### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/Clinical Identification Number:

345284

#### (X2) Multiple Construction

- **A. Building:**
- **B. Wing:**

#### (X3) Date Survey Completed:

07/17/2012

#### (X4) Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>ID Tag</th>
<th>Provider's Plan of Correction</th>
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</thead>
<tbody>
<tr>
<td>F 322</td>
<td>SS=d</td>
<td>483.25(g)(2) NG Treatment/Services - Restore Eating Skills</td>
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</table>

**The Oaks**

- **Street Address, City, State, Zip Code:**
  - 291 Bethesda Rd
  - Winston Salem, NC 27103

**Summary Statement of Deficiencies**

F 322

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

- Based on observations, record review and staff interviews, the facility failed to maintain proper positioning for 1 of 1 sampled resident receiving a continuous tube feeding.

  (Resident #3)

- Resident #3 was admitted to the facility on 4/19/12 with a gastrostomy tube due to a diagnosis of esophageal stenosis and swallowing difficulty.

  A physician’s order, dated 7/8/12, indicated Jevity 1.5 Cal. was to be infused at 60 milliliters per hour from 12:00 pm until 8:00 am.

  A care plan, dated 4/30/12, indicated the resident was at risk for aspiration and included the approach to keep HOH (head of bed) elevated, unless otherwise contraindicated.

  On 7/17/12 at 2:40 pm Nursing Assistant #1 (NA #1) entered Resident #3's room with supplies to provide incontinent care. The resident was observed sitting upright in bed with the head of

**Laboratory Director's or Provider/Supplier Representative's Signature:**

*Susan Halton*

**Title:**

Administrator

08/02/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
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<th>F 322</th>
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<td>the bed elevated approximately 45 degrees and with one pillow behind her head. A feeding pump at the resident 's bedside was observed to be infusing Jevity 1.5 Cal. at 60 milliliters per hour through a gastric tube. A sign was observed taped above the head of the resident 's bed and read in part: HOB (head of bed) elevated @ (at) a min. (minimum) of 450 (degrees) during all tube feedings and for 45 minutes after turned off.</td>
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<td>NA# 1 lowered the head of the bed to the lowest position (flat) while the resident 's head remained on one pillow. When asked if the tube feeding was running, NA# 1 looked at the feeding pump and replied, &quot;Yes&quot;. NA# 1 proceeded to provide incontinent care with the head of the bed in the lowest, flat position.</td>
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<td>NA# 1 was asked about the sign above the resident 's bed. NA# 1 stated this resident was not her regular resident and she did not know if the head of the bed needed to be elevated or not.</td>
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<td>On 7/17/12 at 2:48 pm, Nurse # 1 entered Resident # 3 's room and talked to NA # 1. Nurse # 1 started to leave the room and was interviewed just prior to exiting the room. Nurse # 1 looked at the feeding pump and confirmed the tube feeding was infusing and stated the head of the bed should be elevated. Nurse # 1 then instructed NA # 1 to push the &quot;hold&quot; button on the feeding pump to turn off the infusion, and stated he would restart the tube feeding later when care was finished and the head of the bed could be elevated.</td>
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<td>On 7/17/12 at 3:10 pm NA # 1 was interviewed about her knowledge of taking care of residents</td>
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with tube feedings. NA #1 stated she did not have any residents with tube feedings on her regular assignment, but knew the head of the bed was supposed to be elevated. She stated she was nervous being observed and forgot the head of the bed needed to be elevated for (name); the resident identified as Resident #3.

On 7/17/12 at 3:20 pm, Nurse #2, assigned to Resident #3, stated the head of the bed for Resident #3 and other residents with tube feedings should be elevated when the feeding pump was running and the feeding infusing.

On 7/17/12 at 5:30 pm the Director of Nursing (DON) was interviewed about care of residents with tube feedings. The DON stated she expected that nursing assistants, including NA #1 would be aware that the head of the bed should be elevated when a feeding pump was running, and that the head of the bed of Resident #3 should have been elevated 45 degrees. She indicated NA #1, and other nursing assistants were instructed to go ask a nurse if they had questions, and that NA #1 should have done this if she had questions.