7/11, revealed the assessment action plan: will continue the use of lap buddy at times when up in wheelchair to decrease falls: lap buddy was least restricitve, used to decrease falls. Falls without lap buddy, poor safety awareness due to hx of falls. There was no further documentation regarding the assessment process or alternative measures attempted. Director of Nursing who indicated responsibility for the assessment revealed there was no documentation available of Resident #217 observed releasing the lap buddy or what the assessment process included to implement the or lap buddy or any other alternative devices. Additional review of the facility fall log from 7/3/11 through 3/1/12,	F 221		

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revealed Resident #217 had not had any falls.

During an observation on 2/29/12 at 7:52AM, Resident #217 was seated in the main dining room at the table with lap buddy in place. Resident#217 tray was positioned under the table and she was eating her meal from the main dining room table. She only required meal set only. Resident was reaching over lap buddy trying to get to her meal that was placed on the main table. Food was spilling all over the main table and the tray. Staff were assisting other residents.

During an interview on 2/29/12 at 8:00AM, NA #2 and NA #3 indicated that they generally work the main dining room. NA #2 indicated that the residents in the main dining room generally needed set-up assistance only. She added that the residents wore the lap buddy/trays because they were a fall risk and mobile within the facility. She indicated that the lap buddy or trays was not removed during dining due to the potential for the resident to lean forward or reach for something in the dining area unexpected. NA #3 stated that there have been no falls in the dining room because they did have the lap buddy's or trays in place and that the residents were fall risks. NA#3 stated that anytime a resident had a device like lap buddy or trays while in the dining room, staff would find a table that was at good height that the chair could fit under was used.

During an observation on 2/29/12 at 9:02AM, Resident #217 was set up NA#1 for breakfast meal with lap buddy in place. NA#4 indicated that the lap buddy was not removed during meals. Resident #217 was non-ambulatory and could only assist with pivoting and she was unaware of

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any falls. Resident #217 was unable to remove the lap buddy and she was uncertain why she had the lap buddy. Resident was able to eat her meal independently.

During an interview on 2/29/12 at 9:30AM, Resident #217 seated in her room. Resident#217 stated that she fell once when she first arrived and they put this pillow on me and foot pads and never took it off. I have not fallen. "I dont need it and it makes me feel trapped." I could probably get it off but it is too hard to stick the corners in the arm hole."

During an interview on 2/29/12 at 9:40AM, NA #1stated that Resident #217 had the pillow for more than a year and the nurses told her to put it on Resident#217 everyday to keep her from falling. She stated that she was unaware of the resident falling. Resident #217 could not remove the pillow when staff asked, she could not get the corners of the pillow from the arm rest. The pillow was not properly secured it was bent at the arms and crinkled at the pillow sitting on the resident knees.

During observation 2/29/12 at 10:30AM-11:00AM, Resident seated in room with lap buddy in place, there was no repetitive movements, leaning in any direction or attempts to remove lap buddy.

During an interview on 2/29/12 at 2:39PM, therapy director stated that therapy department did not do any of the assessment or determination. It was all done by the DON.

During an interview on 2/29/12 at 2:49PM, the DON(director of nursing) stated that she was

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OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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F 221	Continued From page 13 responsible for the evaluations/assessments of restraints. She indicated that after review of the record that Resident #217 did not have a medical reason for the use of restraint. She further stated that the therapy department was not generally included in the evaluation/assessment process for restraints and that process included use of the pre-restraint form on a quarterly basis. She added that she did not have a system in place that included what the assessment process entailed or documentation of the observations for the continuation or reduction of a restraint. She further stated " residents should not be restrained at family request and sometimes she gave into family request knowing that was not right " .She further stated that care plans should be updated to reflect the frequency of removal of restraints. She added that none of the identified residents had any recent or recurrent falls. The restraints were either applied per family request or poor safety awareness, there was no medical indicators or physician input in the decision of the use of restraint. During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities.The residents should have a clinical reason for the use of restraint. During an observation on 3/1/12 at 8:53AM, Resident #217 seated in dining hall with lap buddy in place, reaching across the table for her meal after staff set up. She had difficulty getting to meal due to the distance that she had to reach. 4. Resident #281 was admitted to the facility on 1/24/12. The cumulative diagnoses included	F 221		

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F 221	Continued From page 14 vertigo, diabetes, parkinson ' s disease, anemia and gait abnormality. The Minimum Data Set(MDS) dated 1/31/12, indicated that Resident #281 had some short and long term memory and decision making problems. Resident #281 required entensive to total assistance with activities of daily living(transfer/ mobility, dressing), needed some supervision with eating. The MDS indicated that Resident #281 did walk in room at least once or twice.She was not code with the use of restraint due to recent admission. Review of physician ' s order dated 1/25/12, revealed that Resident #281 would receive physical therapy 6 times a week times 12 weeks for theraputic exercise , gait training and w/c managment in group 1:1 act and difficulty walking. Additional review, on 2/9/12, revelaed a lap buddy for poor safety awareness and gait abnormality with falls and family request. On 2/16/12, physical therapy continued no weight bearing left lower extremity. Transfer board when going to bed/chair, continue with upper extremity conditioning, range of motion with hip precautions and follow-up in 4 weeks. Review of care plan dated 2/6/12 identified the problem as; Resident #281was at risk for falls and injury. The goal would be that Resident #281 would not have fall or injuries or adverse effect related to use of restraint in next 90 day. The approaches included keeping call light within reach at all times, bed in low position, lap buddy as ordered, remove from restraint and ambulate per protocol, observe for signs and symptons of anxiety related to lap buddy and offer frequent toileting assistance. During an observation on 2/29/12 at 7:52AM, Resident#281 was seated in the main dining room with lap buddy in place during the meal.	F 221		

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F 221	Continued From page 15 There were three staff assigned to the dining room. Resident #281 was able to state what she wanted for beverage during breakfast. No staff removed the lap buddy from her chair. Resident sat in an upright position without difficulty or repetitive movements. She was able to feed herself without difficulty. She ate her meal from the table. Resident#281 was reaching over lap buddy to get to the table. Her hands were shakey as she raised the coffee cup and food was all over the lap buddy. During an interview on 2/29/12 at 8:00AM, NA #2 and NA #3 indicated that they generally work the main dining room. NA #2 indicated that the residents in the main dining room generally needed set-up assistance only. She added that the residents wore the lap buddy/trays because they were a fall risk and mobile within the facility. She indicated that the lap buddy or trays was not removed during dining due to the potential for the resident to lean forward or reach for something in the dining area unexpected. NA #3 stated that there have been no falls in the dining room because they did have the lap buddy's or trays in place and that the residents were fall risks. NA#3 stated that anytime a resident had a device like lap buddy or trays while in the dining room, staff would find a table that was at good height that the chair could fit under was used. During an observation on 2/29/12 at 12:00PM, Resident #281 was observed seated in wheelchair with blue lap buddy in place. Resident#281 was very confused and unable to remove the lap buddy. She did not have any difficulty with positioning or sitting in an upright position or repetitive movements. During an interview on 2/29/12 at 12:05PM, nurse#2 stated that the reason Resident #281	F 221		

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F 221	Continued From page 16 had the lap buddy was becuase family wanted her to have it and to prevent falls. She stated that the resident was non weigt bearing on the left side and did not ambulate without staff assistance or stand. She added that the Resident #281 did go to therapy and they were working on strenght and gait training. She further stated that Resident #281 did not try to get up or do anything, the main reason was the family. During an interview on 2/29/12 at 2:39PM, therapy director stated that therapy department did not do any of the assessment or determination. It was all done by the DON. During an interview on 2/29/12 at 2:49PM, the DON(director of nursing) stated that she was responsible for the evaluations/assessments of restraints. She indicated that after review of the record that Resident #281 did not have a medical reason for the use of restraint. She further stated that the therapy department was not generally included in the evaluation/assessment process for restraints and that process included use of the pre-restraint form on a quarterly basis. She added that she did not have a system in place that included what the assessment process entailed or documentation of the observations for the continuation or reduction of a restraint. She further stated " residents should not be restrained at family request and sometimes she gave into family request knowing that was not right " .She further stated that care plans should be updated to reflect the frequency of removal of restraints. She added that none of the identified residents had any recent or recurrent falls. The restraints were either applied per family request or poor safety awareness, there was no medical indicators or physician input in the decision of the use of restraint.	F 221		

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F 221	Continued From page 17 During an interview on 2/29/12 at 3:01PM, the Administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities.The residents should have a clinical reason for the use of restraint. During an interview on 2/29/12 at 4:00PM, family member indicated that she was called by the facility nurse and was told that they were putting Resident #281 in lap buddy. She was not aware of the assessment process and she agreed to the use of the restraint based on what the nurse and director of nursing informed her that was occurring with Resident #281. The family indicated acknowledged awareness of the risk for falls and thought an assessment had been done by therapy. She added that she would not have put a restraint on Resident #281 unless and assessment had been done or the doctor had reviewed the case. She stated that the intent was for Resident #281 to receive therapy and return home.She indicated that Resident #281 could sit in an upright position without difficulty and the lap buddy was applied for safety and facility decision. During a follow up interview on 2/29/12 at 4:30PM, the administrator indicated that all restraints within the facility would be reviewed and evaluated. The therapy department and family education would be included in the new process.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to provide a dignified dining experience as evidence by not removing restraints during meals, for 4 of 4 sampled residents(Resident #33, 117, 217 and 281). The findings included: 1. Resident #33 was admitted to the facility on 1/26/10. Resident #33 current diagnoses included dementia, hemi paresis, hypertension diabetes and chronic obstructive pulmonary disease. The Minimum Data Set dated 10/1/11, indicated that Resident #33 had short and long term memory and decision making problems. Resident #33 required assistance with all activities of daily living was coded as non ambulatory with a trunk restraint. Last recorded fall noted on 5/1/11. Review of the last fall risk assessment dated 2/4/08, revealed that Resident #33 was non-ambulatory. Review of the care plan dated 7/27/11, identified the problem as; Resident #33 needs restorative nursing for eating and dining to improve self feeding and risk for weight loss. The goal included that Resident #33 would be able to feed self with minimal assist and would consume 75-100% of each meal. The approaches included encouraging Resident #33 to eat all food and provde verbal cues to assist with task, set-tray each meal, cut up food and open all containers, provide adaptive equipment as needed, monitor assistance needed, record percentage and intake	F 241	**F 241** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** 1. Resident #33, during meal times tray and lap buddy, was removed to allow resident to utilize the table space that is in front of her to maintain and enhance residents dignity and respect in full recognition of their individuality. 2. Resident #117, lap buddy was removed during meal time to maintain and enhance residents dignity and respect in full recognition of their individuality. 3. Resident #217, lap buddy was removed during meal time to enhance residents dignity and respect in full recognition of their individuality. 4. Resident #281, lap buddy was removed during meal times to maintain and enhance residents dignity and respect in full recognition of their individuality. **Corrective action to be accomplished for those residents having the potential to be affected by the same deficient practice:** 1. All residents that required restraints had them removed during meal times to provide a dignified dining experience. 2. Same as #1 3. Same as #1 4. Same as #1	3/29/12

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F 241	Continued From page 19 and notify nursing of any problems during meals that need further evaluation. During an observation on 2/29/12 at 7:29AM, Resident #33 was seated in front of her bedroom with lap tray in place. There was a chair cushion in place and she sat in an upright position without difficulty. There were no repetitive movements or leaning in any directions, both feet were place solid on the floor. During an interveiw on 2/29/12 at 7:32AM, nurse#1 stated that Resident #33 used the lap tray for meals and the tray was removed after meals. She added that resident was able to sit in an upright position without tray and only leans to leftside when she was tired or falls sleep in chair. Resident had not had any falls in months. Resident was unable to remove any type of device independently and she was non-ambulatory, could not recall resident attempting to get up unassisted. DON(director of nursing) handled assessments of restraints. During an interview on 2/29/12 at 7:35AM, NA #1 indicated that Resident#33 used the lap tray all the time, resident would attempt to stand or slid forward in chair. She added that the resident was able to reposition self in chair even when she slid forward. She was unaware of any falls. She indicated that when she slides forward was after she had fallen alseep in the chair. Resident was unable to remove any type of device. During an observation on 2/29/12 at 7:52AM, Resident#33 was seated in the main dining room at the table with lap tray in place. Resident#33 tray was positioned under the table and she was eating her meal from the main dining room table. She only required meal set only. Resident#33 was reaching over tray trying to get to her meal that was placed on the main table. Food was	F 241	**Measures put in place or systemic changes made to ensure that the deficient practice will not occur:** 1. All nursing staff was in-serviced regarding the removal of a restraint during meal times to provide dignity and respect of those individuals during the dining experience. **Monitoring Process** 1. The Director of Nursing and/or designee will monitor residents with restraints to ensure that they are being removed during meal times. Monitoring will take place 3 x week x 90 days then quarterly. Results will be reported to QA committee.	

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F 241	Continued From page 20 spilling all over the main table and the tray. Staff was assisting other residents. During an interview on 2/29/12 at 8:00AM, NA #2 and NA #3 indicated that they generally work the main dining room. NA #2 indicated that the residents in the main dining room generally needed set-up assistance only. She added that the residents wore the lap buddy/trays because they were a fall risk and mobile within the facility. She indicated that the lap buddy or trays was not removed during dining due to the potential for the resident to lean forward or reach for something in the dining area unexpected. NA #3 stated that there have been no falls in the dining room because they did have the lap buddy's or trays in place and that the residents were fall risks. NA#3 stated that anytime a resident had a device like lap buddy or trays while in the dining room, staff would find a table that was at good height that the chair could fit under was used. During an interview on 2/29/12 at 2:49PM, the DON stated that residents should be relaease during meals, activities, toileting and no resident should be eating with restraint in place. During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities. 2. Resident #117 was admitted to the facility on 3/16/07. Resident #117 cumulative diagnoses included hypertension, pulmonary fibrosis and dementia. The Minimum Data Set(MDS) dated 1/4/12, indicated that Resident #117 had short and long term memory and decision making problems. She required total assistance with all areas of daily living. She was coded as needing assistance with meals.	F 241		

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F 241	Continued From page 21 Review of the care plan dated 12/7/11, identified the problem as; Resident #117 was on altered nutrition due to below ideal body weigh and weight loss. The goal included resident would remain stable at 5 pounds above weight through next review. The apporaches included, monitor intake, weight, skin and labs, honor food preferences, must be assisted with meals and provide supplements as ordered. During an observation on 2/29/12 at 8:57AM, resident was being fed by NA#4 with lap buddy in place. During an observation on 2/29/12 at 7:47AM, Resident #117 was brought from bedroom back to main dining area by NA#4. NA#4 stated that the Resident#117 had a lap buddy on since November of last year and at one time the lap buddy was removed and family requested that it be put back on resident. The resident did not have any falls and was unable to remove it independently. During an observation on 3/1/12 at 8:53AM, resident seated at table with lap buddy in place, NA#1 assisting and resident with meal. During an interview on 2/29/12 at 2:49PM, the DON stated that residents should be relaease during meals, activities, toileting and no resident should be eating with restraint in place. During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities. 3. Resident #217 admitted to facility on 4/25/11. The cumulative diagnoses included hypertension, mild dementia, chronic obstructive pulmonary disease, osteoprosis and anxiety. The Minimum Data Set(MDS) dated 8/7/11, indicated that	F 241		

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F 241	Continued From page 22 Resident #217 had some short and long term memory and decision making problems. She required one person assistance with activities of daily living and transfers. She was coded as needed supervision with meals. Review of the care plan dated 10/28/11, identified the problem as; Resident #217 had weight loss and variable intake and low albumin levels. The goal included resident weight would remain stable above 5 pounds. The approaches included honor food preferences, monitor weight, intake, labs and provide recommended diet and nutritional supplements. During an observation on 2/29/12 at 7:52AM, Resident #217 was seated in the main dining room at the table with lap buddy in place. Resident#217 tray was positioned under the table and she was eating her meal from the main dining room table. She only required meal set only. Resident was reaching over lap buddy trying to get to her meal that was placed on the main table. Food was spilling all over the main table and the tray. Staff were assisting other residents. During an interview on 2/29/12 at 8:00AM, NA #2 and NA #3 indicated that they generally work the main dining room. NA #2 indicated that the residents in the main dining room generally needed set-up assistance only. She added that the residents wore the lap buddy/trays because they were a fall risk and mobile within the facility. She indicated that the lap buddy or trays was not removed during dining due to the potential for the resident to lean forward or reach for something in the dining area unexpected. NA #3 stated that there have been no falls in the dining room because they did have the lap buddy's or trays in place and that the residents were fall risks. NA#3 stated that anytime a resident had a device like	F 241		

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lap buddy or trays while in the dining room, staff would find a table that was at good height that the chair could fit under was used.
During an observation on 2/29/12 at 9:02AM, Resident #217 was set up by NA#1 for breakfast meal with lap buddy in place. NA#4 indicated that the lap buddy was not removed during meals. Resident #217 was non-ambulatory and could only assist with pivoting. Resident #217 was unable to remove the lap buddy and she was uncertain why she had the lap buddy. Resident was able to eat her meal independently.
During an interview on 2/29/12 at 2:49PM, the DON stated that residents should be relaease during meals, activities, toileting and no resident should be eating with restraint in place.
During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be relaeased during meals/actvities.
During an observation on 3/1/12 at 8:53AM, Resident #217 seated in dining hall with lap buddy in place, reaching across the table for her meal after staff set up. She had difficulty getting to meal due to the distance that she had to reach.
4. Resident #281 was admitted to the facility on 1/24/12. The cumulative diagnoses included vertigo, diabetes, parkinson ' s disease, anemia and gait abnormality. The Minimum Data Set(MDS) dated 1/31/12, indicated that Resident #281 had some short and long term memory and decision making problems. Resident #281 required extensive to total assistance with activities of daily living(transfer/ mobility, dressing), needed some supervision with eating.
During an observation on 2/29/12 at 7:52AM, Resident#281 was seated in the main dining

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F 241	Continued From page 24	F 241		

room with lap buddy in place during the meal. There were three staff assigned to the dining room. Resident #281 was able to state what she wanted for beverage during breakfast. No staff removed the lap buddy from her chair. Resident sat in an upright position without difficulty or repetitive movements. She was able to feed herself without difficulty. She ate her meal from the table. Resident#281 was reaching over lap buddy to get to the table. Her hands were shakey as she raised the coffee cup and food was all over the lap buddy.

During an interview on 2/29/12 at 8:00AM, NA #2 and NA #3 indicated that they generally work the main dining room. NA #2 indicated that the residents in the main dining room generally needed set-up assistance only. She added that the residents wore the lap buddy/trays because they were a fall risk and mobile within the facility. She indicated that the lap buddy or trays was not removed during dining due to the potential for the resident to lean forward or reach for something in the dining area unexpected. NA #3 stated that there have been no falls in the dining room because they did have the lap buddy's or trays in place and that the residents were fall risks. NA#3 stated that anytime a resident had a device like lap buddy or trays while in the dining room, staff would find a table that was at good height that the chair could fit under was used.

During an interview on 2/29/12 at 2:49PM, the DON stated that residents should be relaease during meals, activities, toileting and no resident should be eating with restraint in place.

During an interview on 2/29/12 at 3:01PM, the administrator indicated the expectation was that therapy be involved in the restraint assessment and done quartely. Residents should be

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	345443	A. BUILDING _____ B. WING _____	C 03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 25 relaeased during meals/actvities.	F 241	**F 371**	3/29/12
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility 1) failed to air-dry bowls and cups, 2) failed to ensure food items in the 1 of 1 upright freezer were labeled and dated when taken out of the original container, and 3) failed to keep exhaust hood filters clean and free of dust and grease. Findings include: 1. During kitchen observation on 2/27/12 at 11:40 a.m., 2 racks of red bowls were observed stacked on top of each other on the serving line, and 3 racks of red cups were observed stacked on top of each other under the serving line, wet and with water running off the bowls. The Dietary Manager acknowledged the condition of the bowls, saying that they were clean but wet, and he did not know who had stacked the wet cups and bowls on top of each other. The Dietary Manger directed a food service worker to remove the wet bowls and cups off the line.	F 371	**Corrective action to be accomplished for those residents found to have been affected by thedeficient practice:** 1. The wet bowls and cups were removed from the line. 2. The clear bag of frozen chicken patties, clear bag of chicken fingers, and the brown bag of French fries were labeled and dated. 3. The exhaust hood filters were hand cleaned by the Director of Dining Services. **Corrective action to be accomplished for those residents having the potential to be affected by the same deficient practice:** 1. The wet bowls and cups were removed from the line to dry properly. 2. The clear bag of frozen chicken patties, clear bag chicken fingers, and the brown bag of French fries were labeled and dated. 3. The exhaust hood filters were hand cleaned by the Director of Dining Services.	

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F 371	Continued From page 26 During a follow-up kitchen observation on 2/29/12 at 3:44 p.m., 4 racks of salad bowls were observed on the serving line, wet and 2 racks of wet cups (50 cups) were observed stacked on top of each other on a cart near the serving line. In an interview on 2/29/11 at 3:50 p.m., the dietary aide stated, " I do not know who stored the bowls wet on the cart. " The dietary aide looked at the clock in the kitchen and stated that they had been there drying roughly 2 hours. 2. During the kitchen tour on 2/27/12 at 11:14 a.m., the following items were observed in 1 of 1 upright freezer: 1 open clear plastic bag of frozen chicken patties, 1 open clear plastic bag of chicken fingers, and 1 brown bag of French fries (as identified by the director of food services), all of which were unlabeled and undated. Subsequent inspection of the kitchen tour on 2/29/12 at 3:44 p.m., the following items were observed in 1 of 1 upright freezer: 1 open clear plastic bag of frozen chicken patties, 2 open clear plastic bags of chicken fingers, and 1 brown bag of French fries (as identified by the director of food services), all of which were unlabeled and undated. During an interview on 2/29/12 at 3:50 p.m., the director of food services stated, " The labels will not stay on the bags. " He proceeded to print the name of the product and date on the food products. 3. During the initial tour of the kitchen on 2/27/12 at 11:00 a.m., the exhaust hood filters above the stove were heavily coated with grease	F 371	**Measures put in place or systemic changes made to ensure that the deficient practice will not occur:** 1. The Director of Dining Services will monitor the drying process daily to ensure all bowls and cups are properly dried before use. 2. Daily inspection of the upright freezer to ensure that all items are labeled and dated. 3. The exhaust hood filters will be cleaned professionally, quarterly, and as needed by the Director of Dining Services. Dietary staff was in-serviced on: 1. The appropriate way to air dry insulated dishes. 2. Insulated dishes are not to be stacked upon each other for drying. 3. Instructed to not use dishes that are still wet or dirty. **Monitoring Process** The Director of Dining Services will monitor the drying process and upright freezer for 30 days, monthly x 3 months, with results report to QA committee.	

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F 371	Continued From page 27 and dust. During a follow-up kitchen inspection on 2/29/12 at 3:44 p.m., the exhaust hood filters above the stove were heavily coated with grease and dust. During an interview on 2/29/12 at 3:50 p.m., the Dietary Manager revealed that " the exhaust hood filters are contracted through a company and are cleaned every 3 months. " The Dietary Manager further stated that the filters were last cleaned in November 2011, and the commercial company will come on March 8, 2012, to clean the filters.	F 371		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345443	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/27/12 at approximately 2:00 PM the following hazardous area was non-compliant, specific findings include the the kitchen storage room door was held open with wire. There must be no impediment to closing of the door.	K 029	K029 **Corrective action accomplished by the facility to correct the deficient practice:** The wire was removed from the kitchen storage door. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The Director of Facility Services inspected all doors to ensure there were not any wires holding them open. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur;** A mag lock was installed to hold the door open properly, when needed. The Director of Facility Services will inspect all doors to ensure there are not any wires holding them open. **Monitoring Process** 1. The inspection of all doors will be conducted monthly for 3 months, and then quarterly by the Director of Facility Services. 2. The results of the inspections will be discussed in the facility's QA meeting.	5/1/12
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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

Administrator — 4/10/12

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	6080 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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K 052	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/27/12 at approximately 2:00 PM the following fire alarm system component was non-compliant, specific findings include there was not an audible signal with loss of power, battery back-up, or loss of phone line at an area where it is likely to be heard. There was a visual and audible at the main fire alarm panel located in the maintenance office down the service hall, however there was only a visual signal at the annunciator panel located at both nurses stations.	K 052	K052 **Corrective action accomplished by the facility to correct the deficient practice:** The annunciator panels at both nurses stations were repaired so that audible signal with loss of power, battery back-up, or loss of phone line will be heard. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The annunciator panels at both nurses stations were repaired so that audible signal with loss of power, battery back-up, or loss of phone line will be heard. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** The Director of Facility Services will inspect both the annunciator panels at both nurses stations, during monthly fire drills, to ensure audible signal with loss of power, battery back-up, or loss of phone line will be heard. **Monitoring Process** 1. The inspection of the annunciator panels will be conducted monthly for 3 months, and then quarterly by the Director of Facility Services. 2. The results of the inspections will be discussed in facility's QA meeting.	4/5/12
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/27/12 at approximately 2:00 PM the facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was located next to a steam kettle without the required splash guard in the dietary kitchen.	K 069		

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OAK FOREST HEALTH AND REHABILITATION	5880 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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K 052	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/27/12 at approximately 2:00 PM the following fire alarm system component was non-compliant, specific findings include there was not an audible signal with loss of power, battery back-up, or loss of phone line at an area where it is likely to be heard. There was a visual and audible at the main fire alarm panel located in the maintenance office down the service hall, however there was only a visual signal at the annunciator panel located at both nurses stations.	K 052	K069 **Corrective action accomplished by the facility to correct the deficient practice:** A required splash guard was placed on the deep fryer **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** A required splash guard was placed on the deep fryer	4/11/12
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/27/12 at approximately 2:00 PM the facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was located next to a steam kettle without the required splash guard in the dietary kitchen.	K 069	**Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** A required splash guard was placed on the deep fryer. **Monitoring Process** 1. The Director of Facility Services will inspect the required splash guard on the deep fryer monthly then quarterly to ensure its effectiveness. 2. The results of the inspections will be discussed in facility's QA meeting.	