STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

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F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, family interview, and staff interviews the facility failed to get a resident out of her bed for two weeks resulting in isolation (Resident #1) and failed to provide a preferred shower (Resident #5) for 2 of 3 residents reviewed for choices. Findings included: 1. The resident was admitted on 6/20/17. Resident #1 ' s quarterly Minimum Data Set dated 10/10/17 revealed the resident had a severely impaired cognition. The resident required extensive assistance and total dependence for transfers and all activities of daily living. The diagnoses were aphasia, hemiplegia, anxiety, depression, osteoarthritis and contracture of the right arm.	F 242	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F242 SELF-DETERMINATION-RIGHT TO MAKE CHOICES. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;	11/10/17

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

Electronically Signed | 11/10/2017

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F 242	Continued From page 1 Resident #1 ' s care plan dated 10/11/17 revealed goals and interventions for at risk for falls which required a Hoyer lift for all transfers, at risk for pressure ulcer use of a gel cushion when up in the chair, communication deficit secondary to stroke and aphasia, right hemiparesis, and shift weight when up to the chair. On 10/18/17 at 10:45 am an observation was done of Resident #1. The resident was in her bed resting with eyes closed, easily aroused by voice. On 10/18/17 at 2:10 pm Resident #1 was observed to be in her bed. On 10/18/17 at 4:20 pm Resident #1 was observed to be in her bed. On 10/18/17 at 5:30 pm Resident #1 was observed to be in her bed. On 10/18/17 at 10:45 am an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated that Resident #1 usually remained in bed after this last hospitalization (readmitted 10/3/17). The resident used to get out of bed to the chair and out of her room before the hospitalization. On 10/18/17 at 10:50 am an interview was conducted with Nurse #2. Nurse #2 stated she was assigned to Resident #1. Nurse #2 stated that the resident does not get out of bed because she required a Geri-chair to sit up and the State informed the facility that a Geri-chair was a restraint. Nurse #2 stated that the resident had not been out of bed since her readmission from the hospital two weeks ago because she was unable to sit up in a wheel chair. Nurse #2 stated there had not been an attempt to get the resident	F 242	The facility failed to get a resident out of her bed for two weeks resulting in isolation (Resident #1) and failed to provide a preferred shower (Resident #5) for 2 of 3 residents reviewed for choices. Resident #1. Care plan meeting was held on 11/7/2017 with the family present, and interdisciplinary team (in attendance were: Nurse practitioner, Minimum Data Set Coordinators, Social Worker, Dietary Manager. Medical Doctor aware of meeting and gave recommendations that were presented by the Nurse Practitioner. This recommendations were to have resident up and out of bed for 2 hours daily on first shift). Resident will be up and out of bed for 2 hours daily on first shift to interact with other residents and participate in activities as tolerated. Resident #5. Resident prefers showers on her scheduled shower days and prefers bed baths on the other days. Resident received showers as scheduled every Friday on day shift, and every Tuesday on day shift. Resident has received showers on 10/20/2017,10/27/17, 10/31/2017, 11/3/2017 and 11/7/2017, 11/10/2017. Resident is alert and oriented x3 and was able to validate that she received showers on her scheduled, preferred days. Resident has a choice to receive a shower at any time when she requests. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 10/30/17, the Nurse Consultant reviewed each resident's Kardex (Care plan interventions are reflected in the Kardex) in the electronic health record to	

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F 242	Continued From page 2 out of bed. On 10/19/17 at 9:00 am Resident #1 was observed to be in her bed. On 10/19/17 at 11:05 am Resident #1 was observed to be in her bed. On 10/19/17 at 1:55 pm Resident #1 was observed to be in her bed. On 10/19/17 at 8:45 am an interview was conducted with the Resident #1 ' s family member. The family member stated that he asked Nurse #2 on several occasions to get the resident out of bed every day. Nurse #2 did not provide the family member a reason why the resident could not get out of bed. The family member stated he always found the resident in bed when he came to visit. On 10/19/17 at 12:30 pm an interview was conducted with the Physician's Assistant who stated there was no reason the resident could not get out of bed with the mechanical lift. On 10/19/17 at 2:38 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she was not aware that Resident #1 had not been out of bed for weeks. The resident ' s last hospitalization was a setback for the resident. The DON stated that physical therapy would need to evaluate the resident ' s chair safety. The DON would follow up with the family. 2. The resident was admitted to the facility on 6/19/17. The quarterly Minimum Data Set dated 7/24/17 revealed Resident #5 had an intact cognition and no behaviors. The resident	F 242	ensure that each resident had a Kardex in the electronic health record. It was found that 100% of the residents had a Kardex. On 10/30/2017 to 11/8/2017 all Kardex' s (Care plan interventions are reflected in the Kardex) were reviewed to ensure that they had a shower schedule for each resident per their preference and appropriate by Minimum Data Set Coordinators, Nurse, Nurse aides, Quality Assurance Nurse Consultant and Director of nursing. Kardex are accurate and appropriate. On 11/1/2017, The Nurse Consultant with the Minimum Data Set Nurse Consultants reviewed residents who are bedfast all or most of the time (e.g., in bed or geriatric chair/recliner) includes bedfast with bathroom privileges to ensure that they were up and out of bed so as to interact with other residents and participate in activities. No other residents were identified as bedfast. On 11/1/17 to 11/8/2017, the Director of nursing, Regional Staff Development Nurse and Quality Assurance Nurse Consultant began in servicing all nurses and nursing assistants: • You are required to review the Kardex (Care plan interventions are reflected in the Kardex) of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. • If you do not see a Kardex then consult with your nurse for further care instructions. • You should always follow the plan of care for the residents as outlined on the Kardex. If the resident's condition has	

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F 242	Continued From page 3 required one-person physical assistance for activities of daily living. The resident' s diagnoses were peripheral vascular disease, urinary tract infection, age related osteoporosis, and deep vein thrombosis. A review of Resident #5 ' s care plan dated 7/24/17 revealed goals and interventions for urinary incontinence and self-care deficit. The resident was scheduled to have a shower twice a week. A review of Resident #5 ' s shower log for August, September, and October of 2017 revealed the resident was scheduled or a shower twice a week on Tuesday and Friday and missed on average one scheduled shower each week. On 10/18/17 at 1:45 pm an interview was conducted with Resident #5. Resident #5 stated sometimes the staff took a while to answer the call light and she had to wait. The resident stated that she liked a shower and had a shower mostly twice a week. The resident washed herself in the bathroom if she did not receive a shower. The resident was not always ready for a shower early in the morning and when she was not ready she was not offered a shower later in the day. The resident stated she would have liked a shower. An interview was conducted with NA #1 on 10/18/17 at 2:57 pm. NA #1 stated she worked at the facility for about 20 years. NA #1 indicated she normally worked on the first shift (7:00 am to 3:00 pm). NA #1 stated her assignment normally included 13-14 residents per day. She indicated it was "extremely difficult" to get all her scheduled showers completed during her normal shift. NA #1 stated if the facility census was not full or if a	F 242	changed, you feel that the plan is unsafe, or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care. • To access the Kardex you can click on the resident's name in the electronic health record and click on the Kardex brick. On 11/1/2017 to 11/8/2017, The Quality Assurance Nurse Consultant and Regional Staff Development Nurse in serviced all Nurses and Nurse Aides (full time, part time and PRN/as needed) to inform them that, each resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. Each resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. Each resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Each resident has a choice of how many times a week they can take a shower or bath. Each resident has a right to receive a shower or a bath per plan of care. As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants) will be allowed to work until the training has been completed. Effective 11/9/2017, this training is incorporated into the new employee	

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F 242	Continued From page 4 resident refused or was not ready for their shower it helped her to complete her assigned tasks. Some showers were pushed off to the next day. Resident #5 sometimes did not receive her shower on the scheduled day. NA #1 indicated if a scheduled shower was not completed, the reason for not giving the shower (ex: resident refusal, resident unavailable) was required to be documented by the NA in the electronic documentation system. If the shower was not documented as being given NA #1 stated could not remember if she gave one. NA #1 revealed she had reported concerns about not being able to complete her assignment (which included scheduled showers) to the Administrator and Director of Nursing in the past, but it had not improved. A phone interview was conducted with NA #2 on 10/19/17 at 11:50 am. NA #2 stated she worked at the facility for 2 years. NA #2 indicated she normally worked on the second shift (3:00 pm to 11:00 pm), but there were occasions when she filled in on other shifts. She reported showers were required to be documented by the NAs in the electronic documentation system. She stated if a shower was not given the reason was required to be documented by the NA. On 10/19/17 at 12:20 pm an interview was conducted with Nursing Assistant (NA) #3. NA #3 stated that it was her fault the shower documentation log had missing documentation for Resident #5 ' s shower. Resident #5 may have gotten a bed bath or may have been asked if she wanted a shower at another time. The nurse was not notified. NA #3 stated that if she had 14 residents on her day shift and a resident was not ready for their shower when asked, there may not be enough time for a shower on that day. The resident	F 242	orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting evening shift of 11/1/2017 each nurse assigned to a unit will be required to monitor change of shift activity to ensure that Nurse Aides are reviewing the Kardex (Care plan interventions are reflected in the Kardex) before they start their assignment. To ensure compliance, the Director of Nursing will review the tools used by the nurses in the unit to ensure that they are monitoring the aide's change of shift on a weekly basis. The nurse aide assigned to each unit will be required to document in the residents electronic medication record that the resident received shower as scheduled or as requested. The Nurse aide will notify the nurse assigned if a resident refuses to have their scheduled shower. The nurse will talk with the resident and if the resident still refuses, the nurse will notify resident's responsible party and document in the electronic medical record. The Director of Nursing and/or Nurse Manager will interview 5 alert and oriented residents each week to ensure that they	

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F 242	Continued From page 5 would then miss their his or her shower for that day. The shower would have to be pushed off to the next day or another day. Not all residents scheduled for a shower on a specific day received their shower on that day. NA #3 stated Resident #5 had been offered a shower early in the morning. The resident was not always ready early and declined an early shower and staff could not always fit in a shower later in the day. NA #3 reported showers were required to be documented by the NAs in the electronic documentation system. She stated if a shower was not given the reason was required to be documented by the NA. An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 2:38 PM. The DON indicated her expectation was for residents to receive showers twice a week as scheduled. She stated if a shower was provided it was to be documented by the NA in the electronic documentation system. She reported if a shower was refused by the resident the refusal was expected to be documented by the NA in the electronic documentation system, the nurse was to be informed verbally by the NA, and the nurse was also to document the refusal in a note. The DON revealed it was not a surprise to her that showers were not provided as scheduled. She stated the facility had issues with showers being provided as scheduled and staffing concerns several months ago. The DON indicated a root cause analysis tool was utilized at that time to find a link between issues with showers not being provided and staffing. She reported staffing was increased on one of the nursing stations as well as rearranging NA assignments based on the acuity of residents. The DON stated she thought these concerns had been resolved. She	F 242	are receiving their showers as scheduled or as requested. This will be done on weekly basis for 4 weeks then monthly for 3 months. The Director of Nursing and/or Nurse Manager will observe 5 cognitively impaired resident each week to monitor for showers as per preferred schedule. The Director of Nursing and /or Nurse Manager will observe 5 residents (Cognitively impaired residents) each week to ensure that they are getting up daily as per their preferences. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Management, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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F 242	Continued From page 6 indicated this issue would warrant looking at again.	F 242		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed follow the plan of care interventions related to falls for 2 of 3 residents (Residents #6 and #8) reviewed for accidents and the interventions related to aspiration precautions for 1 of 1 residents (Resident #1) reviewed with a tube feeding. The findings included: 1. Resident #8 was admitted to the facility on 3/16/10 and most recently readmitted to the facility on 4/16/14 with diagnoses that included hemiplegia (paralysis of one side of the body) following a cerebral infarction affecting unspecified side, contracture of unspecified hand, and obesity. The quarterly Minimum Data Set (MDS) assessment dated 8/7/17 indicated Resident #8 ' s cognition was intact. She was assessed with no behaviors and no rejection of care. Resident #8 was coded as requiring the extensive	F 282	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F282 SERVICES BY QUALIFIED PERSONS/PER CAREPLAN. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed follow the plan of care interventions related to falls for 2 of 3 residents (Residents #6 and #8) reviewed	11/10/17

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F 282	Continued From page 7 assistance of two or more staff with bed mobility and transfers. She had impairment on one side of the upper and lower extremities and utilized a wheelchair. The plan of care for Resident #8 read, in part, "I am at risk for falls related to unsteady balance and hemiplegia. I require [Mechanical Lift #1] and two assist during transfers". The interventions indicated Mechanical Lift #1 was required with two staff assistance for transfers of Resident #8. This plan of care was initiated on 10/22/13 and the last revision was 10/18/17. An observation was conducted on 10/18/17 at 9:25 AM of Resident #8 in her room. Resident #8 was observed to be transferred from bed to wheelchair by Nursing Assistant (NA) #1 utilizing Mechanical Lift #2. There were no other staff members present in Resident #8's room to assist NA #1 with the safe operation of Mechanical Lift #2. An interview was conducted with the Staff Development Coordinator (SDC) on 10/18/17 at 2:45 PM. She stated the facility utilized two types of mechanical lifts, Mechanical Lift #1 and Mechanical Lift #2. She indicated Mechanical Lift #1 was a full body lift utilized for residents who were non-weight bearing and Mechanical Lift #2 was a stand-up style lift utilized for residents who were partially weight bearing. The SDC stated the facility's policy was for two staff members to be present when operating both types of mechanical lifts. She reported this was for the safety of the residents and staff members. An interview was conducted with NA #1 on 10/18/17 at 2:57 PM. NA #1 confirmed she	F 282	for accidents and the interventions related to aspiration precautions for 1 of 1residents (Resident #1) reviewed with a tube feeding. Resident#8 Care plan interventions are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate Resident #6 Care plan interventions are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate. Resident #1.Care plan interventions are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Intervention in place indicating that resident is on aspiration precautions due to tube feeding. Nurse to be notified prior to providing care. Head of bed not to be lowered while tube feeding is infusing. Kardex is accurate and appropriate. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 10/30/17, the Nurse Consultant reviewed each resident's kardex (Care plan interventions are reflected in the	

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F 282	Continued From page 8 utilized Mechanical Lift #2 to transfer Resident #8 from bed to chair that morning (10/18/17). She revealed she utilized Mechanical Lift #2 without another staff member present. She stated she was unaware of the facility's policy for the number of staff members required to be present during the operation of Mechanical Lift #2. NA #1 explained that she was not normally assigned to Resident #8 and she was unfamiliar with the proper procedure to operate Mechanical Lift #2. An interview was conducted with Resident #8 on 10/19/17 at 9:00 AM. Resident #8 indicated she required the assistance of staff as well as a mechanical lift for transfers. She stated normally there was only one staff member present when the mechanical lift was utilized for her transfers. An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 10:25 AM. She indicated it was her expectation that care plan interventions be followed. She additionally indicated she expected the staff to follow the facility's policy to have two staff members present when using Mechanical Lift #1 and Mechanical Lift #2. 2. Resident #6 was admitted to the facility on 6/20/17 with diagnoses that included paraplegia and Multiple Sclerosis (MS). The admission Minimum Data Set (MDS) assessment dated 6/27/17 indicated Resident #6 was cognitively intact. He was assessed with no behaviors and no rejection of care. Resident #6 was coded as requiring the extensive assistance of two or more staff with bed mobility and transfers. He had impairment on both sides of the lower extremities and utilized a wheelchair.	F 282	Kardex) in the electronic health record to ensure that each resident had a kardex in the electronic health record. It was found that 100% of the residents had a Kardex. On 10/30/2017 to 11/8/2017 all Kardex' s (Care plan interventions are reflected in the Kardex) were reviewed to ensure that they were accurate and appropriate by Minimum Data Set Coordinators, Nurse, Nurse aides, Quality Assurance Nurse Consultant and Director of nursing. Kardex are accurate and appropriate. On 11/8/2017, The Nurse Consultant with the Minimum Data Set Nurse Consultants reviewed residents who received tube feeding to ensure that they have interventions in place indicating that: resident is on aspiration precautions due to tube feeding. Nurse to be notified prior to providing care. Head of bed not to be lowered while tube feeding is infusing. On 11/1/17 to 11/8/2017, the Director of nursing, Regional Staff Development Nurse and Quality Assurance Nurse Consultant began in servicing all nurses and nursing assistants: • You are required to review the kardex (Care plan interventions are reflected in the Kardex) of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. • If you do not see a kardex then consult with your nurse for further care instructions. • You should always follow the plan of care for the residents as outlined on the kardex. If the resident's condition has changed, you feel that the plan is unsafe,	

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F 282	Continued From page 9 The Care Area Assessment (CAA) related to falls for the 6/27/17 admission MDS assessment indicated Resident #6 was non-ambulatory. He was noted as required the extensive assistance of staff for transfers. Resident #6 ' s risk factors for falls included MS, paraplegia, and muscle spasms. He was indicated to be at risk for fractures or soft tissue damage that had the potential to lead to immobility and consequently death. The plan of care for Resident #6 indicated he was at increased susceptibility to falling that may cause physical harm related to unsteady gait/balance secondary to non-weight bearing bilateral extremities status due to MS. The interventions indicated Resident #6 required Mechanical Lift #1 for transfers. The plan of care was initiated on 6/21/17. An interview was conducted with Resident #6 on 10/18/17 at 1:30 pm. He indicated he required the assistance of staff as well as a mechanical lift for transfers. Resident #6 stated he was transferred from his bed to his wheelchair by one staff member utilizing Mechanical Lift #2. He reported Mechanical Lift #1 was utilized when staff had to weigh him. He indicated sometimes there was one staff member present when operating Mechanical Lift #1 and other times there were two staff members present. An interview was conducted with the Staff Development Coordinator (SDC) on 10/18/17 at 2:45 PM. She stated the facility utilized two types of mechanical lifts, Mechanical Lift #1 and Mechanical Lift #2. She indicated Mechanical Lift #1 was a full body lift utilized for residents who	F 282	or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care. • To access the kardex you can click on the resident's name in the electronic health record and click on the kardex brick. On 11/1/2017 to 11/8/2017, The Quality Assurance Nurse Consultant and Regional Staff development Nurse in serviced all Nurses and Nurse Aides (full time, part time and PRN/as needed) to inform them that the services provided or arranged by the facility, as outlines by the comprehensive care plan must be provided by qualified persons in accordance with each resident's written plan of care. Nurse Aide Skill's checklist was completed by Regional Staff Development Nurse and Quality Assurance Nurse Consultant by 11/8/2017 on Nurse Aides by completing an observation of use of Mechanical lifts and providing care to resident receiving tube feeding (Full time, part time and PRN/as needed) to ensure that the followed the plan of care as indicated. As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants) will be allowed to work until the training has been completed. Effective 11/9/2017, this training is incorporated into the new employee orientation program.	

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	345284	A. BUILDING _____ B. WING _____	C 10/19/2017

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F 282	Continued From page 10 were non-weight bearing and Mechanical Lift #2 was a stand-up style lift utilized for residents who were partially weight bearing. The SDC stated the facility ' s policy was for two staff members to be present when operating both types of mechanical lifts. She reported this was for the safety of the residents and staff members. An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 10:25 AM. She indicated it was her expectation that care plan interventions be followed. She additionally indicated she expected the staff to follow the facility ' s policy to have two staff members present when using Mechanical Lift #1 and Mechanical Lift #2. 3. The resident was re-admitted to the facility on 10/3/17 with multiple diagnoses that included aphasia, aphagia, hemiplegia, gastrostomy, and gastroesophageal reflux disease. Resident #1 ' s quarterly Minimum Data Set dated 10/10/17 revealed the resident had a severely impaired cognition and no behaviors. The resident required extensive assistance and total dependence for transfers and all activities of daily living. The resident received her nutrition and hydration by gastrostomy tube feeding. Resident #1 ' s care plan dated 10/11/17 revealed goals and interventions for gastrostomy tube feeding and potential for aspiration and to maintain nutrition by tube feeding. Physician ' s order dated 10/3/17 revealed Resident #1 was taking nothing by mouth. Physician ' s order dated 10/12/17 revealed	F 282	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting evening shift of 11/1/2017 each nurse assigned to a unit will be required to monitor change of shift activity to ensure that Nurse Aides are reviewing the Kardex before they start their assignment. To ensure compliance, the Director of Nursing will review the tools used by the nurses in the unit to ensure that they are monitoring the aide’s change of shift on a weekly basis. The Director of Nursing and/or Nurse Manager will observe 5 nurse aides weekly to include weekends (all varies shifts) to ensure that they are following the plan of care as indicated on the (Care plan interventions are reflected in the Kardex) while providing care (At least one of the observations will be done on a resident who receives tube feeding and resident who require use of a mechanical lift). This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly	

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F 282	Continued From page 11 Glucerna 1.5 60 milliliters/hour continuous via gastrostomy tube. On 10/18/17 at 11:30 am an observation was done of Resident #1. The resident was in her bed with the head of the bed elevated (HOB) 45 degrees and the tube feeding was infusing at 60 milliliters per hour. Nursing Assistant (NA) #1 lowered the HOB to flat for care and the tube feeding was still infusing. The resident started coughing and her face turned flush red. NA #1 raised the HOB and realized the TF was still running. On 10/18/17 at 3:45 pm an interview was conducted with NA #1. NA #1 stated that she had lowered Resident #1 ' s HOB and did not realize the tube feeding was running. NA #1 stated that the resident had coughed and became flush and it was then that NA #1 realized the tube feeding was running. NA #1 thought the tube feeding was off. NA #1 stated she raised the HOB and asked Nurse #2 to turn the tube feeding off. NA #1 stated she usually obtained nursing assistance to turn off the tube feeding before she lowered the HOB. On 10/19/17 at 10:20 am an interview was conducted with the Director of Nursing (DON). The DON stated that staff was expected to turn off the tube feeding before lowering the HOB and to keep the HOB elevated 30 to 45 degrees when the tube feeding was running as part of aspirations precautions.	F 282	Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2)	F 312		11/10/17

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F 312	Continued From page 12 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to provide scheduled showers for 2 of 4 residents reviewed for activities of daily living (Residents #1 and #7) and failed to provide incontinence care as needed for 1 of 3 residents reviewed for incontinence care (Resident #1). Findings included: 1a. The resident was admitted to the facility on 6/20/17. Resident #1 ' s quarterly Minimum Data Set dated 10/10/17 revealed the resident had a severely impaired cognition and no behaviors. The resident required extensive assistance and was totally dependence dependent upon staff for transfers and all activities of daily living. The diagnoses were hemiplegia, osteoarthritis and contracture of the right arm. Resident #1's care plan dated 10/11/17 revealed goals and interventions for incontinence care of bowel and bladder, potential for skin breakdown, and total extensive assistant for all aspects of activities of daily living. The resident was to receive a shower twice a week. A review of Resident #1's shower log for August, September, and October 2017 revealed the resident had received her shower two to four times during the month and there was no documentation that the resident received a bed bath on the missed shower days. The resident	F 312	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to provide scheduled showers for 2 of 4 residents reviewed for activities of daily living (Residents#1 and #7) and failed to provide incontinence care as needed for 1 of 3 residents reviewed for incontinence care (Resident #1). Resident #1. Resident representative prefers showers on her scheduled shower days and prefers bed baths on the other days. Resident received showers as scheduled every Monday on day shift, and every Thursday on day shift. Resident has received showers on 10/23/2017,	

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F 312	Continued From page 13 was scheduled to receive a shower twice a week. An interview was conducted with NA #1 on 10/18/17 at 2:57 pm. NA #1 stated she worked at the facility for about 20 years. NA #1 indicated she normally worked on the first shift (7:00 am to 3:00 pm). NA #1 stated her assignment normally included 13-14 residents per day. She indicated it was "extremely difficult" to get all her scheduled showers completed during her normal shift. NA #1 stated if the facility census was not full or if a resident refused or was not ready for their shower it helped her to complete her assigned tasks. Some showers were pushed off to the next day or not completed. The resident sometimes did not receive her shower on the scheduled day. NA #1 indicated if a scheduled shower was not completed, the reason for not giving the shower (ex: resident refusal, resident unavailable) was required to be documented by the NA in the electronic documentation system. If the shower was not documented as being given NA #1 could not remember if she gave one. NA #1 revealed she had reported concerns about not being able to complete her assignment (which included scheduled showers) to the Administrator and Director of Nursing in the past, but it had not improved. A phone interview was conducted with NA #2 on 10/19/17 at 11:50 am. NA #2 stated she worked at the facility for 2 years. NA #2 indicated she normally worked on the second shift (3:00 pm to 11:00 pm), but there were occasions when she filled in on other shifts. She reported showers were required to be documented by the NAs in the electronic documentation system. She stated if a shower was not given the reason was required to be documented by the NA.	F 312	10/26/2017, 11/12/2017, 11/6/2017 and 11/9/2017. Resident Incontinence care provided as needed and as per plan of care as indicated on the Kardex (Care plan interventions are reflected on the Kardex) in the electronic health record. Resident #7. Resident prefers showers on her scheduled shower days and prefers bed baths on the other days. Resident received showers as scheduled every Saturday evening shift and every Wednesday evening shift. Resident has received showers on 10/21/2017, 10/25/2017, 10/28/17, 11/1/2017, 11/4/2017 and 11/8/2017. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 10/30/17, the Nurse Consultant reviewed each resident's kardex (Care plan interventions are reflected on the Kardex) in the electronic health record to ensure that each resident had a kardex in the electronic health record. It was found that 100% of the residents had a Kardex. On 10/30/2017 to 11/8/2017 all Kardex' s (Care plan interventions are reflected on the Kardex) were reviewed to ensure that they had a shower schedule for each resident and appropriate by Minimum Data Set Coordinators, Nurse, Nurse aides, Quality Assurance Nurse Consultant and Director of nursing. Kardex are accurate and appropriate. On 11/1/17 to 11/8/2017, the Director of nursing, Regional Staff Development Nurse and Quality Assurance Nurse Consultant began in servicing all nurses	

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F 312	Continued From page 14 An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 2:38 PM. The DON indicated her expectation was for residents to receive showers twice a week as scheduled. She stated if a shower was provided it was to be documented by the NA in the electronic documentation system. She reported if a shower was refused by the resident the refusal was expected to be documented by the NA in the electronic documentation system, the nurse was to be informed verbally by the NA, and the nurse was also to document the refusal in a note. The DON revealed it was not a surprise to her that showers were not provided as scheduled. She stated the facility had issues with showers being provided as scheduled and staffing concerns several months ago. The DON indicated a root cause analysis tool was utilized at that time to find a link between issues with showers not being provided and staffing. She reported staffing was increased on one of the nursing stations as well as rearranging NA assignments based on the acuity of residents. The DON stated she thought these concerns had been resolved. She indicated this issue would warrant looking at again. 1b. Resident #1 ' s quarterly Minimum Data Set dated 10/10/17 revealed she was admitted to the facility on 6/20/17. The resident had a severely impaired cognition and no behaviors. The resident required extensive assistance and was totally dependent upon staff for transfers and all activities of daily living. The diagnoses were hemiplegia, osteoarthritis and contracture of the right arm. Resident #1 ' s care plan dated 10/11/17 revealed	F 312	and nursing assistants: • You are required to review the kardex (Care plan interventions are reflected on the Kardex) of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. • If you do not see a kardex then consult with your nurse for further care instructions. • You should always follow the plan of care for the residents as outlined on the kardex. If the resident's condition has changed, you feel that the plan is unsafe, or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care. • To access the kardex you can click on the resident's name in the electronic health record and click on the kardex brick. On 11/1/2017 to 11/8/2017, The Quality Assurance Nurse Consultant and Regional Staff development Nurse in serviced all Nurses and Nurse Aides (full time, part time and PRN/as needed) to inform them that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Nurse Aide Skill's checklist was completed by 11/8/2017 on Nurse Aides (Full time, part time and PRN/as needed) to ensure that they followed the plan of care in providing incontinence care as indicated on the Kardex.	

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F 312	Continued From page 15 goals and interventions for incontinence care of bowel and bladder, potential for skin breakdown, and total assistance for all aspects of activities of daily living. On 10/18/17 at 10:45 am an interview was conducted with NA #1 and she stated that Resident #1 last received incontinence care at 8:00 am this morning. NA #1 stated that she had two residents to get up for lunch in the dining room at 12:00 pm and before she could return for Resident #1 ' s incontinence care in about 45 minutes. NA #1 indicated that they were short on the resident ' s hall and she was covering from another hall. On 10/18/17 at 10:50 am an interview was conducted with Nurse #2 who was assigned to Resident #1. Nurse #2 stated that incontinence check and/or care was required to be performed every 2 hours. Nurse #2 stated she was aware that the resident ' s last incontinence care was at 8:00 am this morning. On 10/18/17 at 11:30 am observation of incontinence care was done of Resident #1. The resident was in her bed. NA #1 prepared linen, water, and soap for a bed bath and incontinence care. NA #1 provided stool incontinence care. Resident #1 was noted to have newly developed excoriated buttocks. On 10/18/17 at 11:45 am an interview was conducted with Nurse #3. Nurse #3 stated she was the wound care nurse. Resident incontinence care was required to be performed every two hours and as needed when there was skin breakdown from incontinence. Nurse #3 stated that Resident #1 ' s excoriated buttocks	F 312	As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants) will be allowed to work until the training has been completed. Effective 11/9/2017, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting evening shift of 11/1/2017 each nurse assigned to a unit will be required to monitor change of shift activity to ensure that Nurse Aides are reviewing the Kardex before they start their assignment. To ensure compliance, the Director of Nursing will review the tools used by the nurses in the unit to ensure that they are monitoring the aide’s change of shift on a weekly basis. The nurse aide assigned to each unit will be required to document in the residents electronic medication record that the resident received shower as scheduled or as requested. The Nurse aide will notify the nurse assigned if a resident refuses to have their scheduled shower. The nurse will talk with the resident and if the resident still refuses, the nurse will notify	

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F 312	Continued From page 16 were new and would need incontinence care more often than 2 hours, barrier cream (standing order) and turning every two hours. Nurse #3 stated that the resident ' s contracted legs interfered with peri-anal care. Nurse #3 felt at this time two staff members should provide incontinence care. An interview was conducted on 10/19/17 at 2:38 pm with the Director of Nursing (DON). The DON stated she became aware of an issue with timely incontinence care yesterday (10/18/17) from the surveyor involving Resident #1. She indicated prior to 10/18/17 she was unaware of any issues with incontinence care as needed. She reported the facility began working on a quality improvement plan related to incontinence care on 10/18/17 by looking at staffing for the resident acuity. 2. Resident #7 was admitted to the facility on 6/5/13 and readmitted on 8/9/13 with multiple diagnoses Chronic Obstructive Pulmonary Disease (COPD) and heart failure. The quarterly Minimum Data Set (MDS) assessment dated 9/22/17 indicated Resident #7 ' s cognition was intact. He was assessed with no rejection of care. Resident #7 was coded as requiring the physical assistance of one staff for bathing. He was not steady on his feet, but was able to stabilize without staff assistance. The plan of care for Resident #7 indicated he had a self-care deficit related to the inability to perform Activities of Daily Living (ADLs) satisfactorily related to COPD and heart failure. The interventions indicated Resident #7 required	F 312	resident's responsible party and document in the electronic medical record. The Director of Nursing and/or Nurse Manager will interview 5 alert and oriented residents each week to ensure that they are receiving their showers as scheduled or as requested and that they are receiving incontinent care as per care plan interventions. This will be done on weekly basis for 4 weeks then monthly for 3 months. The Director of Nursing and/or Nurse Manager will observe 5 cognitively impaired resident each week to monitor for showers as per preferred schedule. The Director of Nursing and/or Nurse Manager will observe 5 nurse aides weekly to ensure that they are following the plan of care as indicated on the Kardex while providing incontinence care to cognitively intact and cognitively impaired patients. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Management, Dietary Manager and the Administrator. The title of the person responsible for	

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F 312	Continued From page 17 one staff for assistance with bathing. The plan of care was initiated on 12/2/13 and the last revised on 10/18/17. The Nursing Assistant (NA) Kardex, a care guide, indicated Resident #7 required one staff assistance for bathing. His shower days were indicated as Wednesday and Saturday during the second shift (3:00 PM to 11:00 PM). A review of the shower/bathing documentation from 10/1/17 through 10/17/17 revealed Resident #7 had received 1 of 4 scheduled showers (10/4/17). There was no documentation of a shower as scheduled for Resident #7 on 10/7, 10/11, or 10/14. There was no documentation of a shower refusal or an alternative form of bathing for Resident #7 on 10/7, 10/11, or 10/14. The staff schedule for the dates Resident #7 had not received his scheduled showers were reviewed. NA #2 was assigned to Resident #7 on 10/7, 10/11, and 10/14/17. An interview was conducted with Resident #7 on 10/18/17 at 1:25 PM. Resident #7 stated he required assistance from staff to take a shower. He reported his showers were scheduled for Wednesday and Saturday during the second shift. He revealed he did not always receive his showers as scheduled. Resident #7 stated, "[Staff] will tell you there aren ' t enough staff to give the shower". He reported NA #2 was aware of the issue with him not receiving his scheduled showers and with the staffing. An interview was conducted with NA #1 on 10/18/17 at 2:57 PM. She stated she worked at the facility for about 20 years. She indicated she normally worked on the first shift (7:00 AM to 3:00	F 312	implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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PM). NA #1 stated her assignment normally included 13-14 residents per day. She indicated it was "extremely difficult" to get all of her scheduled showers completed during her shift. She stated if the facility census was not full or if a resident refused their shower it helped her to complete her assigned tasks. She indicated if a scheduled shower was not completed, the reason for not giving the shower (ex: resident refusal, resident unavailable) was required to be documented by the NA in the electronic documentation system. NA #1 revealed she had reported concerns about being able to complete her daily tasks to the Administrator and DON in the past, but things had not improved.

The interview with NA #1 continued. She reported she was familiar with Resident #7. She stated he required assistance with showers. She reported she was unaware of Resident #7 rejecting care from staff.

A phone interview was conducted with NA #2 on 10/19/17 at 11:50 AM. She stated she worked at the facility for 2 years. She indicated she normally worked on the second shift (3:00 PM to 11:00 PM). She reported showers were required to be documented by the NAs in the electronic documentation system. She stated if a shower was not given the reason was required to be documented by the NA. NA #2 indicated she was familiar with Resident #7. She stated he required assistance with showers. The shower documentation from 10/1/17 through 10/17/17 that indicated Resident #7 had received 1 of 4 scheduled showers was reviewed with NA #2. NA #2 stated if she had provided Resident #7 with a shower she would have documented it. She additionally stated if Resident #7 had refused the

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shower she would have documented it. She indicated she was unable to recall why there was no shower provided on 10/7, 10/11, 0r 10/14. NA #2 reported, "I don't know what happened".

An interview was conducted with NA #3 on 10/19/17 at 12:05 PM. She stated she normally worked on the first shift (7:00 AM to 3:00 PM) and her assignment was around 14 residents per day. She indicated sometimes it was difficult to complete all her assigned tasks during her normal shift. She reported showers were required to be documented by the NAs in the electronic documentation system. She stated if a shower was not provided the reason was required to be documented by the NA. NA #3 revealed on days that she was really busy she had asked a resident if it was okay to "push" their scheduled shower to the following day.

An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 2:38 PM. She indicated her expectation was for residents to receive showers as scheduled. She stated if a shower was provided it was to be documented by the NA in the electronic documentation system. She reported if a shower was refused by the resident the refusal was expected to be documented by the NA in the electronic documentation system, the nurse was to be informed verbally by the NA, and the nurse was also to document to the refusal in a note. The DON revealed it was not a surprise to her that showers were not provided as scheduled. She stated the facility had issues with showers being provided as scheduled and staffing concerns several months ago. She indicated a root cause analysis tool was utilized at that time to find a link between issues with showers not being provided

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F 312	Continued From page 20 and staffing. She reported staffing was increased on one of the nursing stations as well as rearranging the NA assignments based on the acuity of residents. The DON stated she thought these concerns had been resolved. She indicated this issue would warrant looking at the concern again.	F 312		
F 322 SS=D	NG TREATMENT/SERVICES - RESTORE EATING SKILLS CFR(s): 483.25(g)(4)(5) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, the facility failed to maintain the head of the bed at 30 to 45 degrees during tube feeding for 1 of 1 residents reviewed with tube feeding	F 322	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in	11/10/17

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F 322	Continued From page 21 (Resident #1). Findings included: Resident #1 was admitted to the facility on 6/20/17 with multiple diagnoses that included aphasia, hemiplegia, anxiety, depression, osteoarthritis and contracture of the right arm. Resident #1 ' s quarterly Minimum Data Set dated 10/10/17 revealed the resident had a severely impaired cognition and no behaviors. The resident required extensive assistance and total dependence for transfers and all activities of daily living. The resident received her nutrition and hydration by gastrostomy tube feeding. Resident #1 ' s care plan dated 10/11/17 revealed goals and interventions for gastrostomy tube feeding and potential for aspiration and maintain nutrition by tube feeding (intervention: head of the bed (HOB) elevated 30-45 degrees during and thirty minutes after tube feeding). Total extensive assistant for all aspects of activities of daily living. Physician ' s order dated 10/3/17 revealed Resident #1 was taking nothing by mouth. Physician ' s order dated 10/12/17 revealed Glucerna 1.5 60 milliliters/hour continuous via gastrostomy tube. On 10/18/17 at 11:30 am an observation was done of Resident #1. The resident was in her bed with the HOB elevated 45 degrees and the tube feeding was infusing at 60 milliliters per hour. Nursing Assistant (NA) #1 lowered the HOB to flat for care and the tube feeding was still infusing. The resident started coughing and her	F 322	compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F322 NG TREATMENT/SERVICES-RESTORE EATING SKILLS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to maintain the head of the bed at 30 to 45 degrees during tube feeding for 1 of 1 residents reviewed with tube feeding (Resident #1). Resident #1. Care plan interventions are reflected on the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Intervention in place indicating that resident is on aspiration precautions due to tube feeding. Nurse to be notified prior to providing care. Head of bed not to be lowered while tube feeding is infusing. Kardex is accurate and appropriate. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 10/30/17, the Nurse Consultant reviewed each resident's Care plan interventions are reflected on the Kardex	

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F 322	Continued From page 22 face turned flush red. NA #1 raised the HOB and realized the TF was still running. The resident recovered without further intervention. On 10/18/17 at 3:45 pm an interview was conducted with NA #1. NA #1 stated that she had lowered Resident #1 ' s head of the bed and did not realize the tube feeding was running. NA #1 stated that the resident had coughed and became flush and it was then that NA #1 realized the tube feeding was running. She thought the tube feeding was off. NA #1 stated she raised the head of the bed and asked Nurse #2 to turn off the tube feeding. NA #1 stated she usually obtained nursing assistance to turn off the tube feeding before lowering the HOB. On 10/19/17 at 10:20 am an interview was conducted with the Director of Nursing (DON). The DON stated that staff was expected to turn off the tube feeding before the HOB was lowered and to keep the HOB elevated 30 to 45 degrees when the tube feeding was running as part of aspirations precautions.	F 322	in the electronic health record to ensure that each resident had a kardex in the electronic health record. It was found that 100% of the residents had a Kardex. On 10/30/2017 to 11/8/2017 all Kardex' s (Care plan interventions are reflected on the Kardex)were reviewed to ensure that they were accurate and appropriate by Minimum Data Set Coordinators, Nurse, Nurse aides, Quality Assurance Nurse Consultant and Director of nursing. Kardex are accurate and appropriate. On 11/8/2017, The Nurse Consultant with the Minimum Data Set Nurse Consultants reviewed residents who received tube feeding to ensure that they have interventions in place indicating that: resident is on aspiration precautions due to tube feeding. Nurse to be notified prior to providing care. Head of bed not to be lowered while tube feeding is infusing. On 11/1/17 to 11/8/2017, the Director of nursing, Regional Staff Development Nurse and Quality Assurance Nurse Consultant began in servicing all nurses and nursing assistants: • You are required to review the kardex (Care plan interventions are reflected on the Kardex) of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. • If you do not see a kardex then consult with your nurse for further care instructions. • You should always follow the plan of care for the residents as outlined on the kardex. If the resident's condition has changed, you feel that the plan is unsafe,	

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or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care.
• To access the kardex you can click on the resident's name in the electronic health record and click on the kardex brick.

On 11/1/2017 to 11/8/2017, The Quality Assurance Nurse Consultant and Regional Staff development Nurse in serviced all Nurses and Nurse Aides (full time, part time and PRN/as needed) to inform them that with assisted nutrition and hydration (includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostromy, and enteral fluids). The facility must ensure that a resident who has not been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident. The facility must ensure that a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers.

Nurse Aide Skill's checklist was completed by Regional Staff Development Nurse and Quality Assurance Nurse Consultant by 11/8/2017 on Nurse Aides

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F 322	Continued From page 24	F 322	by completing on providing care to resident receiving tube feeding (Full time, part time and PRN/as needed) to ensure that the followed the plan of care as indicated. As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants) will be allowed to work until the training has been completed. Effective 11/9/2017, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting evening shift of 11/1/2017 each nurse assigned to a unit will be required to monitor change of shift activity to ensure that Nurse Aides are reviewing the Kardex before they start their assignment. To ensure compliance, the Director of Nursing will review the tools used by the nurses in the unit to ensure that they are monitoring the aide's change of shift on a weekly basis. The Director of Nursing and/or Nurse Manager will observe 5 nurse aides weekly and including the weekends(varies shifts) to ensure that	

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F 322	Continued From page 25	F 322	they are following the plan of care as indicated on the Kardex while providing care to resident who are receiving tube feeding. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum DataSet Coordinator, Unit Manager, Therapy, Health Information Management, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited	F 323		11/10/17

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to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interview, and staff interview, the facility failed to consistently use the appropriate mechanical lift to transfer residents and failed to consistently utilize 2 staff to operate the mechanical lifts for transfers, putting the residents at risk for injury for 2 of 3 residents reviewed for accidents (Resident #6 and #8). The findings included:

1. Resident #8 was admitted to the facility on 3/16/10 and most recently readmitted to the facility on 4/16/14 with diagnoses that included hemiplegia (paralysis of one side of the body) following a cerebral infarction affecting unspecified side, contracture of unspecified hand, and obesity.

The quarterly Minimum Data Set (MDS) assessment dated 8/7/17 indicated Resident #8 ' s cognition was intact. She was assessed with no behaviors and no rejection of care. Resident #8 was coded as requiring the extensive assistance of two or more staff with bed mobility and transfers. She had impairment on one side of the upper and lower extremities and utilized a wheelchair.

The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F323 FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES.
The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
The facility failed to consistently use the appropriate mechanical lift to transfer residents and failed to consistently utilize 2 staff to operate the mechanical lifts for transfers, putting the residents at risk for injury for 2 of 3 residents reviewed for accidents (Resident #6 and #8).

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F 323	Continued From page 27 The plan of care for Resident #8 read, in part, "I am at risk for falls related to unsteady balance and hemiplegia. I require [Mechanical Lift #1] and two assist during transfers". This plan of care was initiated on 10/22/13 and the last revision was 10/18/17. The Care Plan Item/Task Listing Report was reviewed on 10/18/17. This report indicated the specific interventions required for transferring residents. Resident #8 was noted as requiring a Mechanical Lift #1 and two staff assistance with transfers. An observation was conducted on 10/18/17 at 9:25 AM of Resident #8 in her room. Resident #8 was observed to be transferred from bed to wheelchair by Nursing Assistant (NA) #1 utilizing Mechanical Lift #2. There were no other staff members present in Resident #8 ' s room to assist NA #1 with the safe operation of Mechanical Lift #2. An interview was conducted with the Staff Development Coordinator (SDC) on 10/18/17 at 2:45 PM. She stated the facility utilized two types of mechanical lifts, Mechanical Lift #1 and Mechanical Lift #2. She indicated Mechanical Lift #1 was a full body lift utilized for residents who were non-weight bearing and Mechanical Lift #2 was a stand-up style lift utilized for residents who were partially weight bearing. The SDC stated the facility ' s policy was for two staff members to be present when operating both types of mechanical lifts. She reported this was for the safety of the residents and staff members. An interview was conducted with NA #1 on	F 323	Resident#8 Care plan intervention are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate. Resident #6 Care plan intervention are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 10/30/17, the Nurse Consultant reviewed each resident's kardex (Care plan intervention are reflected in the Kardex) in the electronic health record to ensure that each resident had a kardex in the electronic health record. It was found that 100% of the residents had a Kardex. On 10/30/2017 to 11/8/2017 all Kardex' s (Care plan intervention are reflected in the Kardex) were reviewed to ensure that they were accurate and appropriate by Minimum Data Set Coordinators, Nurse, Nurse aides, Quality Assurance Nurse Consultant and Director of Nursing. Kardex are accurate and appropriate. On 11/1/17 to 11/8/2017, the Director of Nursing, Regional Staff Development Nurse and Quality Assurance Nurse Consultant began in servicing all nurses	

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F 323	Continued From page 28 10/18/17 at 2:57 PM. NA #1 confirmed she utilized Mechanical Lift #2 to transfer Resident #8 from bed to chair that morning (10/18/17). She revealed she utilized Mechanical Lift #2 without another staff member present. She stated she was unaware of the facility ' s policy for the number of staff members required to be present during the operation of Mechanical Lift #2. NA #1 explained that she was not normally assigned to Resident #8 and she was unfamiliar with the proper procedure to operate Mechanical Lift #2. An interview was conducted with Resident #8 on 10/19/17 at 9:00 AM. Resident #8 indicated she required the assistance of staff as well as a mechanical lift for transfers. She stated normally there was only one staff member present when the mechanical lift was utilized for her transfers. An interview was conducted with NA #4 on 10/19/17 at 9:35 AM. NA #4 indicated her primary duty was as the facility scheduler, but she was also an NA and worked on the floor if needed. She stated the facility utilized two types of mechanical lifts, Mechanical Lift #1 and Mechanical Lift #2. She indicated Mechanical Lift #1 required two persons to operate it at all times. She reported Mechanical Lift #2 was sometimes able to be used by one person depending on the resident ' s ability to physically assist with the transfer as well as their size. NA #4 was asked how staff knew what mechanical lift was to be utilized for the resident as well as the number of staff that were required. She stated the NA Kardex, a care guide for the NAs, indicated if a mechanical lift was required, the type of mechanical lift, and the number of staff needed to transfer the resident.	F 323	and nursing assistants: • You are required to review the kardex of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. • If you do not see a kardex then consult with your nurse for further care instructions. • You should always follow the plan of care for the residents as outlined on the kardex. If the resident's condition has changed, you feel that the plan is unsafe, or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care. • To access the kardex you can click on the resident's name in the electronic health record and click on the kardex brick. On 11/1/2017 to 11/8/2017, The Quality Assurance Nurse Consultant and Regional Staff development Nurse in serviced all Nurses and Nurse Aides (full time, part time and PRN/as needed) to inform them that the facility must ensure that the resident environment remains free from accident hazards as is possible and; each resident receives adequate supervision and assistance devices to prevent accidents. Nurse Aide Skill's checklist was completed by Regional Staff Development Nurse and Quality Assurance Nurse Consultant by 11/8/2017 on Nurse Aides by completing an observation of use of Mechanical lifts (Full time, part time and PRN/as needed) to ensure that the	

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F 323	Continued From page 29 The NA Kardex for Resident #8 was reviewed on 10/19/17. This form indicated Resident #8 required Mechanical Lift #1 and two staff assistance for safety and transfers. An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 10:25 AM. She indicated it was her expectation that staff followed the facility ' s policy to have two staff members present when using Mechanical Lift #1 and Mechanical Lift #2. She also indicated she expected the staff members to use the appropriate type of mechanical lift for the resident as indicated in their plan of care and the NA Kardex. 2. Resident #6 was admitted to the facility on 6/20/17 with diagnoses that included paraplegia and Multiple Sclerosis (MS). The admission Minimum Data Set (MDS) assessment dated 6/27/17 indicated Resident #6 was cognitively intact. He was assessed with no behaviors and no rejection of care. Resident #6 was coded as requiring the extensive assistance of two or more staff with bed mobility and transfers. He had impairment on both sides of the lower extremities and utilized a wheelchair. The Care Area Assessment (CAA) related to falls for the 6/27/17 admission MDS assessment indicated Resident #6 was non-ambulatory. He was noted as required the extensive assistance of staff for transfers. Resident #6 ' s risk factors for falls included MS, paraplegia, and muscle spasms. He was indicated to be at risk for	F 323	followed the plan of care as indicated. As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants) will be allowed to work until the training has been completed. Effective 11/9/2017, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Starting evening shift of 11/1/2017 each nurse assigned to a unit will be required to monitor change of shift activity to ensure that Nurse Aides are reviewing the Kardex before they start their assignment. To ensure compliance, the Director of Nursing will review the tools used by the nurses in the unit to ensure that they are monitoring the aide’s change of shift on a weekly basis. The Director of Nursing and/or Nurse Manager will observe 5 nurse aides weekly including the weekends (varies shifts) to ensure that they are following the plan of care as indicated on the Kardex while using mechanical lifts. This will be done on weekly basis for 4 weeks then	

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fractures or soft tissue damage that had the potential to lead to immobility and consequently death.

The plan of care for Resident #6 indicated he was at increased susceptibility to falling that may cause physical harm related to unsteady gait/balance secondary to non-weight bearing bilateral extremities status due to MS. The interventions indicated he required Mechanical Lift #1 for transfers. The plan of care was initiated on 6/21/17.

The Care Plan Item/Task Listing Report was reviewed on 10/18/17. This report indicated the specific interventions required for transferring residents. Resident #8 was noted as requiring Mechanical Lift #1 for transfers.

An interview was conducted with Resident #6 on 10/18/17 at 1:30 pm. He indicated he required the assistance of staff as well as a mechanical lift for transfers. Resident #6 stated he was transferred from his bed to his wheelchair by one staff member utilizing Mechanical Lift #2. He reported Mechanical Lift #1 was utilized when staff had to weigh him. He indicated sometimes there was one staff member present when operating Mechanical Lift #1 and other times there were two staff members present.

An interview was conducted with the Staff Development Coordinator (SDC) on 10/18/17 at 2:45 PM. She stated the facility utilized two types of mechanical lifts, Mechanical Lift #1 and Mechanical Lift #2. She indicated Mechanical Lift #1 was a full body lift utilized for residents who were non-weight bearing and Mechanical Lift #2 was a stand-up style lift utilized for residents who

monthly for 3 months.
Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager and the Administrator.

The title of the person responsible for implementing the acceptable plan of correction;
Administrator and /or Director of Nursing.

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	345284	A. BUILDING _____ B. WING _____	C 10/19/2017

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THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

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F 323	Continued From page 31	F 323		

were partially weight bearing. The SDC stated the facility ' s policy was for two staff members to be present when operating both types of mechanical lifts. She reported this was for the safety of the residents and staff members.

An interview was conducted with NA #4 on 10/19/17 at 9:35 AM. NA #4 indicated her primary duty was as the facility scheduler, but she was also an NA and worked on the floor if needed. She stated the facility utilized two types of mechanical lifts, Mechanical Lift #1 and Mechanical Lift #2. She indicated Mechanical Lift #1 required two persons to operate it at all times. She reported Mechanical Lift #2 was sometimes able to be used by one person depending on the resident ' s ability to physically assist with the transfer as well as their size. NA #4 was asked how staff knew what mechanical lift was to be utilized for the resident as well as the number of staff that were required. She stated the NA Kardex, a care guide for the NAs, indicated if a mechanical lift was required, the type of mechanical lift, and the number of staff needed to transfer the resident.

The NA Kardex for Resident #6 was reviewed on 10/19/17. This form indicated Resident #6 required Mechanical Lift #1 for safety and transfers.

An interview was conducted with the Director of Nursing (DON) on 10/19/17 at 10:25 AM. She indicated it was her expectation that staff followed the facility ' s policy to have two staff members present when using Mechanical Lift #1 and Mechanical Lift #2. She also indicated she expected the staff members to use the appropriate type of mechanical lift for the resident

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F 323	Continued From page 32 as indicated in their plan of care and the NA Kardex.	F 323		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		11/10/17

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F 441	Continued From page 33 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to change gloves and wash hands after providing incontinence care and before providing further care for 1 of 3 residents (Resident #1). Findings included:	F 441	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of	

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F 441	Continued From page 34 The facility ' s infection control policy on hand hygiene (undated) revealed it followed the Center for Disease Control ' s guidelines. "Specific indications are for hand hygiene after contact with a resident ' s body fluid or excretion ... and after offering incontinence care..." On 10/18/17 at 11:30 pm an observation of incontinence care was done of Resident #1. The resident was in her bed and Nursing Assistant (NA) #1 prepared for a bed bath and incontinence care. NA #1 provided stool incontinence care. NA #1 used the same incontinence care gloves to open the resident ' s drawer and retrieve a tube of ointment. NA #1 continued using the same gloves and placed the ointment over the resident ' s torso and extremities. At the completion of incontinence care, NA #1 was requested by the surveyor to re-wipe the resident ' s peri and labia areas. NA #1 wiped with peri-wipes which had remaining stool. NA #1 cleaned the additional stool, removed her gloves and washed her hands. On 10/18/17 at 3:45 pm an interview was conducted with NA #1 who stated that she typically changed her gloves after incontinence care before moving on to other care, but had not changed her gloves with Resident #1. NA #1 stated she forgot to remove her gloves and wash her hands before beginning other care. On 10/19/17 at 2:48 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected all staff to follow standard precautions during all resident contact and specifically to change gloves and wash hands after cleaning stool.	F 441	Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F441 INFECTION CONTROL, PREVENT SPREAD, LINENS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to change gloves and wash hands after providing incontinence care and before providing further care for 1 of 3 residents (Resident #1). Resident #1. Incontinence care provided as needed and as per plan of care as indicated on the Kardex (this is a shortened version derived from the care plan that identifies key care needs for the residents) in the electronic health record. Nurse Aide Skill's checklist was completed from 11/1/2017 to 11/8/2017 on Nurse Aides (Full time, part time and PRN/as needed) to ensure that they demonstrated hand hygiene practices after providing incontinence care and before providing further care. Also to ensure that they demonstrated use of hand sanitizer/hand washing practice and how to don/remove/discard and utilize gloves per facility policy. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 11/1/2017 to 11/8/2017, The Quality Assurance Nurse Consultant and Regional Staff Development Nurse in	

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F 441	Continued From page 35	F 441		

serviced all Nurses and Nurse Aides (full time, part time and PRN/as needed) to inform them that the facility has an established infection prevention and control program. Hand hygiene procedures must be followed by staff involved in direct resident contact. Staff must handle linens, store, and process and transport them so as to prevent the spread of infection.

Nurse Aide Skill's checklist was completed by 11/8/2017 on Nurse Aides (Full time, part time and PRN/as needed) to ensure that they demonstrated hand hygiene practices after providing incontinence care and before providing further care. Also to ensure that they demonstrated use of hand sanitizer/hand washing practice. Also to ensure that they demonstrated how to don/remove/discard and utilize gloves per facility policy.

As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistants) will be allowed to work until the training has been completed.
Effective 11/9/2017, this training is incorporated into the new employee orientation program.
This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.

The monitoring procedure to ensure that

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F 441	Continued From page 36	F 441	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Nurse Manager will observe 5 nurse aides weekly including the weekend (varies shifts) to ensure that they demonstrate hand hygiene practices after providing incontinence care and before providing further care. Also to ensure that they demonstrated use of hand sanitizer/hand washing practice. Also to ensure that they demonstrated how to don/remove/discard and utilize gloves per facility policy. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Management, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance.	F 520		11/10/17

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F 520	Continued From page 37 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		

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F 520	Continued From page 38 Based on observation, staff interviews, and record review, the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 5/25/17 recertification survey. This was for three recited deficiencies in the areas of Care Provided by Qualified Persons in Accordance with Care Plan (F282), Assisted Nutrition/Hydration (F322), and Accidents (F323). These deficiencies were cited again on the current complaint investigation survey of 10/19/17. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. F282 - Care Provided by Qualified Persons in Accordance with Care Plan: Based on observation, record review, resident interview, and staff interview, the facility failed follow the plan of care interventions related to falls for 2 of 3 residents (Residents #6 and #8) reviewed for accidents and the interventions related to aspiration precautions for 1 of 1 residents (Resident #1) reviewed with a tube feeding. During the recertification survey of 5/25/17 the facility was cited F282 for failing to follow the care plan interventions for an indwelling urinary catheter. On the current complaint investigation survey of 10/19/17 the facility was cited for failure to follow the care plan interventions related to falls and aspiration precautions. 2. F322 - Assisted Nutrition/Hydration: Based on	F 520	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F520 QAA COMMITTEE-MEMBERS/MEET QUATERLY /PLANS. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 5/25/17 recertification survey. This was for three recited deficiencies in the areas of Care Provided by Qualified Persons in Accordance with Care Plan (F282), Assisted Nutrition/Hydration (F322), and Accidents (F323). These deficiencies were cited again on the current complaint investigation survey of10/19/17. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance program. This tag is cross referenced to F282 Care	

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F 520	Continued From page 39 record review, observation, and staff interview, the facility failed to maintain head of bed at 30-45 degrees during tube feeding for 1 of 1 residents reviewed for tube feeding (Resident #1). During the recertification survey of 5/25/17 the facility was cited F323 for failing to provide tube feeding as ordered by the physician. On the current complaint investigation survey of 10/19/17 the facility was cited for failure to maintain head of bed at 30-45 degrees during tube feeding. 2. F323 - Accidents: Based on observation, record review, resident interview, and staff interview, the facility failed to consistently use the appropriate mechanical lift to transfer residents and failed to consistently utilize 2 staff to operate the mechanical lifts for transfers, putting the residents at risk for injury for 2 of 3 residents reviewed for accidents (Resident #6 and #8). During the recertification survey of 5/25/17 the facility was cited F323 for failing to secure the wheelchair to the floor of the facility van according to manufacturer's instructions before transporting a resident resulting in the resident landing on her back and hitting her head on the van floor. On the current complaint investigation survey of 10/19/17 the facility was cited for failure to consistently use 2 staff to operate mechanical lifts for transfers. An interview was conducted with the Director of Nursing (DON) and Administrator on 10/19/17 at 2:57 PM. They indicated they presently shared the roll of the point person for the facility ' s QAA Committee. They explained the previous head of the QAA Committee had left the position several months ago. They indicated the QAA Committee	F 520	Provided by Qualified Persons in Accordance with Care plan. The facility failed follow the plan of care interventions related to falls for 2 of 3 residents (Residents #6 and #8) reviewed for accidents and the interventions related to aspiration precautions for 1 of 1residents (Resident #1) reviewed with a tube feeding. Resident#8 Care plan interventions are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate Resident #6 Care plan interventions are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate. Resident #1.Care plan interventions are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Intervention in place indicating that resident is on aspiration precautions due to tube feeding. Nurse to be notified prior to providing care. Head of bed not to be lowered while tube feeding is infusing. Kardex is accurate and appropriate. This tag is cross referenced to F322	

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F 520	Continued From page 40 consisted of the Administrator, DON, Minimum Data Set (MDS) Coordinator #1, MDS Coordinator #2, Wound Nurse, Admissions Director, Dietary Manager, Social Worker, Therapy Manager, Medical Director, Environmental Services Manager, and Pharmacy Consultant. The Committee reportedly met monthly with the exception of the Pharmacy Consultant and Medical Director who attended a minimum of quarterly. The Administrator and DON indicated they were aware F282, F322, and F323 were repeat citations from the 5/25/17 recertification survey. They reported the previous Plans of Correction (POCs) were very focused on the exact deficiency that was cited. They indicated as examples that the POC for F282 was focused specifically on catheter care and the POC for F323 was focused specifically on van safety.	F 520	Assisted Nutrition/Hydration The facility failed to maintain the head of the bed at 30 to 45 degrees during tube feeding for 1 of 1 residents reviewed with tube feeding (Resident #1). Resident #1. Care plan interventions are reflected on the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Intervention in place indicating that resident is on aspiration precautions due to tube feeding. Nurse to be notified prior to providing care. Head of bed not to be lowered while tube feeding is infusing. Kardex is accurate and appropriate. This tag is cross referenced to F323 Accidents: The facility failed to consistently use the appropriate mechanical lift to transfer residents and failed to consistently utilize 2 staff to operate the mechanical lifts for transfers, putting the residents at risk for injury for 2 of 3 residents reviewed for accidents (Resident #6 and #8). Resident#8 Care plan intervention are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate. Resident #6 Care plan intervention are reflected in the Kardex in the electronic health record was reviewed on 11/2/2017 by the Quality Assurance Nurse	

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F 520	Continued From page 41	F 520	Consultant, Nurse, Nurse aide, Minimum Data Set Consultant to ensure that they were accurate and appropriate. Kardex is accurate and appropriate. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; This tag is cross referenced to F282 Care Provided by Qualified Persons in Accordance with Care plan. This tag is cross referenced to F322 Assisted Nutrition/Hydration This tag is cross referenced to F323 Accidents On 11/3/2017, The Quality Assurance Nurse in serviced the Administrator in reference to the Quality Assessment and Assurance. A facility must maintain a quality assessment and assurance committee consisting at a minimum of:(i) The director of nursing services;(ii) The Medical Director or his/her designee;(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and The quality assessment and assurance committee must :(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in	

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F 520	Continued From page 42	F 520	so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Effective 11/9/2017, this training is incorporated into the new employee orientation program. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; This tag is cross referenced to F282 Care Provided by Qualified Persons in Accordance with Care plan. This tag is cross referenced to F322 Assisted Nutrition/Hydration This tag is cross referenced to F323 Accidents To ensure compliance, Administrator or Director of Nursing will monitor this issue using the Quality Assurance survey tool. Facility will monitor compliance of Quality Assurance for F282, F322 and F323. This will be done on weekly basis for 4 weeks then monthly for 3 months by Administrator and reviewed monthly by the Quality Assurance Nurse Consultant to ensure compliance. Reports will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA ROAD 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) COMPLETION DATE
F 520	Continued From page 43	F 520	presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager, Wound Nurse. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	