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 12/18/2023

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 A complaint investigation survey was conducted on 12/18/23. Event ID# Y6SN11. The following intakes were investigated NC00211012 and NC00210313. One (1) of the 2 complaint allegations resulted in deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide care in a safe manner and failed to ensure fall mat was in place for 1 of 3 residents reviewed for accidents (Resident #1). Resident #1 sustained a fall from his bed after the Nurse Aide walked away after raising the height of the bed and failed to ensure the fall mat was placed next to his bed when she left to retrieve items from his closet. The fall resulted in a 6.5 centimeter laceration to the forehead, 2 centimeter laceration to the nose, 1.5 centimeter laceration to the upper lip, 1 centimeter laceration inside of the mouth, and an 8 millimeter parenchymal hematoma corresponding in location to a previous hematoma (Resident #1). The resident was sent to the Emergency Department and discharged the following day where he required sutures for his lacerations.	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/28/2023

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F 689	Continued From page 1	F 689		

The findings included:

Resident #1 was originally admitted to the facility on 04/14/22 with diagnoses which included nontraumatic intracerebral hemorrhage and muscle weakness.

The quarterly Minimum Data Set (MDS) assessment dated 09/01/23 indicated Resident #1 was rarely/never understood, was severely impaired for decision making, and had short-term and long-term memory problems. He required extensive assistance with 2 staff members for bed mobility.

Resident #1 was care planned on 10/29/23 for an actual fall with risk for further falls due to poor communication/comprehension and frequent attempts to get out of bed. The interventions included, in part, fall mats to floor at beside and bed in lowest position.

A physician order dated 11/11/22 indicated a fall mat was to be on the floor at bedside every shift.

A nursing note dated 11/21/23 at 11:25 AM read Resident #1 was noted to be lying slightly on his right side on the floor in front of his bed. He was alert and responsive and had some bleeding coming from the middle of his forehead, bridge of nose, and upper left nostril. A full assessment was completed including vital signs, neuro-assessment, and pain. Supervisor, Nurse Practitioner, and Resident #1's Responsible Party were notified. An order to send to the Emergency Department was received. Resident #1 was sent to the hospital for evaluation.

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F 689	Continued From page 2	F 689		

A review of the Incident Summary dated 11/21/23 indicated Resident #1 was noted to be lying slightly on his right side on the floor in front of his bed. He was alert and responsive and had some bleeding coming from middle of his forehead, bridge of nose, and upper left nostril. A full assessment was completed including vital signs, neuro-assessment, and pain. Resident #1 stated he fell out of bed. An investigation of the fall was initiated. Nurse Aide #1 (NA) completed a reenactment of the fall and was suspended pending the investigation. All staff were educated and a 100% audit on bed mobility and transfers were completed on all care plans.

NA #1's written statement dated 11/21/23 stated she arrived in the morning and the previous shift NA gave her report of all her assigned residents. She stated she had not worked on the assignment in months and was not familiar with the care plan for everyone but was told she could assist everyone on her own. She tried logging into the charting system to go over the care plan for each resident but received an error. She started doing rounds when she heard therapy tell the nurse they were going to get up Resident #1 today. She went to his room next. She moved the fall mat and lowered his head and legs and lifted the bed up to her knees. She turned away to pick clothes out of the closet a few feet away. When she looked back, his leg was crossed over the other hanging off as well as his right arm. She stated she was not sure if he "willed" himself off the bed or if the weight from his legs and arms pulled him down, but she saw him fall and hit his head then laid on his side. She immediately got the nurse and vital were taken.

Attempts to interview NA #1 were not successful.

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F 689	Continued From page 3	F 689		

Review of the Emergency Department discharge summary dated 11/22/23 indicated Resident #1 presented to the Emergency Department after a mechanical fall out of the bed. Resident #1 was at the facility when a NA was in his closet with her back turned towards him and Resident #1 rolled off the bed onto the ground. He was alert, oriented, did not verbalize pain, and was not in acute distress. He was noted to have a laceration on the left side of his forehead with blood from his nose, laceration to his nose, laceration to his upper lip, and inside of his mouth all of which required sutures. A Computed Tomography (CT) Scan was performed which showed a small 8-millimeter parenchymal hematoma corresponding in location to a previous hematoma, an acute nasal arch fracture, and a large frontal scalp contusion and laceration without underlying fracture. Neurosurgery was consulted and recommended no acute neurosurgical intervention was necessary.

An interview occurred with Nurse #1 on 12/18/23 at 12:25 PM. She recalled Resident #1's fall on 11/21/23 and explained she was retrieved by the NA. When she entered the room, Resident #1 was lying face down on the floor between the bed and fall mat with blood covering his face. During the assessment, she noticed resident had a laceration to his face and Resident #1 denied pain. She stated Resident #1 was unable to state what happened, but she noticed the fall mat was not near the bed. 911 was called for further evaluation at the Emergency Department.

The facility provided the following corrective action plan for the past non-compliance with a compliance date of 11/24/23.

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F 689	Continued From page 4	F 689		

Corrective action for resident involved:

Resident assessed by the nurse, Medical Director notified, and Responsible Party updated. Resident was sent to the hospital for evaluation.

Corrective action for potentially impacted residents:

On 11/21/23 the DON identified residents that were potentially impacted by this practice by completing the Kardex access and use for all CNA present at the time. This was completed on 11/21/2023. The results included: 3 out of 13 CNAs had not been able to log onto PCC and had not viewed the Kardex. On 11/21/2023 the DON implemented corrective action for those residents which includes: resolving sign in issues for those 3 CNAs and completing bed mobility audits on all current residents.

Systemic changes:

On 11/21/2023, the DON and SDC in-serviced all nursing staff (including agency) on bed mobility policy. This training will include all current staff including agency. This training included: Preventing Injuries with Bed Mobility.

The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 11/24/23 will not be allowed to work until the training is completed.

Quality Assurance:

Beginning 11/28/23 the DON will monitor Kardex access and use weekly for 4 weeks and monthly

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F 689	Continued From page 5 for 2 months for concerns with logging in to PCC and looking at Kardex. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The date of compliance was 11/24/23. As part of the validation process, the plan of correction was reviewed and verified through review of the audit sheet, the in-service records, and staff interviews. Multiples observations were conducted on 12/18/23 of Resident #1's fall mat placement. Each observation showed Resident #1's fall mat was next to his bed while he was in bed. Other observations of other residents with fall mats were conducted on 12/18/23, which revealed fall mats were in place while the residents were in bed. Interviews with the staff involved with the incident dated 11/21/23 were completed and with current staff. Interviews revealed they had received in-service education on preventing injuries with bed mobility. Additionally, interviews with Nurse Aides revealed they had access to the electronic medical chart so they can review each resident's Kardex before starting their assignment. The validation process verified the facility's date of compliance of 11/24/23.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		12/27/23

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F 867	Continued From page 6 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 7 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 8 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following a complaint survey completed on	F 867	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	

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F 867	Continued From page 9 01/20/22 and a recertification and complaint investigation survey completed on 11/15/22. This was for one deficiency in the area of the supervision to prevent accidents and subsequently recited during the complaint survey dated 12/18/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referenced to: F 689 - Based on record review, observations and staff interviews, the facility failed to provide care in a safe manner and failed to ensure fall mat was in place for 1 of 3 residents reviewed for accidents (Resident #1). Resident #1 sustained a fall from his bed after the Nurse Aide walked away after raising the height of the bed and failed to ensure the fall mat was placed next to his bed when she left to retrieve items from his closet. The fall resulted in a 6.5 centimeter laceration to the forehead, 2 centimeter laceration to the nose, 1.5 centimeter laceration to the upper lip, 1 centimeter laceration inside of the mouth, and an 8 millimeter parenchymal hematoma corresponding in location to a previous hematoma (Resident #1). The resident was sent to the Emergency Department and discharged the following day where he required sutures for his lacerations. During the facility's recertification survey of 11/22/22, the facility failed to provide care in a safe manner and/or implement fall safety interventions developed and care planned by its	F 867	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 dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and effective monitoring of interventions the committee put into place following complaint investigation on 12/18/23 in which a resident fell from the bed, and fall mat was not in place. On 11/21/23 the facility failed to maintain fall interventions in place, as the resident fell off the bed, and fall mat was not in place. The facility implemented a plan of correction after that fall on 11/21/2023 to include root cause analysis, education and monitoring with alleged compliance of 11/24/2023 for F 689 to achieve past noncompliance, but the pattern of the facilities inability to sustain an effective quality assurance program resulted in a citation in F867. The root cause analysis to reduce the risk of future harmful events was conducted on 11/22/2023 with the Quality assurance committee members to include the nurse consultant, the director of clinical services and the director of operations with corrective action plan.	

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F 867	Continued From page 10 interdisciplinary team (IDT) for 4 of 5 residents reviewed for falls. During the facility's complaint survey dated 01/20/22, the facility failed to ensure 1 of 2 residents requiring extensive assistance with bed mobility and bathing was provided care safely to prevent injury. An interview was completed on 12/18/23 at 2:43 PM with the Administrator. She stated that the repeat citation could be because even though agency staff were educated before taking an assignment, they were not familiar with the residents.	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 12/26/2023 to review the deficiencies from the December 18, 2023 complaint survey, and reviewed the citations. On 12/26/2023, Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. On 12/26/2023 the nurse consultant, director of clinical services and the director of operations implemented guidance for performing root cause analysis with Performance improvement projects to ensure regulatory guidance. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 12/26/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. On 12/26/23 the Nurse consultant the director of clinical	

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F 867	Continued From page 11	F 867	services and the director of operations provided education to the QAPI team members on Root cause analysis process to include a way to identify breakdowns in processes and systems that contribute to an event and how to prevent future events. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Starting on 12/26/2023 the Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool. Monitoring will be weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with fall interventions. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. The nurse consultant will review the tool weekly x 4 weeks then monthly x 6 months to ensure root cause analysis and	

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F 867	Continued From page 12	F 867	to monitor for any patterns of deficient practice. Date of Compliance: 12/27/2023	