STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/18/19 through 12/19/19 an unannounced complaint investigation was conducted. There were 5 intakes and 15 allegations. Of the 15 allegations, 3 were substantiated. See event ID #329W11.	F 000		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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- §483.25(g)(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 §483.25(g)(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, observation, and staff and physician interview, the facility failed to provide gastrostomy care per orders for 2 of 3 residents sampled for feeding tubes (Resident #1 and Resident #2).	F 693	Oak Forest Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 1/16/2020. Preparation	1/16/20

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

Electronically Signed | 01/21/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 1 Findings included: 1. Resident #1 was admitted to the facility on 09/04/2019 with a recent readmission from the hospital dated 12/03/2019 with a diagnosis of chronic respiratory failure with hypoxia, dysphagia (swallowing difficulties), and a gastrostomy tube. (tube placed in abdomen for artificial feedings) The most recent Minimum Data Set (MDS) dated 12/09/19 indicated Resident #1 remained in a persistent vegetative state and dependent on staff for all activities of daily living care (ADL). The MDS revealed Resident #1 continues to receive 100% of his nutrition via tube. The monthly physician orders for December 2019 for Resident #1 indicated orders for checking placement of g-tube using a 10-30 milliliter (ml) air bolus before medications, feedings, and flushes twice daily and residual checks prior to administration of bolus feedings. If residual is greater than 30cc, hold feeding and recheck in 1 hour. If remains greater than 30cc, notify the physician. It further indicates orders for tube flushing of 10-30 ml. Clean g-tube site with normal saline every shift. Provide enteral flushes using 150 ml of warm water every 4 hours. Flush g-tube with 30 ml of warm water before and after medication administration and provide 5ml of warm water flushes between each medication. Enteral feedings via g-tube with 275 ml bolus of Nutren 1.5 via pump over 30 minutes every 4 hours. An observation on 12/18/19 at 10:18 am revealed Resident #1 lying in bed with his eyes closed and nonverbal. He had a bag labeled Nurten 1.5 tube	F 693	and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. Nurse #1 was educated immediately by the Director of Nursing after being informed of employee not recapping feeding tube, not completing placement or residual checks, and not providing a bolus water flush after feedings for Resident #1. All other bolus feedings were ensured they were capped in resident rooms at this time. Nurse #1 and Nurse #2 were educated immediately by the Director of Nursing after being informed of them not checking placement, residual, or providing water flushes as ordered with pain medication for Resident #2. 100% of all nurses, medication aides, and nurse aide IIs were educated by 1/16/2020 by the Director of Nursing and/or Assistant Director of Nursing on proper gastrosotomy feedings and care per physician orders. 100% of all nurses and medication aides were educated by 1/16/2020 by the Director of Nursing and/or Assistant Director of Nursing on the correct procedures for providing medications via g-tube. Any new nurses, medication aides, and/or nurse aide IIs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 2 feeding attached to his gastrostomy tube; however, the bolus feeding had already infused and the head of the bed was elevated. An observation on 12/18/19 at 12:22pm revealed Resident #1 remained on his back in the bed with tube feeding intact. The tube feeding bag pump was infusing at 400 ml/ hour. Nurse #1 entered the room at 12:34 pm and turned the feeding off, detaching the tubing from the gastrostomy tube and draping the tubing over the pole without recapping. No placement or residual checks were completed. Nurse#1 did not provide a bolus water flush after detaching the tube from feeding. An interview with Nurse #1 on 12/18/19 at 5:12pm revealed that she acknowledged she did not re-cap the tube feeding, provide flushes, and check placement for Resident #1 because she was running behind after several of her patients being placed on precautions that morning. An interview on 12/19/19 at 10:45 am with the Staff Development Coordinator (SDC) and the Director of Nursing (DON) indicated the correct procedure for gastrostomy care and providing medications via g-tube would be to check placement and residual each time medications or feeding is administered. The SDC stated the tubing should be recapped with a plastic cap when detached from the gastrostomy tube to prevent possibility of contamination. The DON revealed placement and residual check were to be performed by the nurse and any concerns with placement should be reported to the physician immediately. She further stated nurses were to follow physician orders to provided flushes as ordered before, after, and between individual medication administration via g-tube to prevent	F 693	hired will also complete gastrostomy feedings on their new orientation competency skills checklist. Any new nurses or medication aides will be checked off on providing medications via the g-tube on their orientation competency skills checklist. Gastrostomy Feeding and Medication Administration audits will be completed by the Director of Nursing, Assistant Director of Nursing, and Nurse Administration team daily for 4 weeks, weekly for 4 weeks, and then monthly for 1 year. Any concerns found will be corrected immediately. A summary of the findings from the Gastrostomy Feeding and Medication Administration audits will be presented to the monthly QAPI meetings by the Director of Nursing and Assistant Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 3	F 693		

the tube from clogging and to ensure the medications were properly administered.

2. Resident #2 was admitted to the facility on 03/27/19 with diagnosis including acute and chronic respiratory failure with hypoxia, attention to tracheostomy care, chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, other specified sepsis, hemiplegia and hemiparesis following a nontraumatic intracerebral hemorrhage affecting the left non-dominant side, dysphagia, attention to gastrostomy tube, type-2 diabetes, and malignant neoplasm of the tongue.

His most recent Minimum Data Set (MDS) dated 12/03/19 indicated Resident #2 was usually able to make needs known and had moderately impaired cognition. He required extensive to total care for all activities of daily living (ADL). It revealed he receives 100 percent of his nutrition via a gastrostomy tube.

The monthly physician orders for December 2019 for Resident #2 indicated orders for checking placement of g-tube using a 10-30 milliliter (ml) air bolus before medications, feedings, and flushes twice daily and residual checks prior to administration of bolus feedings. If residual is greater than 30cc, hold feeding and recheck in 1 hour. If residual remains greater than 30cc, notify physician. It further indicated orders for tube flushing of 10-30 ml, clean g-tube site with normal saline every shift, and flush g-tube with 30 ml of warm water before and after medication administration and provide 5ml of warm water flushes between each medication. Resident #2 is to receive enteral feedings via g-tube with Diabetisource 40ml/hour continuous feeding via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 4	F 693		

pump and eternal flushes with 45ml of water every hour via pump.

An observation on 12/18/19 at 10:25am revealed Resident #2 lying in bed on his back with the head of his bed elevated. A bag labeled Diabetisource 40ml/hour was infusing via the gastrostomy tube. He was alert and used hand gestures to communicate but was non-verbal with this surveyor. Nurse #2 entered the room at 10:35 am to administer pain medications. She administered the medication via a 1ml syringe. She began by holding the feeding, but placement was not checked nor were flushes provided before or after medication was given.

An additional observation on 12/18/19 at 1:38pm revealed Nurse #2 combined 2ml of liquid medication with water from the sink in the bathroom. She detached the tube from the feeding pump, attached the 30ml syringe to the port. She administered 30ml of water and medication combination followed by 2.5 cups of water. No placement or residuals were checked.

An interview with the physician on 12/18/19 at 4:31 pm revealed tube feeding, and medications given via g-tube should be monitored and delivered as ordered.

An interview with Nurse #1 and Nurse #2 was conducted on 2/18/19 at 05:12 pm. Nurse #1 nor Nurse #2 stated they did not check placement, residual, or provide water flushes as ordered with the pain medication administration to resident #2 on the morning of 12/18/19. Nurse #2 stated she administered the pain medication through a small port on the side of the tube for medications. She said she should have used the larger syringe to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 5 check placement, residual, and provide flushes even when giving medication through the special port. Nurse #1 stated she did not check placement, residuals, or provide flush to the g-tube as ordered after administering the pain medications for Resident #2 immediately prior to discharge. An interview on 12/19/19 at 10:45 am with the Staff Development Coordinator (SDC) and the Director of Nursing (DON) indicated the correct procedure for gastrostomy care and providing medications via g-tube would be to check placement and residual each time medications or feeding is administered. The SDC stated the tubing should be recapped with a plastic cap when detached from the gastrostomy tube to prevent possibility of contamination. The DON revealed placement and residual check were to be performed by the nurse and any concerns with placement should be reported to the physician immediately. She further stated nurses were to follow physician orders to provided flushes as ordered before, after, and between individual medication administration via g-tube to prevent the tube from clogging and to ensure the medications were properly administered	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		1/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 6 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, respiratory therapy, and physician interview, the facility failed to provide respiratory care per orders and facility protocol for 2 of 3 residents sampled for oxygen and tracheostomy care. (Resident #1, #2) The findings included: 1.Resident #1 was admitted to the facility on 09/04/2019 with a recent readmission from the hospital dated 12/03/2019 with a diagnosis of chronic respiratory failure with hypoxia, attention to tracheostomy, anoxic brain damage, persistent vegetative state, dysphagia, cognitive communication deficits, attention to gastrostomy, pneumonia due to Escherichia coli (E. Coli-bacteria usually found in the intestines) , hypertension, and anemia. A recent re-admission history and physical dated 12/04/19 revealed Resident #1 had a recent hospitalization with complication secondary to aspiration pneumonia including tracheal aspirate of Proteus Mirabilis (bacteria usually found in the urinary tract) and E. Coli. The quarterly Minimum Data Set (MDS) dated 12/09/19 indicated Resident #1 remains in a persistent vegetative state and dependent for all care. The MDS revealed Resident #1 to have a diagnosis of pneumonia and received 4 days of antibiotic therapy. The MDS further indicated he received suctioning, tracheostomy care, oxygen, and intravenous medications (IV) while in the hospital and continued with suctioning, oxygen,	F 695	RT #1 was educated immediately by the Director of Nursing after being informed of employee reusing a previous water basin for respiratory care, not replacing dirty linen with clean linen when soiled linen visible, completing suctioning as needed, and for not covering the plastic suction tip when not in use for Resident #1. RT #2 was educated immediately by the Director of Nursing after being informed of employee reusing a previous water basin for respiratory care for Resident #2. All water basins left in rooms were thrown away. All bottles not dated were thrown away and not reused. All rooms were checked to ensure suctioning tips were stored in sleeves by bedside. 100% of all nurses, nurse aide IIs, and respiratory therapists were educated on proper trach suctioning procedures and use of trach suctioning kits by 1/16/2020 by the Director of Nursing and/or Assistant Director of Nursing. New employee hires that include nurses, nurse aide IIs, or respiratory therapists will complete trach care training on the facility's new employee orientation checklist. Suction Techniques for Trach Patients Audit will be completed by the Director of Nursing, Assistant Director of Nursing, Nursing Administration, and Respiratory Therapy Manager daily x 4 weeks, weekly x 4 weeks, and then monthly for 1 year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 7 tracheostomy care, and IV medications after return to the facility. The monthly physician orders for December 2019 for Resident #1 indicated orders for oxygen to be administered at 10 liters (L) with humidity via tracheostomy collar and to be checked twice daily by nursing staff. Provide suctioning every 4 hours and hourly as needed documenting the reason, result and time. Tracheostomy dressing care daily including changing the inner cannula, collar ties, clean site and application of gauze dressing. Vital signs were to be obtained twice daily including blood pressure, pulse, temperature, respirations, and oxygen saturation. A copy of an undated suctioning and vent training provided to nursing staff during orientation indicated care for aerosol tracheostomy collar patients to include suction catheters being of a single use indication only and a pop-up basin is provided in each catheter kit for rinsing with sterile water. Head of bed is to be elevated between 30-45 degrees. Respiratory care charting dated 12/17/19 to 12/18/19 indicates flow meter for oxygen was checked and verified to be on 10 L with 2 respiratory therapists on days shift and one respiratory therapist signature on night shift included. An observation of Resident #1 on 12/18/19 at 10:18 am revealed him lying on his back in bed with soiled towels across his chest and around his tracheostomy collecting excess white/light yellow colored phlegm. His eyes were closed, and he was non-verbal. He had oxygen attached at 9 L attached to his tracheostomy tubing. He has a	F 695	Any concerns found will be corrected immediately. A summary of the findings from the Suction Technique Audits will be presented to the monthly QAPI meetings by the Director of Nursing and Assistant Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 8	F 695		

small square container thin clear liquid substance approximately half filling it sitting on the bedside table next to the suctioning machine. A large bottle of opened and undated sterile water was placed next to it. An open and exposed to air hard plastic suction tip (disposable device used to suction) was attached at one end to a long tube leading to the suction canister was lying in a partially open drawer in the bedside table. He had a wet congested cough which resulted in oral secretions that ran down the left side of his face with occasional cough that projected phlegm onto his white pillowcase, towels, and top sheet covering him.

An observation on 12/18/19 at 12:22 pm revealed Nurse #1 entered the room to provide care to gastrostomy tube. Resident #1 had thick secretions covering the left side of his cheek and neck from him coughing. He was laying on his back with the head of his bed (HOB) elevated at 45 degrees and a heavily section soiled towel remained around his tracheostomy tube and across his upper chest. His pillow case revealed dried yellow mucous. Nurse #1 completed care for the tube feeding and left the room without replacing the pillow case or soiled towel.

An observation on 12/18/19 at 12:34 pm revealed resident continued to be lying in bed with a soiled towel across his chest and pillow case soiled on the left side of Resident #1's head. The Respiratory Therapist #1 (RT) entered the room, washed his hands, and applied gloves then approached the resident's bed moving the soiled towel to one side to provide care. He then used his gloved hand to retrieve a package containing a suction catheter from the top drawer of the nightstand which was located under the soiled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 9	F 695		

hard plastic suction catheter laid inside the drawer. He opened the package and began providing suctioning to Resident #1 using a single use suction catheter retrieved from the drawer in the nightstand. The RT#1 did not use the new disposable cup provided in the package and pour fresh sterile water into it, but instead RT #1 placed the tip of the single use suction catheter in the small white container approximately half full with a clear liquid located on the bedside table that had been sitting for an unidentified period of time then continue using it for additional suctioning of the tracheostomy. The tracheostomy dressing was replaced with clean dressing and collar was refitted during the treatment. Following treatment, the RT #1 did not provide oral suctioning despite Resident #1's mouth containing thick white secretions. RT #1 placed the soiled towel back across the resident's chest and left the room. The RT #1 left the room and returned at 12:45 with a portable pulse oximetry machine to check the resident's oxygen saturation which read 90 percent (%) and a pulse of 86 beats per minute (BPM), but again did not provide oral suctioning or clean excess secretions from Resident #1's face or replace the soiled towel.

An observation on 12/19/19 at 07:50 am revealed Resident #1 lying in bed on his back with his eyes closed. Oxygen continued to be set on 9L. The soiled pillowcase behind his head and a soiled towel remained draped across his chest. A small white paper container with clear liquid remained on the nightstand beside the bottle of sterile water and suction cannister.

An interview with the hall Nurse #1 and on 12/18/19 at 05:12 pm revealed oxygen flow rates

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 10	F 695		

were to be checked by the nurses every shift, but that she does not check it daily. She further stated the flow meter at times it is hard to read when set between 9-10 liters because of the way the ball sits in the gauge. Nurse #1 stated nurses provide resident #1 with suctioning every 4 hours and as needed (PRN) and stated clean towels should be placed when resident #1 has excessive secretions to prevent patients gown becoming soiled and usually do this but was behind this morning due to other concerns on the unit and skipped this step while providing care.

An interview with the RT director (RT #1) on 12/19/19 at 09:01 am revealed there was 24-hour respiratory care coverage for the facility and they normally assessed Resident #1 daily in the afternoon. The RT acknowledged the surveyor observation on 12/18/19 but then he indicated the normal procedure was to provide suctioning after proper hand hygiene using a single use disposable suction catheter. He identified the clear liquid in the square paper container to be sterile water solution that is kept at bedside. He stated each sterile packaged contain a new paper cup to use for the sterile water for suctioning and should be disposed of after each use. He said the sterile water from the paper cup nor suction catheter used in suctioning should be re-used. He stated that a hard-plastic suction tip when used should be placed in the sleeve it was originally packaged and placed away from the new sterile equipment because it is used for oral suctioning as needed. He stated the oxygen concentrators should be checked twice daily typically on first and second shift and with each RT treatment to ensure the correct liter is being received. He indicated he had checked the oxygen flow rate when he provided care and thought it was on 10L;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11	F 695		

however, stated that sometimes when it is at high volume rates the ball is difficult to read.

An interview on 12/19/19 at 10:45 am with the Staff Development Coordinator and the Director of Nursing indicated the correct procedure for tracheostomy care and suctioning should be a clean technique procedure; however, the sterile water should not be reused for cleaning the line of the tracheostomy and should be disposed of after each use. Each further indicated the plastic suction tip should always be covered when not in use and delivery of oxygen concentrations should be administered as ordered. Both further indicated that residents should be cleaned when routine care was provided to include changing soiled towels and bed linens.

An interview with the Physician on 12/18/19 at 04:31 pm revealed oxygen flow rates should be monitored and Resident #1 should receive 10 L oxygen as ordered and tracheostomy care should be performed per facility protocol and use of infection control standards for Resident #1.

2. Resident #2 was admitted on 03/27/19 with diagnosis including acute and chronic respiratory failure with hypoxia, attention to tracheostomy care, chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, other specified sepsis, hemiplegia and hemiparesis following a nontraumatic intracerebral hemorrhage affecting the left non-dominant side(paralysis of an extremity), dysphagia, attention to gastrostomy tube, type-2 diabetes, and malignant neoplasm of the tongue.

The Significant Change assessment dated 12/03/19 indicated Resident #2 was usually able

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 12	F 695		

to make needs known and had moderately impaired cognition. He required extensive to total care for all activities of daily living (ADL). The MDS included a prognosis of life expectancy of less than 6 months. He received oxygen, IV meds, and transfusions while in the hospital and oxygen, tracheostomy care, and suctioning while in the facility.

A history and physical dated 09/25/19 indicated Resident #2 is followed by hospice care for squamous cell carcinoma of the tongue which resulted in being oxygen and tracheostomy dependent for respiratory failure.

Monthly physician orders for Resident #2 reveal orders including oxygen at 5L with humidity via tracheostomy collar, tracheostomy care, pulse oximetry every shift, and suctioning every 4 hours and every hour PRN.

An observation of Resident #2 on 12/18/19 at 10:25 am revealed resident lying in bed on his back and leaning towards his left side. He had a tracheostomy collar intact and oxygen via concentrator attached to the tubing set at 5L. A blue hard plastic suction tip was exposed on the night stand. A white paper container with an unlabeled clear liquid substance was on his night stand next to an opened and non-labeled bottle of sterile water.

An additional observation on 12/18/19 at 12:28 pm revealed Resident #2 lying in bed with his eyes closed with increase congested secretions. Respiratory Therapist (RT) #2 entered the room at 12:32pm to provide suctioning and tracheostomy care. She was observed to wash her hands and apply gloves. She followed this by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 13	F 695		

obtaining a new single use suction catheter from the drawer and apply it to the end of the suction tubing. RT #2 used the clear liquid in the white paper container that had been sitting for an unidentified amount of time instead of pouring fresh sterile water into the new disposable white square box provided before irrigating and continuing with suctioning of the tracheostomy. She completed care and left the room.

An interview with the RT director (RT #1) on 12/19/19 at 09:01 am indicated there was 24-hour respiratory coverage for the facility and they normally assessed Resident #2 daily in the afternoon. Observations of RT #2 suctioning Resident #2 on 12/18/19 were shared with the RT #1. He indicated the normal procedure was to provide suctioning after proper hand hygiene using a single use disposable suction catheter. He identified the clear liquid in the white square container on the night stand as sterile water. He stated each sterile packaged contain a new paper cup to use for the sterile water for suctioning and should be disposed of after each use. He said the sterile water from the paper cup nor suction catheter used in suctioning should be re-used. He stated that a hard-plastic suction tip when used should be placed in the sleeve it was originally packaged and placed away from the new sterile equipment because it is used for oral suctioning as needed.

An interview on 12/19/19 at 10:45 am with the Staff Development Coordinator and the Director of Nursing indicated the correct procedure for tracheostomy care and suctioning should be a clean technique procedure; however, the sterile water should not be reused for cleaning the line of the tracheostomy and should be disposed of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 14 after each use. Each further indicated the plastic suction tip should always be covered when not in use and delivery of oxygen concentrations should be administered as ordered. An interview with the Physician on 12/18/19 at 04:31 pm revealed oxygen saturations should be monitored and Resident #2 should have oxygen delivered at 5L as ordered and tracheostomy care should be performed per facility protocol for Resident #2 including single use catheters are to be disposed of after usage, proper use sterile water solution.	F 695		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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;	F 880		1/16/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 §483.80(a)(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; (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 §483.80(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 observations, record review, and staff and physician interview, the facility failed to maintain infection control procedures for 1 of 1 resident (Resident #3) on transmission-based precautions. Findings included: A review of the facilities infection control policy titled "Infection Control Guidelines for All Nursing Procedures" from the Nursing Services Policy and Procedure Manual for Long Term Care revised August 2012 read in part that nursing staff having direct-direct care responsibilities would be provided in-service training on general infection control issues as well as managing infections of residents. It further indicated transmission-based precautions would be used whenever measures more stringent than Standard Precautions were needed to prevent the spread of infection. Employees must wash their hands for 10-15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents and before and after handling items potentially contaminated with blood, bodily fluid, or secretions. In addition to these general guidelines, refer to procedures for any specific infection control precautions that may be warranted. Resident #3 was admitted to the facility on 12/15/19.	F 880	Nurse #1 was educated on following proper infection control protocols for any resident on isolation measures immediately by the Director of Nursing. 100% of all resident rooms on isolation were checked for proper signage and ensured PPE was available for employees immediately. 100% of all facility staff were educated by 1/16/2020 on Infection Control Guidelines for residents on isolation by the Infection Control Nurse, Director of Nursing, and Assistant Director of Nursing. Any new employees will continue to complete training in orientation on infection control safe practices. Isolation Precaution audits will be completed by the Infection Control Nurse and Nursing Administration team daily x 4 weeks, weekly x 4 weeks, and monthly x 1 year. Any areas of concern will be addressed immediately. A summary of the findings of the Isolation Precaution audits will be presented to the monthly QAPI meetings by the Infection Control Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17	F 880		

Physician orders for Resident #3 included an order written on 12/18/19 for contact precaution due to gastrointestinal (GI) symptoms.

A hydration care plan dated 12/18/19 read risk for dehydration secondary to recent episodes of vomiting that resulted in contact precautions.

An observation on 12/18/19 at 10:16 am was made of both an enteric contact and a droplet precaution sign posted on the door of room 207 and Personal Protective Equipment,(masks, gowns, and gloves) were available outside of the door of the room. The enteric based contact precaution sign read: perform hand hygiene before entering room and wash hands with soap and water before leaving, wear gloves when entering the room and with contact with patient's intact skin, surfaces, or in proximity, and wear a gown when entering the room and whenever anticipation of contact with environmental surfaces. The droplet precaution sign read: perform hand hygiene before entering and before leaving the room and wear a mask when entering the room.

An observation of Nurse #1 on 12/18/19 at 1:02pm revealed she removed a lunch tray from the meal delivery cart in the hallway and entered room #207 without wearing any PPE. After entering the room, she set the meal tray down and began setting it up as she was speaking to the resident. Resident #3 then told the nurse she didn't feel like eating and the nurse picked up the meal tray and returned the tray to the meal service cart in the hallway containing other residents unserved meals at 1:05pm. At 1:06pm, Nurse #1 was observed entering the room of 207 carrying Resident #3's roommate's tray without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18	F 880		

donning PPE or washing her hands. Nurse #1 set up the meal tray for the resident and then exited the room and continued serving meal trays to other residents on the unit without washing her hands.

An interview with Nurse #1 on 12/18/19 at 5:12 pm revealed she acknowledged she did not wear any PPE to deliver the meal trays for Room 207. She further stated acknowledged she should remove the tray from Resident #3's room who was on contact precaution and placed the uneaten tray back on the cart with the clean trays being passed to other residents. Nurse #1 stated she knew there was signage posted on the outside of Resident #3's door alerting staff of droplet and enteric contact precautions and she should have worn gloves, a mask, and a gown when she entered the room and removed them upon exiting followed by washing her hands. She stated the day had been hectic with multiple residents newly placed on precautions and she did not think about donning PPE when she delivered the trays. She further acknowledged she should not have placed the tray from the room on the clean meal service cart which contained unserved resident meal trays. She stated contact precautions had been started after Resident #3 and other residents on the unit had experienced Gastrointestinal symptoms nausea and vomiting the day before to prevent further spread.

An interview with the Infection Control (IC) Nurse on 12/19/19 at 10:45 am revealed she was aware of Room #207 being on contact precautions and acknowledged that PPE was provided. She acknowledged signage of both enteric contact and droplet precautions were posted on the door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 12/19/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19	F 880		

of the resident's room on both 12/18/19 and 12/19/19. She stated nursing staff initiated the contact precaution orders to prevent the spread of GI symptoms when multiple residents on the unit exhibited symptoms the previous day. The IC Nurse stated that PPE was available and contact precaution should have been followed to include wearing of gowns and gloves.

An interview with the Director of Nursing (DON) on 12/19/19 at 11:07 am the DON revealed staff were to follow contact precautions to include wearing of gowns and gloves for any resident on contact precautions. She further revealed nursing staff would initiate contact precautions and notify the IC nurse and MD for follow-up and should be reported to hall staff.

An interview with the physician on 12/18/19 at 4:31 pm revealed he had not yet been notified of Resident #3 being placed on contact precautions. He stated staff were provided PPE and should be used when residents are on contact precautions. He further stated PPE is to be changed between residents even within the same room. He stated precautions should be maintained until signage is removed for the safety of residents and the staff.