PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 05/25/2	C 05/25/2017	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/23/2	""	
				901 BETHESDA ROAD			
THE OAKS	S			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	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) MPLETION DATE	
F 000	INITIAL COMMENTS		F 00	00			
	A recertification surve conducted from 5/21/ Immediate Jeopardy	•					
	(J) CFR 483.25 at tag F3	09 at a scope and severity 23 at a scope and severity					
	(J) CFR 483.75 at tags F (J)	490 at a scope and severity					
F 241	Quality of Care. Immediate Jeopardy I removed on 5/25/17. conducted. 483.10(a)(1) DIGNITY	323 constituted Substandard Degan on 9/30/16 and was An extended survey was 7 AND RESPECT OF	F 24	41	6/19	9/17	
SS=D	resident in a manner apromotes maintenance her quality of life recoindividuality. The facil promote the rights of						
	Based on observation interviews and record promote resident dign	review the facility failed to hity by placing a pracelet on one of one alert is (Resident #35).		The statements made on this Plate Correction are not an admission of not constitute an agreement with alleged deficiencies. To remain in compliance with all Federal and Segulations the facility has taken take the actions set forth in this P	to and do the State or will		
	Resident #35 was add 12/28/16 with diagnos	mitted to the facility on ses of diabetes, fracture of		Correction. The Plan of Correction constitutes the facility's allegation compliance such that all alleged			

Electronically Signed

06/16/2017

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.

NAME OF PROVIDER OR SUPPLIER THE OAKS STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NO. 27103 PROFITOR 1A0 FEACH DEPICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC (IDENTEYING INFORMATION) FEACH REGULATORY OR LSC (IDENTEYING INFORMATION) F 241 Continued From page 1 the pelvis, and depression. Review of the most recent Minimum Data Set (MDS), a quarterly, dated 3/29/17 indicated Resident #35 had polysical aggressive behaviors. The MDS indicated Resident #35 was not ambulatory, required supervision with bed mobility, transfers and locomotion on the unit and limited assistance for locomotion off the unit. Resident #35 used a wheelchair for mobility and had no physical alimitations of her extremities. Review of the care plan dated 12/29/16 included a problem of depression with use of an antidepressant. Behaviors of elopement were not included on the current care plan. A physician's progress note dated 5/19/17 indicated Resident #35 had a severe episode of recurrent major depressive disorder, without psychotic features. Current treatment for depression was with a medication Cymbhalta. The resident was in agreement to see the psychiatrist or psychologist. The physician included she had no active wish to die and is requesting help. Resident #35 ad antitted to lifelong psychiatric lilness. The physician included she had no active wish to die and is requesting help. Resident #35 ad mitted to lifelong psychiatric lilness. The physician included she had no active wish to die and is requesting help. Record review of a nurse's note on 5/21/17 revealed Resident #35 had become angry and attempted to hit the nurse. There was no information in the medical record of exit seeking behaviors. Observations were made on 5/22/17, at 9:30 AM,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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information in the medical record of exit seeking behaviors. PRN) to inform them that, the facility must treat and care for each resident in a manner and in an environment that			. .		_		
behaviors. treat and care for each resident in a manner and in an environment that		•					
manner and in an environment that			alea. Toola of oat occaring		,		
		55114710101					
		Observations were m	ade on 5/22/17, at 9:30 AM			nt	

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING	B. WING		C 05/25/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2017
					01 BETHESDA ROAD		
THE OAK	3				VINSTON SALEM, NC 27103		
					· T		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From pag	ne 2	F 2	241			
	5/23/17 at 11:00 and	l 5/24/17 at 4:00 PM and			of his or her quality of life recognizing		
	revealed Resident #3	35 did not leave her room,			each resident's individuality. The facili	tv	
		ning and ate her breakfast			must protect and promote all the rights		
	•	No behaviors were observed			the resident. The facility should promo		
	during the observation	ons and no attempts to leave			care for residents in manner and in an		
					environment that maintains or enhance	es	
	Interview with Nurse	#5 on 5/23/17 at 10:13 AM			each resident's dignity and respect in t	ull	
	revealed the resident had a wander-guard on her				recognition of his or her individuality.		
	ankle due to exit seeking behavior. The resident				This in service was completed by June		
	_	s and say she was going			16th, 2017. Any Nurse (RNs, LPNs, fu		
	home. The nurse was asked if those behaviors would be documented and she explained it would				time, part time, and PRN) and membe	r of	
					the interdisciplinary team who did not		
	be in the nurse's not	es.			receive in-service training will not be	.41	
		and in the state of the state o			allowed to work until training is comple		
	An interview with the				This information has been integrated in		
		117 at 12:33 PM During the worker explained he did not			the standard orientation training and ir required in-service refresher courses f		
		nad a wander-guard on her			all employees and will be reviewed by		
		ealed he was familiar with the			Quality Assurance Process to verify th		
	resident, she was ab				the change has been sustained.	4 (
		to leave and was not					
	_	e. Further interview revealed			Monitoring:		
		become angry at times if			To ensure compliance, Administrator of	r	
	there was something	she didn't want to do. He			Director of Nursing or designee will		
	gave an example that	at she had refused to wear			monitor this issue using the QA survey	,	
		hospital gown. But that was			tool. Facility will monitor compliance by		
		asked again if she was			interviewing 5 alert and oriented reside	ents	
		to make safe decisions, had			weekly to ensure that a wander guard		
		ated "no." The social worker			bracelet was not in place. This is will b		
		was looking for placement in			done on weekly basis for 4 weeks ther	1	
	an assisted living fac	cility close to her family.			monthly for 3 months by the Support		
	Decident #25	torriowed on F/22/47 -t 2:24			Nurse, Unit Manager, or designee.	.,	
		terviewed on 5/23/17 at 3:24			Reports will be presented to the weekl	•	
		re a bracelet on her leg I wanted to leave and they			QA Committee by the Administrator or designee to assure corrective action		
	were afraid I would le				initiated as appropriate. Any immediate	ا ا	
	were arraid i Would It	Cave, but I woll t.			concerns will be brought to the Director		
	Interview with the MI	DS nurse on 05/25/17 at			Nursing or Administrator for appropriat		
		she was not aware the			action. Compliance will be monitored a		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345284	B. WING	B. WING		C 05/25/2017	
NAME OF PR	ROVIDER OR SUPPLIER	010201		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	25/2017	
				901 BETHESDA ROAD			
THE OAKS	5			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 241	further explained the leave "all the time." A completed that includ wandering/elopement reviewed with the MD last risk assessment indihaving no behaviors of interview with the MD plan would need to inwander-guard. The cupdated because she placement on 5/15/17 Interview with the Adri 1:00 PM revealed she bracelet on the reside Resident #35 was in a roommate and the rook Administrator explained Resident #35 and mo After Resident #35 and mo After Resident #35 has remained angry and releave and the Administ During the interview, commented the reside in the next week. Interview with Nurse # revealed she had been Nursing to check Resident wander-guard. Slifind the one on her whon her leg on 5/15/17	reced on the resident. She resident says she wants to a risk assessment would be red behaviors of and the resident says she wants to a risk assessment would be red behaviors of and the resident says she was sassessed as a soft exit seeking. Continued and so nurse revealed a care clude the use of the resident says of the resident says of the resident says of exit seeking. Continued and so nurse revealed a care clude the use of the resident says of the resident says of exit seeking. Continued and so nurse revealed a care clude the use of the resident says of the resident says of the revealed a care clude the use of the resident says of the resident says of the revealed a care clude the use of the resident says of th	F 2-	ongoing auditing program reviews Weekly Quality of Life Meeting. W QA Committee meeting is attende Administrator, Director of Nursing Coordinator, Unit Manager, Suppi Nurse, Therapy, HIM, Dietary Mar Wound Nurse.	/eekly ed by , MDS ort		
	3:15 PM revealed she	t Manager on 5/25/17 at did a risk assessment on anager explained she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345284	B. WING		C 05/25/2017
NAME OF F	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	the continued use of interview, she explai with a room change, to leave. When aske intervention they could Manager explained in the Unit Manager fur practice included continue time the wander-Interview with the Trace 2:45 PM revealed Resee the psychiatrist in Further interview revito be in a facility close physician had seen in the psychiatric consumedication for depret the treatment nurse interventions were alwander-guard was physician was physician. The treatment nurse of anything else that 483.24(c)(1) ACTIVI INTERESTS/NEEDS (c) Activities. (1) The facility must comprehensive asset the preferences of exprogram to support ractivities, both facility individual activities and designed to meet the physical, mental, and	Resident # 35 for the need of the wander-guard. During ned the resident was upset was angry, and threatened ed if there was any other ald have done, the Unit she could not think of any. Ther explained usual impleting a risk assessment at guard was placed. TIES MEET	F 24		6/19/17

	DF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	0.0201		STREET ADDRESS, CITY, STATE, ZIP CODE	05/25/2017	
TO THE OT THE	TO VIBER OIL OUT I EIER			901 BETHESDA ROAD		
THE OAK	3					
			<u>, </u>	WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 248	Continued From page	e 5	F 248			
	and interaction in the This REQUIREMENT by:	community. is not met as evidenced				
	•	ns, record review and staff		The statements made on this Plan of		
		failed to provide ongoing		Correction are not an admission to and	ob t	
	activities for 2 of 3 sa	mpled residents reviewed		not constitute an agreement with the		
	for activities (Residen	t #78 and Resident #149).		alleged deficiencies. To remain in		
				compliance with all Federal and State		
The findings included:		:		Regulations the facility has taken or w		
	1) Resident #78 was admitted to the facility on 6/30/16 with a diagnosis of non-Alzheimer 's			take the actions set forth in this Plan o	†	
				Correction. The Plan of Correction		
	dementia.	sis of non-Alzheimer s		constitutes the facility's allegation of compliance such that all alleged		
	uemenua.			deficiencies cited have been or will be		
	An Activity Review wa	as completed for Resident		corrected by the date or dates indicate		
	·	e review indicated Resident		deriversed by the date of dates maleute		
		s included pets, music,		F248 ACTIVITIES MEET INTERES	Tí	
		lening, television, reading,		OF EACH RES		
		. The resident was noted to		Corrective Action:		
	prefer active participa	tion in activities and wished		Resident #78: Preferences reevaluate	÷d ∣	
		room activities. Information		by completing a Staff assessment of D	-	
	for the review was pro	ovided by the resident.		and Activity preferences on 6/15/2017		
	<u> </u>			resident is not interview able (severely		
		isciplinary Progress Notes		impaired cognitive skills for daily decis		
		notation dated 11/16/16 at		making). Care plan updated appropria	-	
		vity Department: "(Resident		Resident # 149: Preferences reevalua		
		TV, listening to music, s around, going outside		by completing a resident interview of E and Activity preference on 6/15/2017 (
		nice and religious services.		plan updated appropriately.	Jaie	
		r to attend different activities		plan apaated appropriately.		
	of choice."			Identification of other residents who m	ay	
				be involved with this practice:	·	
	An Activity Review wa	as completed for Resident		All residents have the potential to be		
		eview indicated Resident		affected by the alleged practice. On		
		ts included pets, music,		5/24/2017 to 6/16/2017, preferences		
		ening, television, reading,		reevaluated by completing a staff		
		. The review indicated		assessment of Daily and Activities		
		as very important to her to		preferences for all current non-		
	do things with groups	do things with groups of people and to do her		interviewable residents and by comple	ting	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			71. 501251	_		C	
		345284	B. WING				25/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	20/2011
				9(01 BETHESDA ROAD		
THE OAK	S			V	VINSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 248	Continued From page	e 6	F:	248			
	favorite activities. Inf	formation for the review was			a resident interview for Daily and Activi	tv	
	provided by the resid				preferences for all current interviewable	-	
					residents by the Activities Director .Car		
	A review of Resident	#78's April 2017 Activity Log			plans updated appropriately. All Activity		
	revealed the resident	participated in three			assessments that include residents dai	ly	
	activities during the n	nonth. Activity involvement			and activity preferences were placed ir	1	
	noted on the Activity Log included Games and				the Activities book at each nursing stat	on.	
	Puzzles on 4/5/17, pa						
	on 4/19/17 and a Rel			Systemic Changes:			
					Director of Nursing and /or Designee Ir	1	
	_	as completed for Resident			serviced the Activities Director and all		
		eview indicated Resident			Nursing staff (full time, part time, and		
		sts included arts and crafts,			PRN) to inform them that, the facility m	ust	
	pets, music, BINGO,				provide, based on the comprehensive		
	_	nd outdoor activities. The			assessment and care plan and the		
		ident #78 felt it was very			preferences of each resident, an ongoi	ng	
	1	things with groups of			program to support residents in their		
	1 -	favorite activities. The prefer active participation in			choices of activities , both facility-sponsored group and individual		
	I .	to be invited to out of room			activities and independent activities,		
	activities. Information				designed to meet the interests of and		
	provided by the resid				support the physical, mental, and		
	provided by the recid	ont.			psychosocial well-being of each reside	nt	
	A review of Resident	#78's most recent quarterly			encouraging both independence and	,	
		IDS) dated 5/4/17 revealed			interaction in the community.		
	I	essed by staff to have			,		
	severely impaired co	•			Activities assessments for each reside	nt	
	decision making. Sh	-			will be placed in the activities book at		
	_	for all of her Activities of			each nursing station. The assessments	3	
	Daily Living (ADLs), v	with the exception of being			include residents daily and activity		
	totally dependent on	staff for transfers and eating.			preference in which the staff can refer Activities for dependent and debilitated		
	A review of the reside	ent's most recent Care Plan			patients who are bed or room bound w		
		included the following areas			be carried out by the activities departm		
	of focus:	3			and nursing staff daily as needed. Visu		
	"I like to participate	in most activities that are			and tactile stimulating items will be place		
	offered in the facility.				in a plastic bin at the nurse station and		
	Revised on 8/4/15)	•			be accessible to all staff at all times. Si		
	1	tions/tasks for this area of			will be encouraged and reminded to		

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

		E SURVEY IPLETED					
						С	
		345284	B. WING		0	5/25/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAKS				901 BETHESDA ROAD			
THE UAK	•			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248	Continued From pag	e 7	F 24	8			
F 248	focus included:"Provide activities to (Initiated 8/4/15)"Provide me with a month." (Initiated 8/4"The activity directo participation daily." (A review of Resident to date revealed the activities during the r noted on the Activity on 5/2/17, a Religiou on 5/4/17, a Commun and Group Events or An observation was r AM as Resident #78 appeared to be asleed An observation was r as Resident #78 was resident was awake a observed. An interview was cor PM with the facility 's the interview, Reside activities was discuss reported the resident BINGO on occasions not gotten up as muc Resident #78's Activity was asked if the log of participation in as man	calendar of activities each (1/15) or to document on my activity Initiated 8/4/15) #78's May 2017 Activity Log resident participated in 5 month. Activity involvement Log included a Spa Service is Service on 5/4/17, a Social inication Activity on 5/8/17, in 5/12/17. Inade on 5/22/17 at 10:00 was lying on her bed. She exp. Inade on 5/23/17 at 11:45 AM lying on her bed. The and alert. No activities were inducted on 5/23/17 at 3:17 is Activities Director. During in #78's participation in sed. The Activities Director used to get up and come to so, but noted the resident had the lately. Upon review of ty Log, the Activity Director	F 24	disperse these items to the appresidents throughout the day by Director and Unit Manager. Tele CD/music player will be utilized enjoyment. Books on tape will be available for the staff to utilize fination patients identified for the need request of the patient. Television turned on by staff members per throughout the day for those parangement family members will be contacted by the activities deparand/or nursing staff to inquire a patient's preferences, for those unable to voice their choices of entertainment / stimulus on Adra Activities Director will monitor a staff on the appropriate choice for the patient as the need arise Director and nursing staff will determine the medical record resident part in activities. This in service was completed the medical record resident part in activities. This in service was completed to the part time, and PRN) and member interdisciplinary team who did reservice training will not be all work until training is completed information has been integrated standard orientation training an required in-service refresher coall employees and will be review Quality Assurance Process to we the change has been sustained	y Activities evision and for patient be made or those or at the ons will be riodically atients who ce. e artment bout patient's mission. and instruct of activities es. Activity ocument in ticipation by June artment f (full time, per of the not receive lowed to . This d into the d in the ourses for wed by the rerify that		
		made on 5/24/17 at 9:30 AM in a wheelchair in her room.		Monitoring: To ensure compliance, Adminis Director of Nursing or designee			

Facility ID: 923497

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			E SURVEY IPLETED
		345284	B. WING		0.6	C 5/25/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		012312011
				901 BETHESDA ROAD		
THE OAK	5			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 248	Continued From pag	e 8	F 24	3		
	verbal). Resident #7 radio on in the room. observed.			monitor this issue using the QA tool. Facility will monitor compli observing 5 residents weekly to that they are participating in ac choice per their preferences. F	iance by o ensure ctivities of acility will	
An observation was made on 5/24/17 at as Resident #78 sat in a wheelchair in he with her eyes closed. Resident #78 did ratelevision or radio on in the room. No a were observed.		in a wheelchair in her room . Resident #78 did not have		also monitor compliance by revided documentation of resident part activities per their preferences medical record. This is will be divided by weekly basis for 4 weeks then	icipation in in the done on	
	An observed. An observation was made on 5/24/17 at 3:50 PM as Resident #78 sat in a wheelchair in her room. Her eyes were closed. Resident #78 did not have a television or radio on in the room. No activities were observed to be within reach of the resident.			3 months by the Support Nurse Manager, or designee. Report presented to the weekly QA Co the Administrator or designee t corrective action initiated as ap Any immediate concerns will be	e, Unit s will be committee by co assure opropriate. e brought to	
	AM as Resident #78 The resident was aw observed to be engated. An interview was cortain AM with Nurse #3. Note that the care for Resident #7	nducted on 5/25/17 at 10:47 Nurse #3 was assigned to 8 on 1st shift. Upon inquiry, he did not recall the resident		the Director of Nursing or Admi for appropriate action. Complia monitored and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly QA Committe is attended by Administrator, D Nursing, MDS Coordinator, Un Support Nurse, Therapy, HIM, Manager, Wound Nurse.	ance will be g program of Life we meeting director of it Manager,	
	An interview was conducted on 5/25/17 at 11:20 AM with Nursing Assistant (NA) #2. NA #2 was assigned to care for Resident #78. Upon inquiry regarding the resident 's involvement in activities, NA #2 reported Activities came and assisted the resident to attend a Sing-along earlier that morning. An interview was conducted on 5/25/17 at 12:38 PM with the facility's Director of Nursing (DON).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 05/25/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 901 BETHESDA ROAD WINSTON SALEM, NC 2710		33/23/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 248	incorporate some of enjoyed into her day 2) Resident #149 wa 12/28/16 with a diag An Activity Review wa #149 on 12/28/16. The state of the state o	the Activities Department to the things the resident as admitted to the facility on nosis of dementia. The review indicated Resident ests included arts and crafts, BINGO, movies, gardening, and outdoor activities. The perfer active participation in to be invited to out of room in for the review was lent. Disciplinary Progress Notes d 1/4/17 by the Activity tation revealed Residenting to music, watching TV, reading, going outside when naving family around, and	F2			
	for the review was poor A review of Resident Minimum Data Set (I	#149's most recent quarterly MDS) dated 3/29/17 revealed essed by staff to have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		· /	ATE SURVEY DMPLETED			
		345284	B. WING			C 05/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		03/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 248	moderately impaired decision making. Stassistance from staft Daily Living (ADLs), totally dependent on dressing, and person A review of the residerevised on 1/30/17 in focus: "I am increased risconfusion, gait/balar 1/9/17) The planned interve focus included, in parelle courage me to promote exercise, plastrengthening and in (Specify)." No activit 1/30/17) Resident #149's Cararea of focus specific A review of Resident Log revealed the reseactivities during the noted on the Activity a Group Event on 3/3/23/17. A review of Resident Log revealed there we resident participation A review of Resident Log to date revealed 10 activities during the involvement noted on the Activity involvement noted on the sident Log to date revealed there we resident participation activities during the involvement noted on the Activity involvement noted on the Activities during the resident participation activities during the involvement noted on the Activities during the resident participation activities during the involvement noted on the Activity and the involvement noted on the Activity activities during the involvement noted on the Activity activity activity activity activities during the involvement noted on the Activity ac	l cognitive skills for daily ne required extensive f for all of her Activities of with the exception of being staff for locomotion, nal hygiene. lent's most recent Care Plan included the following area of k for falls related to ince problems." (Initiated intions/tasks for this area of int: participate in activities that	F 24	8		

AND DI AN OF CORRECTION IN INDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345284	B. WING			C 05/25/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	I	09/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 248	a Religious Service a Group Event on 5/9/ 5/10/17, a Group Ev 5/16/17 and 5/18/17 5/18/17. An observation was as Resident #149 sa The resident was aw respond to questions not have a television activities were obser An observation was as Resident #149 sa The resident was aw #149 did not have a room. No activities was as Resident #149 sa The resident was aw #149 did not have a room. No activities was as Resident #149 sa The resident was aw #149 did not have a room. No activities was discus reported the resident was discus reported the resident done, looking at mag television. Upon inq confirmed the resident watch TV. Upon rev Log, the Activities Di had done "some thir could not recall spec	and a Social on 5/4/17, a 17, an Exercise Activity on ent on 5/12/17, a Social on , and an Exercise Activity on made on 5/22/17 at 11:45 AM at in a wheelchair in her room. Wake and alert but did not so posed. Resident #149 did for radio on in the room. No wed. made on 5/22/17 at 2:50 PM at in a wheelchair in her room. Wake and alert. Resident television or radio on in the were observed. made on 5/23/17 at 11:43 AM at in a wheelchair in her room. Wake and alert. Resident television or radio on in the wake and alert. Resident television or radio on in the	F 24	8			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		LETED
		345284	B. WING			C 25/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	•	23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 248	resident participation would like it to, she would like it to, she An observation was as Resident #149 s. The resident was at #149 did not have at room. No activities An observation was as Resident #149 wroom. The resident open. Resident #14	s asked if the log reflected in in as many activities as she reported it did not. If made on 5/24/17 at 9:30 AM at in a wheelchair in her room. Wake and alert. Resident a television or radio on in the were observed. If made on 5/24/17 at 2:50 PM was lying on the bed in her it was awake with her eyes 49 did not have a television or	F 24	18		
	observed. An observation was as Resident #149 w room. Her eyes we not have a televisio activities were observed. An interview was concerned as a signed to concerned as a signed to conquiry regarding the nurse stated Reside in her wheelchair to stated that as far as go to activities. An interview was concerned as a signed as a signed to activities. An interview was concerned with the facility of the interview nursing staff did engactivities on occasion.	amade on 5/24/17 at 3:50 PM vas lying on the bed in her re open. Resident #149 did n or radio on in the room. No reved. onducted on 5/25/17 at 10:47 Nurse #3 was the 1st shift hare for Resident #149. Upon the resident's activities, the ent #149 did go out in hallway day. However, the nurse to she knew, the resident didn't onducted on 5/25/17 at 12:31 to producted on 5/25/17 at 12:31				

		(X3) DATE SURVEY COMPLETED					
		345284	B. WING		C 05/25/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 248	Continued From pag	ge 13	F 24	818			
F 272 SS=D	483.20(b)(1) COMP	reflect her participation. REHENSIVE	F 27	72	6/19/17		
	(b) Comprehensive	Assessments					
	must make a compriresident's needs, str preferences, using the instrument (RAI) speassessment must in: (i) Identification and (ii) Customary rout (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and behad (vii) Psychological work (viii) Physical furber problems. (ix) Continence. (x) Disease diagnoth (xi) Dental and nutron (xii) Skin Conditions (xiii) Activity purofixion (xv) Special treatmed (xvi) Discharget (xvii) Documental regarding the addition the care areas of the Minimum Data (xviii) Documental (xviii) Documental (xviii) Documental (xviii) Documental (xviii) Documental (xviii) Documental (xviiii) Documental (xviiiii) Documental (xviiiiii) Documental (xviiiiiii) Documental (xviiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	d demographic information ine. d d demographic information ine. d d demographic information ine. d d d d d d d d d d d d d d d d d d d					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 05/25/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 272	the resident, as well a licensed and non-licensed on all shifts. The assessment prodobservation and comas well as communication as well as communication and the complete don and the complete	a and communication with as communication with as communication with and direct care staff members are staff members at a staff members on all are staff members on all are staff interviews, the rehensively assess the 3 sampled residents and and staff of dental status and	F 272	The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or w 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 indicate F272 COMPREHENSIVE ASSESSMENT Corrective Action: Resident #77: Oral assessment completed on 5/26/2017. An OBRA Comprehensive assessmen with assessment reference date of 5/23/2017 was completed on 6/6/2017 ar Care Areas completed on 6/6/2017 ar Care Plan decisions completed on 6/8/2017. Assessment was submitted accepted to the QIES ASAP system o 6/9/2017. Care plan updated	ill of ed. tt, od	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 56.2516		С	
		345284	B. WING		05/25/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2017	
				901 BETHESDA ROAD		
THE OAKS	3					
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 272	Continued From page	: 15	F 272	2		
	not reported as being	edentulous (no natural		appropriately.		
	teeth). The Care Area			Identification of other residents who m	nav	
		/ of the MDS revealed the		be involved with this practice:	- ,	
	_	ental Care did not trigger		All residents have the potential to be		
	for review or potential care planning.			affected by the alleged practice. On		
				5/24/2017 to 6/16/2017 comprehensiv	/e	
	A review of the Nursir	ng Admission / Readmission		oral assessments were completed on		
		15/16 indicated Resident		current residents. Care plan updated		
	#77 had. "Some/all na	atural teeth lost - does not		appropriately. All Comprehensive OB	RA I	
	have or does not use denture (or partial plates)."			assessments within the last 6 months		
		, , ,		were reviewed on 6/16/2017 for accur		
	A Speech Therapy sc	reen dated 7/15/16 was		for Section L-Oral-Dental Status by th		
	reviewed. The screen noted no skilled speech			RN MDS coordinators and modification		
	therapy was warrante	d at that time. The resident		completed respectively.		
	received a Level 2 Na	itional Dysphagia Diet		Systemic Changes:		
	(NDD) with thin liquid	s. A Level 2 NDD diet		On 5/24/2017 The RN MDS Coordina	tors	
	consisted of foods that	at were moist, soft-textured,		and any other Interdisciplinary team		
	and included ground	or minced meats.		member that participates in the MDS		
				assessment process was in serviced		
	A review of the Nursir	ng Quarterly Reviews dated		/educated by the Corporate MDS Nur	se	
		revealed the resident had,		Consultant.		
		h lost - does not have or				
	does not use denture			Section L: Oral /Dental status is intend		
		the Nursing Quarterly		to record any dental problems presen	t in	
		indicated the resident did		the 7day look back period. Poor oral		
		oncerns (such as dentures,		health has a negative impact on quali		
	missing, broken, loos	e or carious teeth, or		life, overall health and nutritional statu		
	inflamed gums).			Oral assessment can identify periodol		
				disease that can contribute to or caus		
		#77 's most recent quarterly		systemic diseases and conditions suc	ii as	
		ed 2/28/17 indicated the		aspiration, malnutrition, pneumonia,	otoo	
	resident had intact co	•		endocarditis and poor control of diabe		
	decision making. Res			Oral assessments will be completed or		
	-	r dressing and locomotion red extensive assistance for		each resident to help identify resident who may be at risk for aspiration,	.s	
	-	s, toileting, and personal		malnutrition, pneumonia, endocarditis	.	
		s, tolleting, and personal supervision only for eating.		and poor control of diabetes. Referral		
		revealed the resident		dental consult will be done when	101	
		c and mechanically-altered		warranted.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING		0,	C 5/ 25/2017	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	0	0/20/2017	
	10115211 011 001 1 2.2.11			901 BETHESDA ROAD			
THE OAK	3						
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272	Continued From page	e 16	F 27	2			
	diet. She weighed 18	B5#.		The education focused on the F	ederal		
				regulations at 42 CFR 483.20(b)(1)		
	A review of the reside	ent 's Care Plan included the		(xviii),(g), and (h) require that: T	he		
	following area of focu	ıs, in part:		assessment accurately reflects	the		
	I have a potential n	utritional problem related to		residents status. A registered N	urse		
	receiving mechanically altered and therapeutic			conducts or coordinates each a	ssessment		
	diets, fair intake and	weight loss (initiated 7/23/15		with the appropriate participation			
	and revised on 5/22/	17).		professionals. The assessment	process		
				includes direct observation, as v			
		#77 ' s May 2017 Physician '		communication with the residen			
		vealed her current diet		direct care staff on all shifts. An	accurate		
	prescription was a No Added Salt, Level 2 NDD with thin liquids. The resident was on a 1500			assessment requires collecting			
				information from multiple source			
	milliliter (ml) per day			of which are mandated by regul			
	received fortified food			Those sources must include the			
		ereal, potato, or pudding at		and direct care staff on all shifts			
	-	ml of Med Pass 2.0 (a high		should also include the resident			
		iquid nutritional supplement)		record, physician, and family, gu			
	three times daily due	to weight loss.		significant other as appropriate acceptable. The information obt			
	A raviou of the reside	ent 's paper and electronic		should cover the same observation			
	medical records reve			as specified by the MDS items of	•		
		ental consult for Resident		assessment, and should be vali			
	#77.	crital consult for resident		accuracy (what the resident's ac			
	<i>#11.</i>			status was during the observation			
	An observation and i	nterview were conducted on		the interdisciplinary team compl			
		with Resident #77. The		assessment.	ourig uro		
	observation revealed			The Observation (Look Back) P	eriod is		
		he interview, Resident #77		the time period over which the r			
	_	s did not fit well so she		condition or status is captured b			
		em. She did not report any		assessment. The observation pe	-		
	problems at that time			particular assessment for a part			
				resident will be chosen based u			
	An interview was con	ducted on 5/23/17 at 4:50		regulatory requirements concert			
	PM with MDS Nurse	#1. During the interview, the		and the ARDs of previous asses	sment.		
		she did not think Resident		Most MDS items themselves red	quire an		
	#77 was edentulous.			observation period, such as 7 or	14 days,		
				depending on the item. Since a	day		
	Accompanied by MD	S Nurse #1, Resident #77		begins at 12:00 a.m. and ends a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG		, ا	2	
		345284	B. WING _			l	25/2017	
NAME OF F	ROVIDER OR SUPPLIER		.	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,		
THE OAK	0			90	01 BETHESDA ROAD			
THE OAK	5			W	/INSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 272	was observed on 5/2 on the bed in her roo and alert. When the resident to open her teeth, Resident #77 s The resident then told had not fit for a long to sitting in her drawer. has gone without were resident stated, "a lor inquiry, the resident vindicated it had likely last wore her denture. An interview was comply with MDS Nurse nurse stated the resident was content to MDS nurse was a known about a change she stated she would about any changes weekday clinical meek Managers). The MDS known about Residershe would likely have change MDS to asse MDS Nurse #1 stated would have been madentist, a referral made evaluation, and a med Department to make dentition. Upon inquiedentulous resident would, the MDS nurse	3/17 at 4:51 PM as she laid m. The resident was awake MDS nurse asked the mouth and let her see her stated, "I ain't got no teeth." d the nurse that her dentures time and they were just When asked how long she aring her dentures, the ng time." Upon further was a bit uncertain but been a year or so since she is. Iducted on 5/23/17 at 4:55 #1. Upon inquiry, the MDS dent may have stopped	F	272	p.m., the observation period must also cover this time period. When completin the MDS, only those occurrences durin the look back period will be captured. If did not occur during the look back period it is not coded on the MDS. The Director of Nursing or RN Designe will review OBRA assessments to ensuraccurate coding for Section L-Oral /Desistatus. Any issues will be reported to the Director of Nursing or Administrator for appropriaction. During the daily Clinical Meeting (Monothrough Friday), the RN MDS Coordinator Designee will review assessment reference dates for OBRA assessments. The Daily Clinical Meeting is attended the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others a needed. This in service was completed by June 16th, 2017. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not recein-service training will not be allowed to work until training is completed. 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. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a reviewing the QA Assessment Accuracy Township in the process to the process to the process to the process of the process to the process of	g g g g g g g g g g g g g g g g g g g		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 05/25/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CIT 901 BETHESDA ROAL WINSTON SALEM,	D	03/23/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT DEFICIENCY)		
F 272	PM with Nurse #1. Ishe had worked at the years. The nurse not assigned to work on asked how long Researing her denture been a long time. The actually recall a time dentures. Upon furth the resident had been year. An interview was condemned by the resident had been year. An interview was condemned by the resident had been without her and been without her at 10:27 AM MDS Not interview, MDS Nursenormally look in a resident mouth in June of 2 knew the resident. The spoke to Resident was confirmed the resident, "I missed it." An interview was condemned by the period of the MDS period was for the MDS period at the period of the MDS period was for the MDS period work on the state of the MDS period was for the MDS period work on the manual MDS period was for the MDS period was for the MDS period work on the manual mount of the mou	Inducted on 5/23/17 at 5:00 Upon inquiry, Nurse #1 stated the facility for more than 10 obted she was normally Resident #77 's hall. When ident #77 had gone without is, the nurse stated it had the nurse reported she did not is when the resident wore their inquiry, Nurse #1 stated in edentulous for at least one inducted on 5/23/17 at 5:05 is stant (NA) #1. NA #1 or ked at the facility for 6 or 7 ally assigned to Resident #77 or, NA #1 reported the resident in dentures for at least a year.	F2	Five residents reviewed week monthly for thre reviewed on the Tool will include Status. Identified immediately to Administrator for Compliance with ongoing auditing weekly QA Meeting is atternamed Nursing, MDS Support Nurse.	OBRA assessments will be dy for 4 weeks, and then ee months. The items ie QA Assessment Accurate: Section L-Oral/Dental ed issues will be reported the Director of Nursing of or appropriate action. If the monitored and ing program reviewed at the eting. The weekly QA ended by the Director of Coordinator, Unit Manager, Therapy, HIM, Dietary the Administrator.	r ne	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		345284	B. WING _			C 05/25/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	,	03/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278 SS=D	(g) Accuracy of Assemust accurately reflection (h) Coordination A registered nurse reach assessment with participation of health (i) Certification (1) A registered nurse the assessment is considered in the assessment of the assessment must signature that portion of the assessment must signature who willfully and known will an assessment will assess will be a second will an assessment will be a second will be a	essments. The assessment ect the resident's status. Inust conduct or coordinate ith the appropriate th professionals. See must sign and certify that completed. Who completes a portion of the gn and certify the accuracy of essessment. Cation and Medicaid, an individual owingly- all and false statement in a t is subject to a civil money than \$1,000 for each Individual to certify a material in a resident assessment is ney penalty or not more than essment. ment does not constitute a	F 2	78		6/19/17
	Based on observati	on, resident and staff rd review the facility failed to		The statements made on this P Correction are not an admission	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING				C 25/2017
NAME OF DE	ROVIDER OR SUPPLIER	0.020.		ST.	REET ADDRESS, CITY, STATE, ZIP CODE	05/	25/2017
NAME OF F	NOVIDER OR SUFFLIER						
THE OAKS	3				1 BETHESDA ROAD		
				WI	INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 278	Continued From page	20	F 2	278			
	accurately code on th	e comprehensive Minimum			not constitute an agreement with the		
	_	ssment a level two PASRR			alleged deficiencies. To remain in		
		ning and Resident Review)			compliance with all Federal and State		
		esident #9) reviewed for			Regulations the facility has taken or wil	I	
	1	urately complete section L of			take the actions set forth in this Plan of		
		um Data Set (MDS) for 1 of			Correction. The Plan of Correction		
		reviewed for dental status			constitutes the facility □s allegation of		
	(Resident #105) and	failed to accurately code the			compliance such that all alleged		
	Minimum Data Set (MDS) assessment to indicate				deficiencies cited have been or will be		
	the reason why an inf	luenza vaccination was not			corrected by the date or dates indicated	d.	
	provided for 1 of 5 sa	mpled residents reviewed			F278 ASSESSMENT		
	for vaccination status (Resident #240).				ACCURACY/COORDINATION/CERTIF	FIE	
					D		
	Findings included:				Corrective Action:		
					Resident #9 Prior Comprehensive		
						VEL	
		idmitted to the facility on			TWO PASRR		
		es that included anxiety			A Significant Correction to Prior		
	disorder and depress				Comprehensive Assessment (SCPA) w		
		R Level II Determination			opened with an Assessment Reference)	
		0/17 revealed that Resident			Date of 5/23/2017. The Assessment		
		be a PASRR level two (The			Reference Date was set within 14days		
		Il screening is to assure that			after the determination that a significan	τ	
		us mental illness entering or			error in the prior comprehensive		
	_	certified nursing facilities			assessment occurred (ARD= Determination date 5/23/2017 + 14		
	receive appropriate p	lacement and services).			calendar days). The Significant Correct	tion	
	A review of the comp	ehensive MDS assessment			to Prior Comprehensive Assessment	1011	
		d Resident #9 was not			completion date (item Z0500B) was		
	coded as a level two				6/5/2017. (No later than 14days from		
	33404 40 4 10 VOI (WO I				ARD). The CAA(s) completion date		
	An interview was com	pleted with MDS Nurse #1			(itemV0200B2) was 6/5/2017. (No late	r	
		M. She stated the resident			than 14days from ARD).The Care Plan		
		ASRR number from the			completion date (Item V0200C2) was		
	hospital and that it too				6/5/2017. (No later than 7days after the	9	
	number so she did no				CAA(s) completion date (item V0200B2		
		the MDS. MDS Nurse #1			Resident #105	,	
	-	eted a significant correction			OBRA Comprehensive assessment AR	.D	
	on 5/23/17.				5/4/2017 Section L- Oral/Dental Status		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING			1	05/0047
NAME OF D	ROVIDER OR SUPPLIER	040204	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	05/.	25/2017
NAME OF T	TOVIDER OR SOLT EIER				DI BETHESDA ROAD		
THE OAKS	3						
				٧v	/INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	e 21	F 2	78			
					Item set L0200Z coded Yes. Resident # 240 A Modification Request was created for the OBRA Admission Assessment with Assessment Reference Date of 3/7/207	the	
	4/27/17 with diagnose	es admitted to the facility on es which included: diabetes ron deficiency anemia, and			This corrected record has all items included, not just the items in error. The Correction Request Section X items we completed on 6/12/2017 and includes to corrected record. Item 00250C has a	ere	
	dated 4/27/17 docum	w of the Admission Nursing Assessment 4/27/17 documented Resident #105 had no ng or broken teeth or dentures.			value of 2, indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 6/13/201 Identification of other residents who may	7	
	indicated Resident # had no dental issues	sion MDS dated 5/04/17 105 was cognitively intact, , no swallowing or chewing therapeutic, mechanical soft ght loss.			be involved with this practice: All residents have the potential to be affected by the alleged practice. All OB comprehensive assessments within the last 6 months were reviewed for accurator Item Set O0250C (Reason why an	RA	
	2:50 p.m., Resident # visible tooth located i area. The resident re	n and interview on 5/22/17 at #105 was noted to have one n front of his lower gum vealed he only had three blems chewing food and no ms.			influenza vaccination was not provided Section L □Oral/Dental Status, and assessment of level two PASRR (Preadmission Screening and Resident Review) by 6/16/2017 by the RN MDS coordinators. Systemic Changes:	t	
	observed in his room resident consumed a	o.m., Resident #105 was finishing his lunch. The pproximately 98% of a meal pot pie, green peas, apple d tea, and water.			On 5/24/2017 The RN MDS Coordinate and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Corporate MDS Nurse Consultant.		
	Nurse#1 stated the M the resident's MDS m Nursing Admission as	on 5/23/17 at 3:50 p.m., MDS MDS nurse who completed hay have relied on the ssessment when he #105's Admission MDS.			The education focused on the Federal regulations at 42 CFR 483.20(b)(1) (xviii),(g), and (h) require that: The assessment accurately reflects the residents status. A registered Nurse		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _				25/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2017	
					01 BETHESDA ROAD			
THE OAKS	3							
				٧١	/INSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 278	Continued From pag	ue 22	F 2	278				
	MDS Nurse#1 stated	that the normal protocol			conducts or coordinates each assessm	nent		
		ysical observation of a			with the appropriate participation of he	alth		
		sing him or her to ensure			professionals. The assessment proces			
		S. She stated that Resident			includes direct observation, as well as			
	#105's MDS would b				communication with the resident and			
	accuracy of section L of the MDS.				direct care staff on all shifts. An accura	ate		
	3. Resident #240 wa	as admitted to the facility on			assessment requires collecting			
	2/28/17 from another	r nursing home or swing bed.			information from multiple sources, som	ıe		
	Her cumulative diagnoses included diabetes and				of which are mandated by regulations.			
	renal insufficiency.				Those sources must include the reside	nt		
					and direct care staff on all shifts, and			
		t #240's admission Minimum			should also include the resident□s			
		essment dated 3/7/17 was			medical record, physician, and family,			
	•	O of the MDS indicated the			guardian, or significant other as			
		ive the influenza vaccine in			appropriate or acceptable. The			
		S reported the reason the			information obtained should cover the			
		ive the vaccination was,			same observation period as specified by	-		
		facility during this year's			the MDS items on the assessment, an			
	influenza vaccination	n season."			should be validated for accuracy (what			
	A :	- d t - d			resident □s actual status was during the			
		nducted on 5/24/17 at 10:30 s Director of Nursing (DON).			observation period) the interdisciplinar	y		
	During the interview,	• ,			team completing the assessment.			
	•	was reviewed. The DON			The Observation (Look Back) Period is the time period over which the resident			
		nfluenza vaccination was			condition or status is captured by the N			
	declined by the resid				assessment. The observation period for			
	decimed by the resid	iont.			particular assessment for a particular	<i>"</i> "		
	An interview was cor	nducted on 5/25/17 at 10:17			resident will be chosen based upon the	ا د		
		#1. Upon inquiry, the MDS			regulatory requirements concerning tin			
		ion O of Resident #240's			and the ARDs of previous assessment	-		
		The MDS nurse reported the			Most MDS items themselves require a			
		t #240 did not receive an			observation period, such as 7 or 14 da			
	_	n at this facility was coded			depending on the item. Since a day	-		
		ed the MDS should have			begins at 12:00 a.m. and ends at 11:59	9		
	•	240 received the vaccination			p.m., the observation period must also			
		Upon further inquiry as to			cover this time period. When completing			
		would have been obtained,			the MDS, only those occurrences durir			
	the MDS nurse state	ed a negative response			the look back period will be captured. I	-		
	(which indicated a re	esident did not get the			did not occur during the look back peri-	od,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING			05/2	: :5/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 901 BETHESDA ROAD WINSTON SALEM, NC 27103	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	I	(X5) COMPLETION DATE	
F 278	from what the admiss electronic record. Aft reported she needed staff member, resider reason why the reside vaccination at the fact A follow-up interview at 12:43 PM with the DON reiterated that be had reviewed, the resporty actually decline	in this facility) carried over ion staff put into the er that, the MDS nurse to talk with the admission at, or family to determine the ent did not receive the ility. was conducted on 5/25/17 DON. Upon inquiry, the ased on the records she ident and/or responsible do the flu vaccination upon ity. The DON stated her except the code the MDS as	F2	it is not coded on the MDS. The Director of Nursing or R will review OBRA assessme accurate coding for Item Set (Reason why an influenza v not provided), Section L D Status, and assessment of I PASRR (Preadmission Screen Resident Review) Any issues will be reported to f Nursing or Administrator fraction. During the daily Clinical Meet through Friday), the RN MD or Designee will review assereference dates for OBRA and The Daily Clinical Meeting is the Director of Nursing, Unit MDS Coordinators, Support Therapy, Health Information Dietary Manager, Social Work Administrator and others as This in service was completed 16th, 2017. Any MDS nurse part time, and PRN) and mee interdisciplinary team who do in-service training will not be work until training is completed information has been integral standard orientation training required in-service refreshed all employees and will be required in-service refreshed and the refreshed and the refreshed and the refreshed and the re	ents to ensure to 00250C accination of pral/Dental evel two eening and to the Director appropriation of the distribution of th	tor ate day tor s. Dy		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345284	B. WING _			C 05/25/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103	DE	00/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 280 SS=D	PARTICIPATE PLANI 483.10 (c)(2) The right to par and implementation or plan of care, including (i) The right to participal including the right to be included in the plane revisions to the personal company of the personal including the right to be included in the plane revisions to the personal including the right to be included in the plane revisions to the personal including the right to participate the plane included in the plane in the p	3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP ticipate in the development of his or her person-centered g but not limited to: Date in the planning process, identify individuals or roles to anning process, the right to	F 2	Five residents OBRA assess reviewed weekly for 4 weeks monthly for three months. The reviewed on the QA Assessing Tool will include: for Item Set (Reason why an influenza vanot provided), Section L □ Or Status, and assessment of let PASRR (Preadmission Screen Resident Review) Identified reported immediately to the Information Manager, Dietary Administrator, and Medical Dietary Administrator, and Medical Dietary Administrator, and Medical Dietary Reviewels weekly QA Meeting. The weekly QA Meeting and the weekly QA Meeting. The weekly QA Meeting and the weekly QA Meeting. The weekly QA Meeting and the weekly QA Meeting. The weekly QA Meeting and the weekly QA Meeti	s, and then ne items ment Accura t 00250C accination v ral/Dental evel two ening and issues will Director of appropriate nonitored ar viewed at the ekly QA Director of Jnit Manag alth y Manager,	acy was be end he

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			l	25/2017
NAME OF PE	ROVIDER OR SUPPLIER		•	9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BETHESDA ROAD VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	included in the plan of (v) The right to see the right to sign after sign of care. (c)(3) The facility shall right to participate in his shall support the residual support the inclusive strengths and needs. (iii) Include an assess strengths and needs. (iiii) Incorporate the recultural preferences in 483.21 (b) Comprehensive C (2) A comprehensive C (i) Developed within 7 the comprehensive as	ve the services and/or items of care. e care plan, including the difficant changes to the plan of the resident and/or plan of the resident and/or plan of the resident and/or plan of the resident and plan of the plan of th	F	280			
	(B) A registered nurse resident.	e with responsibility for the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		LETED
		345284	B. WING _			1	C 25/2017
NAME OF PR	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BETHESDA ROAD VINSTON SALEM, NC 27103	1 00	20,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	e 26	F 2	280			
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	d and nutrition services staff.					
	the resident and the in An explanation must medical record if the	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined be development of the					
		staff or professionals in ined by the resident's needs e resident.					
	team after each asse comprehensive and c assessments.	vised by the interdisciplinary ssment, including both the quarterly review is not met as evidenced					
	interview the facility f	ns, record review and staff ailed to update a care plan a sampled residents with			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State	l do	
	Findings included:				Regulations the facility has taken or wi take the actions set forth in this Plan of		
	Resident # 190 was a 7/28/16 with diagnosi	admitted to the facility on s of a stroke.			Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged		
	3/6/17 indicated Resi	um Data Set (MDS) dated dent #190 had an intact long bry, required supervision for tion. The MDS included he injury.			deficiencies cited have been or will be corrected by the date or dates indicate F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345284	B. WING _				C 25/2017
NAME OF P	ROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE 1 BETHESDA ROAD INSTON SALEM, NC 27103	1 00/	20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	included a problem of Interventions for this a fall mat to be place. Observation on 5/23/mat on the floor besident on the floor besident on the floor besident of the floor some time. Nurse had been discontinued. Interview with the ME AM revealed the fall removed from the catexplained she was not discontinued. Resident it may not have a interview revealed the not appropriate anymetrics.	ed care plan on 3/6/17 If at risk for falls. problem included the use of d beside his bed. If at 9:30 AM revealed no de the bed. If at 9:30 AM rev	F2	280	Corrective Action: Resident #190 Resident Care plan was reviewed and updated. Identification of other residents who make involved with this practice: All residents have the potential to be affected by the alleged practice. On 6/16/2017 a falls review meeting was hin the Weekly Quality of Life meeting. From assessments were completed on all current residents by 6/16/2017. In this meeting all residents were reviewed for high falls risk and current interventions place to prevent falls and the need for additional interventions for residents with poor safety awareness. This was completed on 6/16/2017. In addition to this, any new interventions put in place were added to the individual residents care plan by the MDS Coordinator and were reflected on the Kardex and Care plan respectively. Systemic Changes: On 5/25/2017 The RN MDS Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the QA nurse consultant. The education focused on the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after a completion of the comprehensive assessment; prepared by an	eld Risk in th	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C / 25/2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2017
				901 BETHESDA ROAD		
THE OAK	S			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	Continued From page	÷ 28	F 28	interdisciplinary team, that includes attending physician, a registered myith responsibility for the resident, other appropriate staff in disciplined determined by the resident's needs to the extent practicable, the partic of the resident, the resident's family resident's legal representative; and periodically reviewed and revised be team of qualified persons after each assessment. An explanation must included in a resident's medical recite the participation of the resident and resident representative is determined by the development of residents care plan. Other appropristaff or professionals in disciplines determined by the resident. Good assessment is the starting person determined by the resident. Good assessment is the starting person determined by the resident. The resident has a right to participate the development and implementation in the development and implementation of including but not limited to: The right participate in the planning process, including the right to identify individe roles to be included in the planning process, he right to request meeting the right to request meeting the right to request revisions to the person-centered plan of care. The participate in establishing the expegoals and outcomes of care, the ty amount, frequency, and duration of and any other factors related to the effectiveness of the plan of care. To receive the services and/or items	arse and a as , and, pation or the y a n pe ord if their ed not the as or as wint for ecision on of a ate in on of care, at to uals or uses and right to cted be, c care, me right	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	12312011	
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				WINSTON SALEM, NC 27103			
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F 280	Continued From page	29	F 28	included in the plan of care. The resee the care plan, including the risign after significant changes to the of care. The facility shall inform the resident of the right to participate her treatment and shall support the resident in this right. The planning process must facilitate the inclusion resident and/or resident represent The facility must include an assess of the resident's strengths and net facility must incorporate the reside personal and cultural preferences developing goals of care. A comprehensive care plan must be developed within 7 days after conformation of the comprehensive assessment. The Director of Nursing or RN Dewill review comprehensive assess to ensure that a comprehensive conformation is completed for each resident perequirements as listed above. Any issues will be reported to the of Nursing or Administrator for apaction. During the daily Clinical Meeting of through Friday), the RN MDS Coor Designee will review assessmenterence dates for OBRA assess. The Daily Clinical Meeting is attenthe Director of Nursing, Unit Manamatical MDS Coordinators, Support Nurs Therapy, HIM, Dietary Manager, Support Nurs Therapy HIM, Dietary Manager, Support Nurs Therapy HIM, Dietary Man	ght to ne plan e in his or ne pon of the tative. ssment eds. The ent's in enpletion t. signee sments are plan r the RAI Director propriate Monday prodinator ent ments. nded by agers, e, Social ners as June time, of the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345284	B. WING			05/	25/2017
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE 11 BETHESDA ROAD		
THE OAK	5				INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280 F 281 SS=D	Continued From page 483.21(b)(3)(i) SERV PROFESSIONAL STA	ICES PROVIDED MEET		280	in-service training will not be allowed to work until training is completed. 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. Monitoring: To ensure compliance, Administrator of Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by completing a daily falls (Monday through Friday) review during daily clinical Qual of life meeting to ensure a complete investigation of the fall, root cause, and interventions are initiated and care planned. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee the Administrator or designee to assure corrective action initiated as appropriate Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing prograr reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manages Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse.	e or the at the at the by the e. the months of	6/19/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 05/25/2017
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05/25/2017
				901 BETHESDA ROAD	
THE OAK	8			WINSTON SALEM, NC 27103	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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F 281	Continued From page		F 28	1	
	(b)(3) Comprehensive	e Care Plans			
		d or arranged by the facility, nprehensive care plan,			
	(i) Meet professional: This REQUIREMENT by:	standards of quality. is not met as evidenced			
	,	ns, resident and staff		The statements made on this Plan of	
		d review, the facility: 1)		Correction are not an admission to an	d do
		pre-operative physician		not constitute an agreement with the	
	order to ensure a resi	dent did not eat or drink		alleged deficiencies. To remain in	
	anything after midnigl	nt the day before a		compliance with all Federal and State	
	scheduled surgery for	1 of 1 resident (Resident		Regulations the facility has taken or w	ill
	#191) reviewed with p	preoperative physician		take the actions set forth in this Plan of	of
	orders; and, 2) Failed	to give a supplement as		Correction. The Plan of Correction	
	ordered by the physic	ian for 1 of 7 residents		constitutes the facility's allegation of	
	(Resident #21) review			compliance such that all alleged	
	The findings included	:		deficiencies cited have been or will be corrected by the date or dates indicate	
		admitted to the facility on		F281 SERVICES PROVIDED MEE	ET
	11/3/16 from a hospita			PROFESSIONAL STANDARDS	
	diagnoses included a	-		Corrective Action:	
		s when tissue protrudes		Resident #191	
	through a weak spot i	n the lower abdominal wall).		Physician was notified on 5/25/2017. I	
				physician orders obtained and initiated	d.
		nt's most recent Care Plan		Resident representative notified on	
	'	included the following area		5/25/2017.	
	of focus:			Resident #21	.
		ay have acute pain around		Physician was notified on 5/25/2017. I	
		ea (Date initiated: 11/4/16;		physician orders obtained and initiated	d.
	Date revised: 11/4/16).		Resident representative notified on 5/25/2017.	
	Δ review of Resident	#191's most recent quarterly		Identification of other residents who m	lav
		IDS) dated 5/2/17 revealed		be involved with this practice:	lu y
		essed to have moderately		All residents have the potential to be	
		Ils for daily decision making.		affected by the alleged practice. On	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 901 BETHESDA ROAD		0/20/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 281	Continued From pag	e 32	F 28	31		
	He was totally dependent required extensive as locomotion, dressing limited assistance wis supervision only for particles of the residual as surgical consultation of the surgical repair of the hydrocele (a fluid-fille testicle). Further review of Resident revealed a fax received Anesthesia Departm PM. The fax outlined which noted Resident drink anything after rescheduled surgery. A review of Resident revealed a verbal phon 5/24/17 to keep the mouth) after midnigh The order was noted 5/24/17. An interview was coron 5/25/17 at 3:00 Peresident stated he unscheduled for today rescheduled to 6/1/1	dent on staff for transfers; ssistance for bed mobility, , and toileting; required th eating; and, needed personal hygiene. ent's medical record revealed on was completed on tation report recommended right inguinal hernia and		s/24/2017 to 6/16/2017 2017 was initiated for all current re facilities to ensure that all phy were followed and initiated. I also initiated to ensure that al were initiated as ordered by t and communicated to the Die Department to ensure contini service. The audit was also in ensure that all dietary supple were followed and initiated po orders. The chart audit was the Nurse Management Tean Nursing, Unit Manager and S Nurse). All physician orders of and initiated as ordered. Systemic Changes: Director of Nursing and /or D serviced all Nurses (RNs, LP part time, and PRN) and the interdisplinary care planning fact that the services provide by the facility, as outlined by comprehensive care plan, mu professional standards of qua Nurses (RNs, LPNs, full time and PRN) were also educate that it is the nurse's responsi physician, follow and initiate orders. All NPO physician ord initiated and followed as order communicated to the Dietary to ensure continual of service orders received from the phy communicated to the Dietary	esidents in the sysician orders in audit was all NPO orders the physician etary ual of initiated to ement orders er physician completed by in (Director of Support were followed esignee in NS, full time, team on the d or arranged the ust meet ality. All in part time, and on the fact bility to notify Physician ders will be ered and in Department exican will be in Department exican orders will be in Department exican will be in Department exican orders will be in Department exican order will be in Department exic	
	PM with Nurse #2. N	nducted on 5/25/17 at 3:05 Nurse #2 was assigned to 91. Upon inquiry, Nurse #2		by using the dietary commun The dietary communication s filled by nursing, the white or go to the Dietary department	lip will be iginal slip will	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		B) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	0.20.20.1	
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F 281	Continued From page	∋ 33	F 2	81			
F 281	reported she knew th surgery earlier this m reported after she be medication cart this n breakfast trays had b Nurse #2 stated she room and discovered breakfast tray and ha The nurse stated she Responsible Party (R came in to see him. called the surgical se resident had eaten broeded to be NPO fo surgery. Nurse #2 in expected the Dietary received the NPO or resident so he would tray the morning of 5/2 An interview was con PM with the Unit Man #191's hall. During the Manager explained R originally scheduled f surgical service called afternoon (5/24/17) a reported his surgery in day to 5/25/17. The input the resident 's promputer on 5/24/17,	e resident was scheduled for orning (5/25/17). The nurse gan to work on the norning, she saw the een delivered to the floor. went into Resident #191's he had been served his d already eaten his eggs. It told the resident's tell') about this when she the nurse also reported she rivice to inform them the reakfast and was told he ar at least 8 hours prior to dicated she would have Department to have der written on 5/24/17 for this not have gotten a breakfast (25/17). ducted on 5/25/17 at 3:10 hager working on Resident the interview, the Unit the interview, the Unit the facility yesterday round 2:30 or 3:00 PM and the had been moved up by one Unit Manager reported she e-operative orders into the including an order for the	F 2	yellow copy will be kept in the medical record. Supplement of received from the physician wentered into the residents elect medical record. The nurses we supplemental orders as order physician and document in the electronical medication administed. The nurses will administed and followed as order physician orders. If resident retake Dietary Supplements, do of refusal will be indicated in the Electronic Medication Administed Physician and Resident representation of the week. Physician plantage due day of the week. Physician plantage due day of the week. Physician plantage of the week are located and nurse's station in the notebood unable to reach the attending the physician on call, call the medical director within 30 minicontacting the primary physician or does not call back within 30 director does not call back within 30 directors are located and appropriation of call back within 30 directors.	orders will be ctronical will initiate the ed by the e resident wistration ister the ders. red will be red per efuses to cumentation he stration. sentative will be called 24 ek. This to time or hone t each k. If you are physician or facility wutes of ian. If the al director ate response o minutes		
	The Unit Manager sta shift, 2nd shift, and 3 resident 's surgery so order for him to be NI	fter midnight on 5/24/17. ated all of the nurses (1st and shift) knew about the cheduled for 5/25/17 and the PO after midnight on the reported the nursing		then the nurse is to contact the immediately for further instruct. This in service was completed 16th, 2017. Any Nurse (RNs, time, part time, and PRN) and the interdisciplinary team who	ctions. If by June LPNs, full If member of odd not		
		ow Resident #191 wasn't hen the resident's breakfast		receive in-service training will allowed to work until training i			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY PLETED
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NAME OF D	ROVIDER OR SUPPLIER	0-1020-1	1	STREET ADDRESS, CITY, STATE, ZIP CODE		5/25/2017
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THE OAK	S			901 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From page	e 34	F 28	31		
F 281	tray was on the cart to him. When asked knew about the 5/24/Manager stated, "It's stated she would hav Department to hold it since the NPO order computer system the Manager reported Reneeded to be resched at 3:30 PM with the rescheduling of Resid discussed during the to how the delay may resident, the physicia an elective surgery. While the reschedulin "frustrating and an ur would not cause harr." An interview was con PM with the facility 's During the interview, was asked what the fichange a diet order for Services Director repreceived an order for give her a Dietary Cothat point, she would the Dietary Departmet Upon further inquiry, stated a change in Resident and the state of the control of the con	his morning, it was delivered if the Dietary Department 17 NPO order, the Unit hould." The Unit Manager re expected the Dietary he resident 's breakfast tray had been put into the day before. The Unit resident #191's surgery duled for 6/1/17. If was conducted on 5/25/17 resident 's physician. The dent #191's surgery was interview. Upon inquiry as a potentially impact the in reported the surgery was The physician also stated g of the surgery was, infortunate circumstance," it	F 28	This information has been interested the standard orientation training required in-service refresher or all employees and will be reviewed. Quality Assurance Process to the change has been sustained Monitoring: To ensure compliance, Director or designee will monitor this is the QA survey tool. The facility compliance by reviewing 5 rest charts with NPO physician ordensure that physician ordensure that physician ordensure that physician ordensure that physician orders were followed, initiated and community department to ensure that physician ordered to ensure that physician ordered to ensure that physician are followed and initiated as or will be done on weekly basis for then monthly for 3 months by the following of Nursing, Support Nurse, Un or designee. Reports will be put he weekly QA Committee by the weekly QA Committee by the weekly QA Committee by the Director of Nursing or Adm for appropriate action. Compliants and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly QA Committee is attended by Administrator, Dursing, MDS Coordinator, Universing, MDS Coordinator, Universing, MDS Coordinator, University will be considered in the process of the standard or the process of	ig and in the ourses for ewed by the verify that d. or of Nursing sue using a will monitor idents' ers to vere inicated to ure ity will also ong 5 supplements an orders or 4 weeks the Director it Manager, iresented to he ssure oppopriate. The brought to inistrator ance will be g program and of the program of the progra	
	(not via computer). T stated she would nee	ietary Communication Slip The Food Services Director and to check her records to be Dietary Department had		Support Nurse, Therapy, Healt Information Manager, Dietary I Social Services.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345284	B. WING		05/25/2017
NAME OF P	ROVIDER OR SUPPLIER	1 2.052		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 281	A follow-up interview at 4:00 PM with the that time, the Food S Dietary Department make Resident #19 5/24/17. The Food S she would have exporder to be communicated in the statement of the state	Resident #191 was supposed night on 5/24/17. was conducted on 5/25/17 Food Services Director. At Services Director reported the did not receive an order to I NPO after midnight on Services Director indicated ected the resident's NPO icated to the Dietary ould not have been sent a	F 28	31	
	1/15/16 with diagnos and non-Alzheimer's A review of the complete (MDS) assessm Resident #21 had in decision making skill assistance with one resident's weight was A review of care plant A care plan interven	orehensive Minimum Data ent dated 12/21/16 revealed npaired cognition and ls, and needed extensive person for eating. The			
	The care plan further responsible for the transfer of the physic revealed "Magic cup." An observation of Roman and the physic cup. An observation of Roman and the physic cup.	r revealed the discipline ask was a nurse's aide. ician's order dated 3/11/16 with meals for anorexia." esident #21 on 5/23/17 at urse aide #4 (NA #4) had fed stated the resident was "a			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		03/23/2017	
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F 281	she liked to eat. Not didn't eat well she cas a peanut butter a stated, at times, she eat more by reward shake" but did not magic Cup. An observation of F 5/23/17 at 6:48 PM the meal tray. An interview was con Manager on 5/24/11 Magic Cups were go they were not placed dietary department. Supplement to their gave them out. An interview was con 5/24/17 at 9:45 AM came out on the med kitchen and got the An interview with N revealed he had fed times and fed her wore ported he had no meals. An interview was con Dietician (RD) on 50 the kitchen delivered them in the nourish staff passed the supplement any supplement to the supplement to the meals.	A #4 reported if Resident #21 offered her an alternative, such and jelly sandwich. NA #4 e encouraged the resident to ing her with a "chocolate mention there was an order for Resident #21 was completed. The Magic Cup was not on ompleted with the Dietary 7 at 9:37 AM. She stated the iven by the nursing staff and ad on the meal trays by the The kitchen staff brought the nourishment room and nurses ompleted with Nurse #2 on She stated the Magic Cups eal trays or "we went up to the	F 28			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		03/23/2011
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	A review of the May 2 Administration Recor were signed off as gives stated in her interview the Magic Cups came. A second interview we 5/24/17 at 4:45 PM. give the Magic Cup to she was fed. She stagave the supplement dinner. "I saw what saked for something stated during meal time. Magic Cup unless the more or had not eater.	that they be passed and e."	F 2	81		
F 282 SS=D	Nursing (DON) on 5/2 stated the facility had and they would be try ensure supplements trays. Her current ex would place the supp from the nourishment expected to give the 483.21(b)(3)(ii) SERV PERSONS/PER CAP (b)(3) Comprehensive The services provided	apleted with the Director of 25/17 at 8:43 AM. She changed dietary managers ring a different system to were placed on the meal pectation was that the nurse lements on the meal trays room and nurse aides were supplement to the resident.	F 2	82		6/19/17

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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F 282	Continued From pag	e 38	F 2	282			
		ualified persons in h resident's written plan of					
	care. This REQUIREMEN by:	Γ is not met as evidenced					
	Based on observation	ons, staff interviews and			The statements made on this Plan of		
	record review the fac	ility failed to follow care plan			Correction are not an admission to and	l do	
		of one sampled residents			not constitute an agreement with the		
	_	nary catheter, Resident			alleged deficiencies. To remain in		
	#258.				compliance with all Federal and State		
					Regulations the facility has taken or wi		
	The findings included	1:			take the actions set forth in this Plan of	f	
					Correction. The Plan of Correction		
		idmitted to the facility on			constitutes the facility's allegation of		
	4/10/17 with diagnos				compliance such that all alleged		
	dysfunction of the bla	adder.			deficiencies cited have been or will be corrected by the date or dates indicate	d.	
	Review of the admiss	sion Minimum Data Set					
		indicated Resident #258			F282 SERVICES BY QUALIFIED		
	had an indwelling uri	nary catheter.			PERSONS/PER CARE PLAN Corrective Action:		
	Review of the care p	lan dated 4/19/17 included a			Resident #258		
		n indwelling urinary catheter.			Indwelling catheter: Physician notified,		
	-	cated the resident would be			orders initiated and implemented per		
	free from catheter rel	ated trauma and to have no			physician orders. Care plan updated or	n	
	signs or symptoms o	f an infection. The			5/24/2017 by MDS Coordinator.		
	interventions include	d for staff to keep the urinary			Identification of other residents who ma	ay	
		I adequately to promote			be involved with this practice:		
		nd to secure the catheter,			All residents have the potential to be		
		ary catheter bag and tubing			affected by this practice. On 6/15/2017		
		bladder and away from the			Director of Nursing initiated a chart aud		
	entrance room door.				on all current residents to ensure that a		
		2/47 - 1 40 40 414			residents with indwelling catheters had		
		3/17 at 10:10 AM revealed			orders initiated, implemented as ordere		
		n bed, with a urinary catheter			and care planed initiated and followed.		
		bottom of the bedframe.			of residents have indwelling catheters.		
		d no privacy covering and door to the hallway. A			physician Orders initiated, implemented as per physician orders, care plan up to		
	was lacing the open	acor to the hanway. A			as per priyololari ordero, care piari up t	-	

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		345284	B. WING _		05	5/25/2017	
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THE OAK	S			WINSTON SALEM, NC 27103			
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F 282	Continued From pa	nge 39	F 2	82			
	securing device wa	s not in place to prevent		date.			
		n the catheter tubing.		Systemic Changes:			
				Director of Nursing and /or D	esignee in		
	Interview with Nurs	e Aide #6 (NA #6) on 5/23/17		serviced all Nurses (RNs, LP	Ns, full time,		
		ed she had looked for a		part time, and PRN) and the			
	_	d said he did not have one.		interdisplinary care planning			
		omeone put tape on the tubing		fact that the services provide			
		ame loose from his leg. At		by the facility, as outlined by			
		view, NA #6 was observed to inst the resident's leg to secure		comprehensive care plan, mu professional standards of qua			
	the tubing.	inst the resident's leg to secure		Nurses (RNs, LPNs, full time	•		
	the tubing.			and PRN) were also educate			
	An observation on	5/24/17 at 8:07 AM were made		that it is the nurse's responsil			
		Nurse. The observation		physician, follow and initiate	-		
	revealed a securing	g device was not in place to		orders. All residents who are	admitted or		
	secure the catheter	tubing. The tape was no		readmitted to the facility with	an indwelling		
	longer on the tubing	g.		catheter, nurse must ensure			
	l			written order for the use of th	•		
		reatment Nurse on 5/24/17		appropriate diagnosis to supp			
	_	tion at 8:07 AM revealed a		of the catheter, treatment and			
		old be used to secure the bing. She further explained		catheter, presence of a revisual updated care plan with focus			
		prefer the strap. The		interventions as appropriate.	•		
		sked Resident #258 if he		should be called 24 hours a c	•		
		e of the strap. The resident		days a week. This process d			
		e Treatment Nurse applied the		change due to time or day of			
		urinary tubing. The Treatment		Physician phone numbers or			
		ne would get a privacy bag for		located at each nurse's static	on in the	the on	
	the urinary catheter	r drainage bag.		notebook. If you are unable to			
				attending physician or the ph			
		onducted on 5/24/17 at 11:42		call, call the facility medical d			
		who was the charge nurse for		30 minutes of contacting the	•		
		5/23/1. Interview revealed she		physician. If the attending ph	•		
	· ·	sterday that Resident #258 did to secure the urinary catheter		medical director does not pro appropriate response or does			
	tubing.	o to secure the unitary catheter		back within 30 minutes then t			
	tabilig.			to contact the DON immediat			
	Interview with the F	Director of Nursing on 5/24/17		instructions.	, 101 1011101		
		d she would expect the		This in service was complete	d by June		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _		C 05/25/2	/2017	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/20/	.2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE	
F 382	resident to have a leg and a privacy cover o care plan.	extrap to secure the catheter in the drainage bag per the		16th, 2017. Any Nurse (RNs, LPNs, fitime, part time, and PRN) and membe the interdisciplinary team who did not receive in-service training will not be allowed to work until training is complet. This information has been integrated in the standard orientation training and in required in-service refresher courses for all employees and will be reviewed by Quality Assurance Process to verify the change has been sustained. Monitoring: To ensure compliance, Director of Nuror designee will monitor this issue using the QA survey tool. The facility will monompliance by reviewing 5 residents' charts with indwelling catheter to ensure that care plans are updated and follow. This will be done on weekly basis for a weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Under Manager, or designee. Reports will be presented to the weekly QA Committee the Administrator or designee to assur corrective action initiated as appropriate Any immediate concerns will be broughted birector of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing programe reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting attended by Administrator, Director Nursing, MDS Coordinator, Unit Mana Support Nurse, Therapy, HIM, Dietary Manager, Social Services.	ted. too the or the or the at sing g nitor re ed. e by e te. nt to r be am ng of ger,	19/17	
22=J	TORTHORIEST WELL						

	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345284	B. WING		C 05/25/2017
	1		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/20/2011
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION
483.24 Quality of life Quality of life is a fur applies to all care ar residents. Each res facility must provide services to attain or practicable physical, well-being, consister comprehensive asset 483.25 Quality of car Quality of care is a fapplies to all treatme facility residents. Ba assessment of a residents receiv accordance with propractice, the comprecare plan, and the rebut not limited to the with the facility must ensprovided to residents consistent with professions the comprehensive pand the residents who requires a consistent with professions. The facility must ensprovided to residents of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehenses. This REQUIREMEN by: Based on record residents.	indamental principle that and services provided to facility ident must receive and the the necessary care and maintain the highest mental, and psychosocial into with the resident's essment and plan of care. The undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure the treatment and care in fessional standards of thensive person-centered esidents' choices, including following: The sure that pain management is so who require such services, the sessional standards of practice, the person-centered care plan, the pollowing and preferences. Ility must ensure that the dialysis receive such with professional standards or ehensive person-centered esidents' goals and This not met as evidenced wiew and staff interviews the	F 30	The statements made on this Plan of	
				iiu uo
	Continued From page 483.24 Quality of life is a fur applies to all care ar residents. Each resifacility must provide services to attain or practicable physical, well-being, consister comprehensive asset 483.25 Quality of car Quality of care is a frapplies to all treatmer facility residents. Basessment of a rest that residents receiv accordance with propractice, the comprehensive in the facility must ensprovided to residents consistent with profession to the comprehensive pand the residents' go. (I) Dialysis. The faci residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices, consistent of practice, the comprehensive pand the residents who requires revices. This REQUIREMEN by: Based on record revision of the preferences of the comprehensive pand the residents who requires revices and the residents review of the residents review o	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	A BUILDING 345284 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRÉCEDED BY FULL REQUATORY OR LSC (DENTIFY NO INFORMATION) Continued From page 41 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SUND PLAN OF CORRECTION (X3) DATE SUND PLAN OF COMPLEX (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE SUND PLAN OF COMPLEX (X6) DATE SUND PLAN OF CORRECTION (X6) DATE SUND PLAN OF CORRECTION (X6) DATE SUND PLAN OF CORRECTION (X7) DATE SUND PL						
			A. BOILDII			,	
		345284	B. WING				25/2017
NAME OF P	ROVIDER OR SUPPLIER	0.020.	<u> </u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE	05/	25/2017
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				VVI	NSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	ge 42	F3	309			
	· ·	structions before transporting			alleged deficiencies. To remain in		
	one of one resident				compliance with all Federal and State		
		dent #54. During transport			Regulations the facility has taken or wi	II	
		Resident #54 fell backwards			take the actions set forth in this Plan of		
		nding on her back and hitting			Correction. The Plan of Correction		
		n floor. Resident #54			constitutes the facility's allegation of		
	complained of right	shoulder pain after the			compliance such that all alleged		
	incident. The Tran	sportation Aide failed to call			deficiencies cited have been or will be		
		after the incident and moved			corrected by the date or dates indicate	d.	
		a sitting position in the					
		incident. Resident #54			F309 PROVIDE CARE/SERVICES		
		shoulder pain after the			FOR HIGHEST WELL BEING		
		for one of one residents			Corrective Action:		
	transported in the fa	acility van Resident #54.			Resident #54		
	luana adiata ia an andu	, harron an 0/20/40 at 5:00 DM			Discharged from facility.		
		v began on 9/30/16 at 5:00 PM Ever #1 failed to secure the			Identification of other residents who mabe involved with this practice:	ау	
	_	cility van floor according to			All residents have the potential to be		
		ommendation. Immediate			affected by the alleged practice. On		
		on 5/25/17 when the facility's			5/25/2017, the nurse managers assess	ed	
		allegation of compliance was			all 6 current patients for signs/sympton		
		will remain out of compliance			of injuries related to possible transport		
	-	erity level D (no actual harm			injuries such as unexplained bruising,		
	-	ore than minimal harm that is			swelling or pain to extremities for those	,	
	not immediate jeopa	ardy) to allow the facility time			who had been transported via the facili	ty	
	to monitor and fully	implement the new			owned van from 10/6/2016 to 10/25/20	16.	
	procedures for secu	ıring wheelchairs in the facility			No injuries were identified. No residen	ts	
	van for resident trar	nsport.			were transported via the facility owned		
					van from 10/26/2016 to 6/16/2017 .		
	The findings include	ed:			Systemic Changes:		
	D : ("	e i la companya di seria			Director of Nursing and /or Designee in		
		Ifacturer's recommendations			serviced all Nurses (RNs, LPNs, full tin	ie,	
	secure the wheelch	the following instructions to			part time, and PRN) on the fact that Quality of life is a fundamental principle		
		air: air facing forward in			that applies to all care and services	-	
		pply wheel locks or turn power			provided to facility residents. Each		
	off.	Phil Mileel locks of fall howel			resident must receive and the facility m	nust	
		ns into floor anchorages and			provide the necessary care and service		
	ensure they are lock				to attain or maintain the highest		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPL		E SURVEY IPLETED
	345284	B. WING			С
NAME OF BROWERS OF GURBLUSS	345264	B. WING	0.775.57.45.75.75.05.75.75.75.75.75.75.75.75.75.75.75.75.75		5/25/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=	
THE OAKS			901 BETHESDA ROAD		
5/11.0			WINSTON SALEM, NC 27103		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309 Continued From page	· 43	F 30	9		
3. Attach the four tiemembers or weldmen tie-downs are fixed at and are within angles hooks to wheels, plas wheelchair. 4. Ensure all tie-down tensioned. If necessary and forth or manually take up additional well resident transportation 6/09 included in part: "Transportation Policy should be completed been trained to do so be current Nursing As Medication Techniciar valid CPR training emergency, call 911. Implement CPR if it is heartbeat or breathing injury is suspected or Resident #54 was add 8/3/15 with diagnoses behaviors, cerebral in polyneuropathy. The Minimum Data Schange, dated 7/12/10 had no impairment will she exhibited no behaviore equired extensive bed mobility, dressing	e-down hooks to solid frame tts, near seat level. Ensure approximately 45 degrees, shown. Do not attach tic, or removable parts of was are locked and properly ary, rock wheelchair back tension retractor knobs to obing slack. Policy and procedure for an, with a revision date of on page 4 of 8, or 1. Resident transportation by employees who have a Transportation aides must esistants or Emergency as. The must also have so indicated such as no g. Do not move patient if unless life is threatened" In the devent of an and transfer in the device of two staff for and transfer. She was not irred extensive assistance of two staff for and transfer. She was not irred extensive assistance of	F 30	practicable physical, mental, a psychosocial well-being, consithe resident's comprehensive and plan of care. Quality of ca fundamental principle that app treatment and care provided to residents. Based on the comp assessment of a resident, the ensure that residents receive that and care in accordance with p standards of practice, the comperson-centered care plan, an resident choices, including but to the following: Pain Manager Dialysis. The facility must ensuranagement is provided to re require such services, consiste professional standards of practice plan, and the residents' goals preferences. The facility must residents who require dialysis such services, consistent with professional standards of practice plan, and the residents' goals preferences. On 5/24/2017, the Director of educated all nurses (FT, PT, EPN) in reference to incidents Investigation of incident: When has an incident, the person distince the resident reassures the resimmediately alerts the primary nurse assesses the resident for after notification of incident. If refuses to be assessed after no fincident notify Director of nursident nursident nursident nursident nursident nursident nursi	istent with assessment re is a plies to all of facility rehensive facility must treatment rofessional aprehensive d the treatment and ure that pain sidents who ent with stice, the ed care and ensure that receive stice, the ed care and with the treatment receive stice, the ed care and ensure that receive stice, the ed care and with stice, the ed care and ensure that receive stice, the ed care and with stice, the ed care and ensure that receive	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION (X3) DATE SUI DING COMPLET			
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		345284	B. WING _			05/	/25/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
				90	1 BETHESDA ROAD		
THE OAK	S			WI	INSTON SALEM, NC 27103		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	Continued From pa	ge 44	F3	309			
	Review of Transpor	tation Aide (TA) #1's safety			limbs, the limbs in question are		
	training for use of the	ne van dated 8/24/16 revealed			immobilized. When other fractures are	÷	
	a check list that inc	luded "Secure Resident Safely			suspected the resident is kept		
	for Lift Operation" a	and "Secure resident for			immobilized and put in place and an or	rder	
	transport with appro	oved system safety device			to send to the ER is obtained. Vital Si	gns	
	which includes usin	g seat belts to secure the			are obtained. The attending physician	is	
	person and using a	pproved safety straps, belts			notified immediately of the incident if ir	ıjury	
		e the chair." Both of these			is apparent. If no injury is apparent the		
		icating she had been			physician is notified. Notify the family of		
	observed and was	able to perform the tasks.			legal representative. Initial documenta		
					in the nurse's notes needs to be comp	lete	
		ent report dated 9/30/16 at 6:43					
		lent #54 was observed during			thoroughly assessed every shift after t	-	
		ort, while in-route, to have her			incident with complete vital signs for 73		
		hen viewed by the TA #1 in her A #1 stopped the van, found			hrs. A neuro assessment is done every shift for 72 hours or according to MD	1	
		on her back in the wheelchair.			orders. Incident Reporting: A Quality		
		indicated the whole			Assurance Incident Report is to be		
	1	wards. Resident #54			completed in detail and all spaces		
		iver her wheelchair fell			completed. The Director of nursing or		
	backwards while the				designee should make sure that the		
		3			resident has been thoroughly assesse	d.	
	Review of the nurse	e's note dated 9/30/16 at 7:34			the physician and the family have been		
	PM indicated the nu	urse was informed of the			notified, and the incident report has be		
	incident after Resid	ent #54 was in the dining			fully completed. Then the incident rep	ort	
	room eating dinner.	After the resident finished			should be investigated as follows. All		
	her meal, the nurse	took her to her room for an			resident who have a van incident shou	ld	
	assessment. The r	esident had no "bumps or			be referred to the Quality Assurance		
		nd and no bruises or red areas			Committee.		
	noted on her body.	Full range of motion of her			This in service was completed by May		
		ecked with no #1 after			25th, 2017. Any Nurse (RNs, LPNs, fu		
		n the dining room eating			time, part time, and PRN) and membe	r of	
		sident finished her meal, the			the interdisciplinary team who did not		
		er room for an assessment.			receive in-service training will not be		
		o "bumps or bruises" on her			allowed to work until training is comple		
		s or red areas noted on her			This information has been integrated in		
	, ,	motion of her extremities was			the standard orientation training and in		
		nitations. Resident #54			required in-service refresher courses f		
	complained of pain	of the right shoulder when her			all employees and will be reviewed by	tne	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY IPLETED
			D. WING			С
		345284	B. WING			5/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ė	
THE OAKS				901 BETHESDA ROAD		
THE UAK	•			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From page	e 45	F 30	09		
F 309	arm was raised. Nursand the on call Physicof the incident. An or the resident's right shade revealed an X-Ray results for a fracture of shoulder. The X-Ray chronic rotator cuff te and osteopenia. Review of a self-report 10/7/16 revealed a reneglect that occurred report indicated Residuackward in the whee of the investigation in TA#1. TA #1's statema doctor's office arou	se #1 documented the family cian's Assistant were notified der was obtained to X-Ray noulder. ' note dated 10/1/16 eport indicated negative for dislocation of the right of indicated Resident #54 had far, moderate osteoporosis ert by the facility dated eport of an allegation of on 9/30/16 at 5:00 PM. The	F 30	Quality Assurance Process to the change has been sustained Monitoring: To ensure compliance, Director or designee will monitor this is the QA survey tool. A quality mimplemented when transports back once we start using the fowned van. The director of nure also review incident reports duclinical meeting for accidents to involve the van. If an event is the chart will be checked by the of Nursing to ensure that the passessed promptly by the nurse evidence will also be validated interviewing the patient and the ensure that assessments were promptly. If errors are the Quality Assurance Committee will reviewent for appropriate corrective.	or of Nursing sue using eview will be are started acility rsing will uring daily that may identified be Director patient was se. Chart I by e nurse to e conducted ality iew the	
	seatbelt strap around through the right side securing both straps made a left turn onto resident informed her over. She looked into realized the resident's proceeded to drive us afe and secure place contact with the residence conscious. She was facility when she stop resident if she was all resident informed her	y straps. She placed the the resident's waist and of the resident's arm rest, in place. As the driver (Street Name) road, the the wheelchair had fallen to the rearview mirror and is foot was upright. She had she was able to find a set to park. She kept in verbal ent to ensure she was about 2 blocks from the uped the van. She asked the right and/or hurt. The that she had hit the right nst the van floor. The		This will be done for 4 weeks, monthly for three months. The Nursing will review all incident daily during daily clinical quality meeting (Monday through Frick Reports will be presented to the QA Committee by the Administ designee to assure corrective initiated as appropriate. Any in concerns will be brought to the Nursing or Administrator for an action. Compliance will be moongoing auditing program revieweekly Quality of Life Meeting QA Committee meeting is atternative Administrator, Director of Nurse, Coordinator, Unit Manager, St. Nurse, Therapy, HIM, Dietary	e Director of s reports by of life lay). The weekly trator or action mediate e Director of opropriate pritored and ewed at the g. Weekly nded by sing, MDS upport	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E SURVEY PLETED
		345284	B. WING		0.5	C 5/ 25/2017
NAME OF P	ROVIDER OR SUPPLIER	2,1,2,5		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03	12312011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	wheelchair upright." secured with all four resident and placed hagain, she checked topen wounds or bruis with the seatbelt and facility while talking to the facility, she unl brought her into the badministrator of the in Resident #54 had be facility to an assisted neighboring state. Si interview. Interview on 5/23/17 Administrator revealed demonstration of how wheelchair in the van was determined TA#device correctly to location to secure it. The up" driver. It was detinvestigation TA #1 dithe incident. The Addriver to call 911, not proceed to the facility own personal cell phococcurred. The adminhad not been used by "sister" facility had the (5/23/17). The keys to administrator's office administrator. Further	e the seatbelt strap to e resident and secure the After the wheelchair was straps in place, she lifted the ner into the wheelchair. In see if the resident had any see. She then secured her proceeded back to the other than the resident. Upon arrival coaded the resident and coulding. She notified the notident. In discharged from the living facility in a ne was not available for that and had not placed the securing can be tied down the set and had not pulled it evan driver was the "back termined in the facility id not follow protocol after ministrator would expect the move the resident and not to the transfer of the van driver had her one when the incident instrator explained the van the van driver had her one when the incident instrator explained the van the van are in the and secured by the er interview revealed TA#1 on 10/7/16. The main TA#2	F 30	Social Services.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			OMPLETED	
		345284	B. WING _			C 05/25/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		03/23/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From page	ge 47	F 3	09			
	management staff b The administrator di be using the van aft At present, there wa when the van would had occurred during prior to 9/30/16. Interview with the Di 5/23/17 at 11:10 AM an incident had occu van. The resident ti transport from a doc Further interview rev who called her. The an investigation of the demonstration was a presence of the Adn suspended pending investigation and all van was suspended Interview with the N PM revealed the TA the incident. Nurse Resident #54. The A her and asked her to on the occurrence. resident before she and was not sure wh returned to the facili the facility approxim was informed about completed the incide resident after Reside supper. Nurse #1 c observed during her An attempt to call the	despress the facility would er the training was completed. In some a date certain as to be used. No other incidents transport with the facility van director of Nursing (DON) on a revealed she received a call turred with Resident #54 in the lated backwards during stor's visit to the facility. It was the outcome of the transports using the facility on 9/30/17. The TA #1 was the outcome of the transports using the facility on 9/30/17. The Had not informed her of #1 was the charge nurse for administrator had approached to complete an incident report She had not observed the was brought into the facility onen Resident #54 had ty. The resident returned to ately 5:00 PM and the nurse two hours later. She ent report and assessed the ent #54 had finished eating arified there were no injuries					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ELE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C
NAME OF PR	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		05/25/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 48	F 30	09		
	5/24/17 at 4:40 PM been in use from O 2016. Review of th indicated it was cor corporate staff men On 5/24/17 the Adn	ninistrator was informed at				
	3:45 PM of immediate jeopardy. The facility provided the following Credible Allegation of Compliance on 5/25/17 at 2:22 PM:					
	The facility immedia incident involving re 9/30/2016 in which transported back to appointment. In rou	r Affected Residents ately began investigating the esident #54 occurring on resident was being the facility after a medical te to the facility resident #54 ansportation aide that her				
	transportation aide mirror and realized The van transportat drive until she was place to park, while sure patient remain transportation aide facility when she sto	then looked into the rearview the patient's foot was upright. ion aide then proceeded to able to find a safe and secure talking to the patient to make ed conscious. The van was about two blocks from the opped the van. The van				
	alright and or hurt. transportation aide she proceeded to s release and move p wheelchair upright. upright and secured	then asked resident if she was The patient per the van had no apparent injuries so ecure the seatbelt strap to patient so she could secure the Once the wheelchair was If with all four straps in place, on aide lifted the patient				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		1, ,	(X3) DATE SURVEY COMPLETED	
					С	
	345284	B. WING _			05/25/2017	
OVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	E .	00/20/2011	
			901 BETHESDA ROAD			
i			WINSTON SALEM, NC 27103			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE	
placing her into the transportation aide to the patient did not horuises. The van trapatient with seatbelt facility while continuarriving to the facility unloaded the reside facility dining room. Informed Administrator then not that resident was on a doctor's appointment transportation aides view mirror and saw. The administrator contact the van transpobus and found reside wheelchair on the floadministrator was now was in the dining roof finished notifying the nurse went into the resident was eating was talking with other resident that she ne assessment due to the van. Resident the van transpobus and found resident that she ne assessment due to the van. Resident the van the van the van the van transferre completed a full bod assessed residents	wheelchair. The van hen checked to make sure ave any open wounds and or nsportation aide then secured and proceeded back to the ing to talk to patient. Upon y, the van transportation aide nt and brought her into the The van transportation aide tor of the incident. The otified the nurse on the hall in the facility van coming from ent when the van said she looked in her rear resident's legs up in the air. ontinued to inform the nurse retation aide then stopped the ent lying on her back in her our. At that time, when otifying the nurse, the resident om. When the administrator en nurse of the incident, the dining room to find the her dinner independently and er residents. Nurse informed eded to complete an the incident that happened in the nord asked if the nurse was done with dinner. Ow any signs of distress, no signs of injury were noted. Ompleted her dinner, the to take resident back to the diner to the bed. The nurse head with a flash light and	F	,			
	Continued From page placing her into the stransportation aide to the patient with seatbelt facility while continuarriving to the facility unloaded the reside facility dining room. informed Administrated administrator then in that resident was on a doctor's appointment transportation aide sview mirror and saw. The administrator contact the van transpotation aide sview mirror and saw. The administrator was now and found resid wheelchair on the floadministrator was now as in the dining roof finished notifying the nurse went into the resident was eating was talking with other resident that she ne assessment due to the van. Resident the van transportation aide so the van. Resident the van transportation aide so the van transportation are went into the resident was eating was talking with other resident that she ne assessment due to the van. Resident the van transferre could wait until she can be resident of the reside	CORRECTION IDENTIFICATION NUMBER: 345284 COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 placing her into the wheelchair. The van transportation aide then checked to make sure the patient did not have any open wounds and or bruises. The van transportation aide then secured patient with seatbelt and proceeded back to the facility while continuing to talk to patient. Upon arriving to the facility, the van transportation aide unloaded the resident and brought her into the facility dining room. The van transportation aide informed Administrator of the incident. The administrator then notified the nurse on the hall that resident was on the facility van coming from a doctor's appointment when the van transportation aide said she looked in her rear view mirror and saw resident's legs up in the air. The administrator continued to inform the nurse that the van transportation aide then stopped the bus and found resident lying on her back in her wheelchair on the floor. At that time, when administrator was notifying the nurse, the resident was in the dining room. When the administrator finished notifying the nurse of the incident, the nurse went into the dining room to find the resident was eating her dinner independently and was talking with other residents. Nurse informed resident that she needed to complete an assessement due to the incident that happened in the van. Resident then told the nurse that she wanted to finish dinner and asked if the nurse could wait until she was done with dinner. Resident did not show any signs of distress, no apparent or obvious signs of injury were noted. Once the resident completed her dinner, the nurse then proceed to take resident back to the room and transferred her to the bed. The nurse completed a full body assessment. The nurse assessed residents head with a flash light and observed no bumps or discolorations. Full range	CONTRECTION SASSEAN B. WING	OVIDER OR SUPPLIER 345284 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY REQUILATORY OR LSC IDENTIFYING INFORMATION) CONTINUED CONTINUED CONTINUED FROVIDERS PLAN OF CORRECTION INCACHORITY FROVIDERS PLAN OF CORRECTION (RACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 PROVIDERS PLAN OF CORRECTION INCACHORITY FROVIDERS PLAN OF CORRECTION INCACHORITY TAGS F 309 PROVIDERS PLAN OF CORRECTION INCACHORITY INCACHORITY TAGS F 309 PROVIDERS PLAN OF CORRECTION INCACHORITY INCACHORITY TAGS F 309 PROVIDERS PLAN OF CORRECTION INCACHORITY INCACHORITY TAGS F 309 PROVIDERS PLAN OF CORRECTION INCACHORITY INCACHORITY INCACHORITY INCACHORITY INCACHORITY TAGS F 309 PROVIDERS PLAN OF CORRECTION INCACHORITY INCACHORITY	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345284	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	0.0204		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		5/25/2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	did complain about his when she raised her initiated and were all signs were obtained P-87, and R -20 B/P Daughter and Physic and informed of the iright shoulder x ray FX -Ray to right should 9/30/2016. Impression of acute fracture or compatible with chromoderate osteoporososteopenia. On 9/30/2016, the factor operation through 10 was completed on 9/30/2016, the factor operation through 10 was completed on 10 transportation companies are professional medical The facility owned variom 9/30/2016 through 10 facility staff designations were van trainer utilizing the Straint manufacturer van trainer has recein Straint/Surelock National products in Septembetrainer utilizes the trainer utilizes the tr	arm up. Neurochecks were within normal limit. Vital and were Temperature 98.7, 125 /72. Resident #54 cians Elder Care were called noident. Order obtained for a Physician Assistant. der was completed on on: No radiographic evidence islocation, findings nic rotator cuff tear, sis demonstrated, moderate cility van was taken out of /5/2016. A 24 hour report 30/2016 and a 5 day report 0/7/2016. Outside any was used to scheduled for the facility. The involved spended on 9/30/2016 and ated on 10/7/2016. determined the root cause eing assessed promptly was a personnel assess resident. In was taken out of operation 19/10/5/2016. On 10/5/2016, on 1	F 30	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		05/2	: :5/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 03/2	.5/2017
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	educate van transporalso completed wher demonstrate the skill included educating the need to stop and occurs during transporation to the completed by the cortolof/2016 prior to the completing any van to van was placed back through 10/25/2016. Van was then utilized 5/23/2017. The facility owned van since 10/0 owned van keys are one has access to the van will be out of seridesignated and trainer. Corrective Action for Residents On 5/25/2017, the number of the properties of the	ters. A skills validation is a the staff member must appropriately. This also be new team members on call 911 for any accident that corts. Training was porate van trainer on a transportation aide transports. The facility owned in service from 10/6/2016 On 10/26/2016 facility owned by sister facility through y has not utilized the facility with the Administrator and no exelogy. The facility owned vice until new facility staff are end by the corporate van Potentially Affected The managers verified that the transported by our facility Six current patients were a facility owned van from 1016. On 5/25/2017, the essed all 6 patients for juries related to possible the as unexplained bruising, tremities. No injuries were 7, the nurse managers also the reports to verify that there injuries or accidents that sessed by emergency ing the time frame of	F 30	9		
	transport injuries such swelling or pain to exidentified. On 5/25/1 reviewed the incident were no van related should have been as medical services dur 10/6/2017 to 10/25/2 Systemic changes	h as unexplained bruising, tremities. No injuries were 7, the nurse managers also t reports to verify that there njuries or accidents that sessed by emergency ng the time frame of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 05/25/2017	
NAME OF PI	ROVIDER OR SUPPLIER	0.020		STREET ADDRESS, CITY, STATE, ZIP COI		19/29/2017	
THE OAK	S			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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	patient on the compace conducting the transpectorporate van trainer the policy statement emergency, STOP at first aid. Implement on heartbeat or breating in the policy suspected of This information has standard orientation in-service refresher of who operate the facility the Quality Assurathe change has been Any staff member detransportation or any the facility transportation or any the facility transportation facility owned van under the two TAs to verify safety training, verifice certified, review of the the corporate staff mention was keys kept in the safety and keys kept in the s	ed to aide in facility cation included; ent: Prior to transporting any any owned van, the employee cort must be trained by our r. This training will included that: In the event of an and call 911. Provide basic CPR if it in indicated such as thing. Do not move patient if r unless life is threatened. been integrated into the training and in the required courses for all employees lity van and will be reviewed ance process to verify that	F3	09			
F 322 SS=D		TREATMENT/SERVICES - SKILLS	F 3	22		6/19/17	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 5/25/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 901 BETHESDA ROAD WINSTON SALEM, NC 27103		3/23/2017	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 322	both percutaneous of percutaneous endored fluids). Based comprehensive assisted ensure that a resided (4) A resident who halone or with assistated methods unless the demonstrates that elindicated and consectives the approproproproful for estore, if possibly prevent complication but not limited to as vomiting, dehydratic and nasal-pharynge. This REQUIREMEN by: Based on observation record review the fafeeding as ordered freeding. Findings included: 1. Resident #102 w 6/20/16 with diagnor following cerebral in A review of the communication severely impaired disease.	n and hydration. ric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's essment, the facility must ent- has been able to eat enough ance is not fed by enteral resident's clinical condition enteral feeding was clinically ented to by the resident; and as fed by enteral means riate treatment and services e, oral eating skills and to has of enteral feeding including piration pneumonia, diarrhea, has, metabolic abnormalities,	F3	The statements made on thi Correction are not an admiss not constitute an agreement alleged deficiencies. To rema compliance with all Federal a Regulations the facility has to take the actions set forth in the Correction. The Plan of Correction. The Plan of Corrections the facility's allegations to the facility's allegations to the facility allegations are such that all allegatic encies cited have been corrected by the date or date F322 NG TREATMENT/S RESTORE EATING SKILLS Corrective Action: Resident #102	sion to and do with the ain in and State aken or will his Plan of rection ation of ged or will be as indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _				C 25/2017
NAME OF P	ROVIDER OR SUPPLIER	1 0.020.		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	25/2017
TO UNIC OF T	TO VIDER OR OUT FEEL				01 BETHESDA ROAD		
THE OAK	3				/INSTON SALEM, NC 27103		
					·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 322	Continued From pag	e 54	F 3	322			
	nutrition through tube	e feeding.			Physician notified on 5/24/2017. Physi	cian	
					orders initiated, implemented and follo		
	A review of care plan	problems included Resident			as ordered and care plan updated.		
	#102 required tube fe				Identification of other residents who ma	ay	
	maintaining nutrition	al status due to dysphagia			be involved with this practice:	•	
	from a stroke (dated	9/11/14) and that she could			All residents who are on tube feeding		
	not have anything by	mouth (dated 8/23/16). A			have the potential to be affected by thi	S	
	care plan intervention	n dated 9/11/14 revealed			practice. All G-tube residents were		
		ding formula and water			identified and assessed for appropriate	•	
	flushes as ordered by	y physician."			orders. Also facility ensured that all		
					enteral feeding orders were initiated,		
		cian's order dated 6/20/16			implemented and followed as per		
		.5 at 55 cubic centimeters			physician orders. The review was		
		18 hours. On at 14:00 (2			completed on 5/26/2017 by Director of		
	PM), off at 08:00 (8 A	AM)."			Nursing and/or designee.		
	An absorbation of Da	soidant #102's room was			Systemic Changes:	_	
		esident #102's room was 7 at 2:49 PM. Resident #102			Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full tir		
		ne tube feeding was not			part time, and PRN) on the fact that ar		
		ing as ordered for Glucerna			assisted nutrition and hydration.(Include		
		The pump was off and			naso-gastric and gastrostomy tubes, b		
	tube was disconnect				percutaneous endoscopic gastrostomy		
					and percutaneous endoscopic		
	An observation of Re	esident #102's room was			jejunostomy, and enteral fluids). Based	d on	
	completed on 5/23/1	7 at 3:39 PM. Resident #102			a resident's comprehensive assessme		
	was in her bed and tl	ne tube feeding was not			the facility must ensure that a resident		
	administered or runn	ing as ordered. The pump			who has been able to eat enough alon	e or	
	was off and tube was	s disconnected.			with assistance is not fed by enteral		
					methods unless the residents clinical		
		esident #102's room was			condition demonstrates that enteral		
		7 at 4:02 PM. Resident #102			feeding was clinically indicated and		
		he tube feeding was not			consented to by the resident; and a		
		ing as ordered. The pump			resident who is fed by enteral means		
	was off and tube was	s aisconnected.			receives the appropriate treatment and		
	An chos	sold ont #100la races			services to restore, if possible, oral eat	ırıg	
		esident #102's room was			skills and to prevent complications of	4 40	
		7 at 4:55 PM. Resident #102			enteral feeding including but not limited		
		ne tube feeding was not ing as ordered. The pump			aspiration pneumonia, diarrhea, vomiti dehydration, metabolic abnormalities,		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES			OIVID IV	O. 0930-039 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY IPLETED
						С
		345284	B. WING		0:	5/25/2017
NAME OF PI	ROVIDER OR SUPPLIER		\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S			001 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 322	Continued From page	2.55	F 222			
1 322	Continued From page		F 322		141	
	was off and tube was	alsconnected.		nasal-pharyngeal ulcers. Also e regarding appropriate G-tube of		
	An observation of Re	sident #102's room was		admission/re-admission. In-ser		
		7 at 5:57 PM. Resident #102		included education of notification		
		ne tube feeding was not		Registered Dietician of needed		
		ing as ordered. The pump		evaluation. All enteral feeding		
	was off and tube was	-		orders should be implemented		
				followed as ordered.		
		sident #102's room was		This in service was completed	by June	
		7 at 6:26 PM. Resident #102		16th , 2017. Any Nurse (RNs,		
		ne tube feeding was not		time, part time, and PRN) and		
		ing as ordered. The pump		the interdisciplinary team who		
	was off and tube was	disconnected.		receive in-service training will r		
	An absorvation of Da	sident #102's room was		allowed to work until training is This information has been integ	•	
		7 at 6:51 PM. Nurse #4 was		the standard orientation training		
		interview stated she would		required in-service refresher co		
	· ·	g "after I stop flushing her."		all employees and will be revie		
	3	3		Quality Assurance Process to		
	An observation of Re	sident #102's room was		the change has been sustained	-	
	· •	7 at 6:55 PM. The tube		Monitoring:		
	feeding was running	as ordered by the physician.		To ensure compliance, Director		
				or designee will monitor this iss		
		sident #102's room was		the QA survey tool. The facility		
	· •	7 at 7:58 AM. Resident #102		compliance by observing 5 re-		
	as ordered.	ne tube feeding was running		enteral tube feeding orders to each resident is receiving tube		
	as ordered.			per physician orders. These ob	-	
	An observation of Re	sident #102's room was		will ensure that enteral tube fee		
		7 at 8:24 M. Resident #102		orders are started and stopped	•	
		ne tube feeding was being		physician order. This will be do	•	
	administered.			weeks, and then monthly for th		
				months. The Director of Nursin	•	
		sident #102's room was		review all incidents reports dail		
		7 at 8:55 AM. Resident #102		daily clinical quality of life meet		
		ne tube feeding was being		(Monday through Friday). Repo		
	administered.			presented to the weekly QA Co		
	An observation of Bo	sident #102's room was		the Administrator or designee to corrective action initiated as ap		
	Ali observation of Re	SIGCIIL # IUZ S IUUIII Was	1	- corrective action initiated as ap	γριυριιαι ς .	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING		0.5	C / 25/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 901 BETHESDA ROAD WINSTON SALEM, NC 27103	•	12312011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 322	Continued From page completed on 5/24/1 was in her bed and the administered. An observation of Recompleted on 5/24/1 was in her bed and the stopped. The pumped disconnected. An interview was conditionally be concerned and the tube feeding at 8 would be concerned and the tube feeding at 8 would be concerned and the expected the expected the physician would expected to run at 18 issue."	e 56 7 at 9:05 AM. Resident #102 he tube feeding was being esident #102's room was 7 at 9:35 AM. Resident #102 he tube feeding had been was off and tube was mpleted with Nurse #2 on and she stated she stopped :15 that morning. mpleted with the Medical at 12:05 PM. He stated he if the tube feeding was not ed full amount of time. He hat if there was a reason it he full amount of time that be notified. "It would be 3 hours unless there is an	F 32	DEFICIENCY	Il be brought to dministrator pliance will be iting program ality of Life ittee meeting r, Director of Unit Manager, ealth	DATE	
	5/24/17 at 3:09 PM. Nurse #4 stated when she went in to Resident #102's room on 5/23/17 at around 6:45 PM to flush the tube she observed the tube feeding was not running. She stated she gave the resident the 5:00 PM medications then started the tube feeding. She stated she did not document that the tube feeding started late. An interview was completed with Nurse #2 on 5/24/17 at 3:12 PM. Nurse #2 stated she started the tube feeding on 5/23/17 at 2:00 PM. When told the tube feeding was observed off until 6:55 PM she stated the tube was clogged and that she was not good at unclogging the tube. Nurse #2						

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION G	COMF	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C / 25/2017
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 322	that the tube was close a tube is clogged and tube with lukewarm with physician would be she did not call the pleadocument that the tube. A review of nurses' nor revealed no document that Resident's #102 nor that the physician any issues with the tube. A second interview with 3:15 PM revealed she #2 on 05/23/17 that the troom about 6:45 PM was clogged and uncontrolled the physician and t	econd shift nurse (Nurse #4) gged. Nurse #2 stated when attempt is made to flush the vater and if it is still clogged, be called. Nurse #2 stated hysician and did not be was clogged. otes from 5/21/17-5/24/17 htation in the clinical record feeding tube was clogged, h was contacted regarding libe being clogged. ith Nurse #4 on 5/24/17 at the was not notified by Nurse he tube was clogged. Nurse went in to Resident #102's she saw the feeding tube	F 32	22		
F 323 SS=J	6:55 PM. She stated staff would follow the resident received the feeding. 483.25(d)(1)(2)(n)(1): HAZARDS/SUPERVIOLATION (d) Accidents. The facility must ensure from accident hazard	her expectation was that physician's order so that adequate amount of tube -(3) FREE OF ACCIDENT ISION/DEVICES ure that -	F 32	23		6/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 05/25/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	'	00/20/2011
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	and assistance device (n) - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure correct maintenance of bed to the following elemication of the following elemication of the following elemication of the resident or	facility must attempt to use ves prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited tents. The ent for risk of entrapment to installation. and benefits of bed rails with tent representative and obtain for to installation. The ed's dimensions are resident's size and weight. This not met as evidenced view and staff interviews the in Aide failed to secure the for of the facility van according structions before transporting reviewed for van dent #54. During transport Resident #54 fell backwards ding on her back and hitting	F 3	The statements made on this F Correction are not an admission not constitute an agreement wit alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correct constitutes the facility's allegatic compliance such that all alleged deficiencies cited have been or corrected by the date or dates i F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEV Corrective Action: Resident #54 Discharged from facility. Identification of other residents	n to and do th the in d State en or will Plan of etion on of d will be indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 BOILEST	_		، ا	2	
		345284	B. WING			l	25/2017	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2017	
				90	01 BETHESDA ROAD			
THE OAK	3			V	/INSTON SALEM, NC 27103			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 323	Continued From page	e 59	 F;	323				
	· -	d Resident #54 if she was			be involved with this practice:			
	alright, and checked				All residents have the potential to be			
		1 proceeded to lift Resident			affected by the alleged practice. On			
		ck into the wheelchair and			9/30/2016, the facility van was taken of	ut		
	-	acility. Immediate jeopardy			of operation through 10/5/2016. On			
	was lifted on 5/25/17	when the facility's			10/5/2017, the corporate van trainer			
	acceptable credible a	llegation of compliance was			completed the Vehicle Inspection: Safe	ty		
		will remain out of compliance			Inspection check list for the one facility			
		ity level D (no actual harm			owned van. No concerns were			
	•	e than minimal harm that is			identified.On 10/1/2016 the administrat			
		dy) to allow the facility time			began interviewing all alert and oriente	d		
	to monitor and fully in	· ·			residents that were transported on the			
	-	ng wheelchairs in the facility			facility owned van to ensure they were	- 14		
	van for resident trans	port.			secured by the shoulder and lap seatboand front and back floor retractors	eit		
	The findings included	·			according to facility policy and Q' Strain	nt.		
	Review of the manufa				manufacturer guidelines. This audit wa			
	"Q'Straint" provided to				conducted weekly for 4 weeks. No	3		
	-	ir facing forward in			concerns were identified. Employee #1			
		ply wheel locks or turn power			was terminated on 10/7/2016. Current			
	off.	,			residents that were transported on the			
	2. Attach tie-downs	into floor anchorages and			facility owned van from 10/6/2016 to			
	ensure they are locke				10/25/2016 have the potential to be			
	3. Attach the four ti	e-down hooks to solid frame			affected by this alleged practice. An au	dit		
	members or weldmer	nts, near seat level. Ensure			was completed on 05/24/2017 by the			
		t approximately 45 degrees,			Administrator to determine which			
	_	shown. Do not attach			residents were transported by the facili	ty		
		stic, or removable parts of			van from 10/6/2016 to 10/25/2016. 6			
	wheelchair.				Current residents were identified. On			
		wns are locked and properly			05/24/2017, the Director of Nursing			
		ary, rock wheelchair back tension retractor knobs to			interviewed the identified 6 alert and oriented residents that were transporte	Ч		
	take up additional we				10/6/2016 to 10/25/2016 for any safety			
		policy and procedure for			concerns during transports and to valid			
		n, with a revision date of			that the following technique was used the			
		n part: on page 4 of 8,			secure their wheelchair during	-		
		y: 1. Resident transportation			transportations: all 4 floor retractors are	9		
		by employees who have			hooked to the wheelchair, the seat belt			
		. Transportation aides must			attached across the residents lap and	-		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	TE SURVEY MPLETED
			A. BUILDIN	G		
		345284	B. WING			C 5/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2017
				901 BETHESDA ROAD		
THE OAK	3					
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 60	F 32	23		
	be current Nursing As	ssistants must also have		secured to floor restraints, and	I the	
	valid CPR training			shoulder strap is positioned ac		
	_	Provide basic first aid.		shoulder and secured to the la		
		s indicated such as no		alert and oriented residents sta	•	
	•	g. Do not move patient if		above procedures have been to		
		unless life is threatened"		their transports occurring from		
		mitted to the facility on		to 10/25/2016 and they did not		
		s of dementia without		safety concerns.	· · · · · ,	
	behaviors, cerebral ir					
	polyneuropathy.			Systemic Changes:		
				Director of Nursing and /or De	signee in	
	The Minimum Data S	Set (MDS), a significant		serviced all staff (full time, part	t time, and	
	change, dated 7/12/1	6 indicated Resident #54		PRN) to inform that the facility	/ must	
	had no impairment w	ith long or short memory and		ensure that the resident enviro	nment	
	she exhibited no beh	aviors. The MDS indicated		remains as free of accident ha	zards as is	
		e assistance of two staff for		possible; and each resident re	ceives	
	bed mobility, dressing	g and transfer. She was not		adequate supervision and assi	istance	
	ambulatory, and requ	ired extensive assistance of		devices to prevent accidents.		
	one staff member for	personal hygiene.		10/5/2016, 2 facility staff desig		
				aide in facility transportations		
		ortation Aide (TA) #1"s		checked off by the corporate v		
		e of the van dated 8/24/16		utilizing the skills checklist and		
		that included "Secure		manufacturer guidelines. The		
	•	ift Operation" and "Secure		van trainer has received trainir	-	
	-	with approved system		from Q' Straint/Surelock Nation	-	
	•	ncludes using seat belts to		Seminar products in September		
	-	ld using approved safety		The corporate van trainer utiliz		
		ks to secure the chair." Both		training he received, Q' Straint		
		checked" indicating she had		manufacturer guidelines, and a		
		vas able to perform the		checklist to educate van transp		
	tasks.			skills validation is also completed the staff member must demonst		
	Review of an inciden	t report dated 9/30/16 at 6:43		skills appropriately. This also in		
		nt #54 was observed during		educating the team members		
		rt, while in-route, to have her		to stop and call 911 for any ac		
		en viewed by TA #1 in her		occurs during transports. On		
		#1 stopped the van, found		training was completed by the		
		n her back in the wheelchair.		van trainer for facility staff desi	•	
	The incident report in			transport prior to completing a		
			1	i i i i i i i i i i i i i i i i i i i	, . 	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION (X3) DATE SU COMPLE		
		345284	B. WING			05/2	25/2017
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	_			9(01 BETHESDA ROAD		
THE OAKS	5			V	VINSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 61	F:	323			
	wheelchair fell backw	ards. Resident #54			transports. A quality review will also be	,	
	informed the van driv	er her wheelchair fell			implemented when transports are start	ed	
	backwards while the	bus (van) was turning.			back on 10/6/2016. The review include	es	
					the administrator or maintenance direc	tor	
		note dated 9/30/16 at 7:34			in their absence will observe facility var	ı	
	PM and signed by Nu	ırse #1, indicated Nurse #1			transports weekly for 2 weeks to ensur		
		ncident after Resident #54			residents and the chair are secured to	the	
	_	m eating dinner. After the			vehicle by visualizing that all 4 floor		
		meal, the nurse took her to			retractors are hooked to the wheelchair		
		ssment. The resident had			that the seat belt is attached across the	,	
	no "bumps or bruises				residents lap and secured to floor		
		noted on her body. Full			restraints, shoulder strap is positioned		
	_	r extremities was checked			across the shoulder and secured to the	;	
		esident #54 complained of			lap belt. The administrator will be		
	raised.	lder when her arm was			responsible for ensuring safe transportation of residents. In addition		
	raiseu.				this, alert and oriented residents will be		
	Review of the medica	al record revealed			interviewed asking if their wheelchairs	1	
		nents were initiated on			were secured and seat belts applied		
	9/30/16 at 7:34 PM as				according to Q'Straint manufacturer		
		ent #54 had no symptoms of			instructions. If errors are identified the		
	a head injury per the				employee will be suspended pending a	n	
	, , , , , , , , , , , , , , , , , , , ,				investigation of the allegations.		
	Review of the nurses	' note dated 10/1/16			This in service was completed by June		
	revealed an X-Ray wa	as ordered of the right			16th, 2017. Any Nurse (RNs, LPNs, fu		
	shoulder with negativ	e results			time, part time, and PRN) and member	of	
	for a fracture or disloc	cation. The X-Ray indicated			the interdisciplinary team who did not		
	Resident #54 had chr	ronic rotator cuff tear,			receive in-service training will not be		
	moderate osteoporos	is and osteopenia.			allowed to work until training is comple	ted.	
					This information has been integrated in	to	
	-	practitioner's progress note			the standard orientation training and in		
		ed the resident was seen			required in-service refresher courses for		
		wheelchair while inside the			all employees and will be reviewed by		
		as assessed and found to			Quality Assurance Process to verify the	it	
	_	motion of bilateral shoulders			the change has been sustained.		
	which was chronic. T						
	findings were reviewe	ea with no tracture or			Monitoring:		
	dislocation noted.	tod diagnaca as alternia			To ensure compliance, Director of Nurs		
	The progress note lis	ted diagnoses as chronic			or designee will monitor this issue usin	y	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ILTIPLE CONSTRUCTION (X3) DATE S DING			
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		345284	B. WING				25/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00//	20/2017
				9(01 BETHESDA ROAD		
THE OAK	8			W	VINSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 62	F	323			
	torn rotator cuff, osteo	oporosis and osteopenia.			the QA survey tool. A quality review wil	l be	
					implemented when transports are start	ed	
	Review of self-report	by the facility dated 10/7/16			back once we start using the facility		
	-	n allegation of neglect that			owned van. The director of nursing will		
		at 5:00 PM. The report			also review incident reports during dail	y	
		54 had tipped backward in			clinical meeting for accidents that may		
	the wheelchair during	· · · · · · · · · · · · · · · · · · ·			involve the van. If an event is identified		
		on included a statement by			the chart will be checked by the Directo		
		arrived at a doctor's office			of Nursing to ensure that the patient wa		
		/30/16, to pick the resident to the facility. She "secured			assessed promptly by the nurse. Char evidence will also be validated by	١	
		wheelchair with safety straps.			interviewing the patient and the nurse t	_	
	She placed the seatb	•			ensure that assessments were conduc		
	-	hrough the right side of the			promptly. If errors are the Quality	.00	
		ecuring both straps in place.			Assurance Committee will review the		
		left turn onto [Street Name]			event for appropriate corrective actions	j.	
		ormed her the wheelchair			This will be done for 4 weeks, and ther		
	had fallen over. She	looked into the rearview			monthly for three months. The Director	of	
	mirror and realized th	e resident's foot was			Nursing will review all incidents reports		
		led to drive until she was			daily during daily clinical quality of life		
		d secure place to park. She			meeting (Monday through Friday).		
		t with the resident to ensure			Reports will be presented to the weekly	/	
		She was about 2 blocks			QA Committee by the Administrator or		
	l -	she stopped the van. She			designee to assure corrective action		
	l	she was alright and/or hurt.			initiated as appropriate. Any immediate	_	
		d her that she had hit the			concerns will be brought to the Directo		
	resident had no appa	against the van floor. The			Nursing or Administrator for appropriate action. Compliance will be monitored a		
	proceeded to "secure				ongoing auditing program reviewed at		
	•	e resident and secure the			Weekly Quality of Life Meeting. Weekly		
		After the wheelchair was			QA Committee meeting is attended by		
	. •	straps in place, she lifted the			Administrator, Director of Nursing, MDS		
		ner into the wheelchair.			Coordinator, Unit Manager, Support		
	•	o see if the resident had any			Nurse, Therapy, HIM, Dietary Manager		
	_	ses. She then secured her			Social Services.		
	with the seatbelt and	proceeded back to the					
		the resident. Upon arrival					
	· ·	oaded the resident and					
	brought her into the b	ouilding. She notified the				ļ	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	E SURVEY IPLETED
		345284	B. WING		0.6	C 5/ 25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00	5/25/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	facility to an assisted neighboring state. Sinterview. Interview on 5/23/17 Administrator reveal return demonstration wheelchair in the var was determined the securing device corrupulled it tight to securing device administrator's office administrator's office administrator. Furth had been terminated will be in-serviced by staff before using the administrator did expusing the van after the At present, there was when the van would had occurred during prior to 9/30/16. Interview with the Di 5/23/17 at 11:10 AM an incident had occuran. The resident till transport from a doc Further interview revenue an investigation of the state	een discharged from the diving facility in a she was not available for at 8:46 AM with the eed she had the TA#1 do a not how she tied down the m. After the demonstration, it TA#1 had not placed the ectly to lock it and had not are it. TA #1 was the "back ninistrator explained the van by the facility since 9/30/16. A ne van until yesterday to the van were in the er interview revealed TA#1 on 10/7/16. The main TA#2 of the corporate management er van again. The press the facility would be ne training was completed. It is not a date certain as to be used. No other incidents transport with the facility van rector of Nursing (DON) on revealed she received a call arred with Resident #54 in the ted backwards during tor's visit to the facility. It is realed she did not remember administrator had completed	F 32	23		

NAME OF PROVIDER OR SUPPLIER THE OAKS STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD	(X5) COMPLETION
WHO TON GALLIN, NO 27 103	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 323 Continued From page 64 presence of the Administrator. TA#1 was suspended pending the outcome of the investigation and all transports using the facility van was suspended on 9/30/17. Interview on 5/23/17 at 8.46 AM with the Administrator revealed she had TA#1 do a return demonstration of how she tied down the wheelchair in the van. After the demonstration, it was determined TA #1 had not placed the securing device correctly to look it and had not pulled it tight to secure it. TA#1 was the "back up" driver. It was determined in the facility investigation TA#1 did not follow protocol after the incident. The Administrator would expect the driver to call 911, not move the resident and not proceed to the facility. The van driver had her own personal cell phone when the incident occurred. Interview with the Nurse #1 on 5/23/17 at 1:02 PM revealed TA#1 had not informed her of the incident. Nurse #1 stated the Administrator had approached her and asked her to complete an incident report on the occurrence. The nurse explained she had not observed the resident before she was brought into the facility. Nurse #1 completed the incident report and assessed the resident after Resident #54 had finished eating supper. She clarified there were no injuries observed during her assessment. An attempt to call TA#1 on 5/23/17 at 3:00 PM was made with no answer at the phone number provided. Follow up interview with the Administrator on 5/24/17 at 4:40 PM revealed the facility van had	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		05/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/23/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 323	2016. Review of th indicated it was con corporate staff men	ctober 6, 2016 to October 25, e re-training of TA#2 and #3 npleted on 10/5/16 by a nber.	F 32	3	
	Allegation of Comple Credible Allegation Corrective Action for The facility immedia incident involving R 9/30/2016 in which transported back to appointment. In rou informed the van trawheelchair had falle transportation aide mirror and realized The van transportat drive until she was place to park, while sure patient remain transportation aide facility when she ste transportation aide was alright and or had transportation aide when the proceeded to so release and move pusheelchair upright. Upright and secured the van transportation the	r Affected Residents ately began investigating the esident #54 occurring on resident was being the facility after a medical te to the facility Resident #54 ansportation aide that her			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		MPLETED
		345284	B. WING _		,	C 05/25/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		33/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323		nsportation aide then secured	F3	223		
	patient with seatbelt facility while continui arriving to the facility unloaded the resider facility dining room. Informed Administrate administrator then not that resident was on a doctor's appointment transportation aide so view mirror and saw. The administrator count the van transportation aide so view mirror and saw. The administrator count the van transport bus and found reside wheelchair on the fload Administrator was not resident was in the dadministrator finished incident, the nurse whind the resident was independently and was residents. Nurse information.	and proceeded back to the ng to talk to patient. Upon the van transportation aide of and brought her into the The van transportation aide or of the incident. The otified the nurse on the hall the facility van coming from and she looked in her rear resident's legs up in the air. Intinued to inform the nurse tation aide then stopped the ent lying on her back in her tor. At that time, when otifying the nurse, the lining room. When the dependent of the dentity in the dining room to be eating her dinner was talking with other timed resident that she				
	incident that happen told the nurse that shand asked if the nurse done with dinner. Resigns of distress, no injury were noted. On her dinner, the nurse resident back to the the bed. The nurse cassessment. The nu with a flash light and discolorations. Full raher extremities. Nurse all extremities well be	an assessment due to the ed in the van. Resident then he wanted to finish dinner se could wait until she was esident did not show any apparent or obvious signs of ince the resident completed e then proceed to take from and transferred her to completed a full body assessed residents head observed no bumps or ange of motion was done to be noted that resident moved but did complain about her gowhen she raised her arm				

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE COMP	LETED
	345284	B. WING			2 5/2017
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/2	25/2017
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
up. Neurochecks we within normal limit. were Temperature /72. Resident #54's Elder Care were caincident. Order obta Physician Assistant X -Ray to right sho 9/30/2016. Impress of acute fracture or compatible with chamoderate osteopor osteopenia. On 9/30/2016, the operation through was completed on transportation comnecessary transport 10/1/2016 to 10/5/2 #1 was suspended subsequently termi 10/5/2016, the corp the incident and deevent was the transthe front floor retrawheelchair according guidelines. The facility owned from 9/30/2016 through a facility staff desig transportations were van trainer utilizing	vital signs were obtained and 98.7, P-87, and R -20 B/P 125 a Daughter and Physicians alled and informed of the ained for a right shoulder x ray t. ulder was completed on sion: No radiographic evidence of dislocation, findings ronic rotator cuff tear, rosis demonstrated, moderate of acility van was taken out of 10/5/2016. A 24 hour report 10/7/2016. Outside pany was used to schedule test for the facility from 2016. The involved employee on 9/30/2016 and nated on 10/7/2016. On porate van trainer investigated determined the root cause of this esportation aide failed to secure cors to the resident's right of 2016. On 10/5/2016, and was taken out of operation ough 10/5/2016. On 10/5/2016, mated to aide in facility re checked off by the corporate the skills checklist and Q'	F 32	· ·		
wheelchair according guidelines. The facility owned from 9/30/2016 through 2 facility staff design transportations were van trainer utilizing Straint manufacture van trainer has reconstraint/Surelock Na	van was taken out of operation ough 10/5/2016. On 10/5/2016, mated to aide in facility re checked off by the corporate the skills checklist and Q' er guidelines. The corporate eived training directly from Q' ational Training Seminar				
	SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM SUPPLIER ON SUPPLIER SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM SUPPLIER REGULATORY CONTINUED FROM SUPP	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 up. Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R -20 B/P 125 /72. Resident #54's Daughter and Physicians Elder Care were called and informed of the incident. Order obtained for a right shoulder x ray Physician Assistant. X -Ray to right shoulder was completed on 9/30/2016. Impression: No radiographic evidence of acute fracture or dislocation, findings compatible with chronic rotator cuff tear, moderate osteoporosis demonstrated, moderate osteopenia. On 9/30/2016, the facility van was taken out of operation through 10/5/2016. A 24 hour report was completed on 9/30/2016 and a 5 day report was completed on 10/7/2016. Outside transportation company was used to schedule necessary transports for the facility from 10/1/2016 to 10/5/2016. The involved employee #1 was suspended on 9/30/2016 and subsequently terminated on 10/7/2016. On 10/5/2016, the corporate van trainer investigated the incident and determined the root cause of this event was the transportation aide failed to secure the front floor retractors to the resident's wheelchair according to Q' Straint manufacturer	A BUILDING 345284 B. WING SOVIDER OR SUPPLIER S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 up. Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R -20 B/P 125 //2. Resident #54's Daughter and Physicians Elder Care were called and informed of the incident. 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The facility owned van was taken out of operation from 9/30/2016 through 10/5/2016. On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training Seminar products in September 2016. The corporate van	A BUILDING 345284 ROVIDER OR SUPPLIER 345284 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 up. Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R-20 B/P 125 7/2. Resident #54's Daughter and Physicians Elder Care were called and informed of the incident. Order obtained for a right shoulder x ray Physician Assistant. X. 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On 10/5/2016, 2 facility staff designated to aide in facility transportations were checked off by the corporate van trainer utilizing the skills checklist and Q' Straint/Surelock National Training Seminar products in September 2016. The corporate van	A BUILDING 345284 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHERDAR ARAD WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES (IEACH DEFICIENCY MUST BET PRECEDED BY FULL, RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 67 up, Neurochecks were initiated and were all within normal limit. Vital signs were obtained and were Temperature 98.7, P-87, and R-20 B/P 125 772. Resident #54's Daughter and Physicians Elder Care were called and informed of the incident. Order obtained for a right shoulder x ray Physician Assistant. X. 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The corporate van trainer this skells checklist and Q' Straint manufacturer guidelines. The corporate van trainer has received training directly from Q' Straint's unelock National Training Seminar products in September 2016. The corporate van trainer has received training directly from Q' Straint's unelock National Training Seminar products in September 2016. The corporate van trainer has received training directly from Q' Straint's unelock National Training Seminar products in September 2016. The corporate van trainer

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· /	MPLETED
		345284	B. WING			C 05/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		33/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	also completed when demonstrate the skill included educating to the need to stop and occurs during transprompleted by the co 10/5/2016 prior to the completing any vanivan was placed back through 10/25/2016. Van was then utilized 5/23/2017. The facility owned van since 10/0 owned van keys are one has access to the vanival be out of series designated and trainstrainer. Resident #54 was not were placed on her word on 10/3/2016 Employed the administrator and into the van, securin patient's wheelchair placed the seatbelt sand through the righ securing both straps. The root cause of the not follow Q' Straint facility policy in secur wheelchair prior to concertive Action for Residents. On 9/30/2016, the facility portion through 10 corporate van trainer.	reters. A skills validation is re the staff member must appropriately. This also he new team members on a call 911 for any accident that corts. Training was reporate van trainer on the transportation aide transports. The facility owned is in service from 10/6/2016. On 10/26/2016 facility owned is by sister facility through the transports of the facility with the Administrator and no the keys. The facility owned wice until new facility staff are the dother to recall how the straps wheelchair. The facility owned with the incident to dother the stated "I loaded the patient of all four bases of the with safety straps. I also strap around patient's waist at side of patient's armrest, in place." The incident is employee #1 did manufacturer guidelines and ring the resident and ompleting the transport.	F 32	23		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345284	B. WING		05/25/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 323	identified. On 10/1/2016 the adinterviewing all alert were transported on ensure they were selap seatbelt and from according to facility manufacturer guidel conducted weekly for identified. Employee #1 was te Current residents the facility owned van from have the potential to practice. An audit was by the Administrator were transported by 10/6/2016 to 10/25/2 were identified. On 05/24/2017, the interviewed the iden residents that were the 10/25/2016 for any set transports and to vate technique was used during transportation hooked to the wheel attached across the floor restraints, and positioned across the floor restraints, and positioned across the stated the above profor their transports of 10/25/2016 and they concerns. Systematic Changes	Iministrator began and oriented residents that the facility owned van to cured by the shoulder and at and back floor retractors policy and Q' Straint ines. This audit was ar 4 weeks. No concerns were rminated on 10/7/2016. The twere transported on the com 10/6/2016 to 10/25/2016 to be affected by this alleged as completed on 05/24/2017 to determine which residents the facility van from 2016. 6 Current residents Director of Nursing tified 6 alert and oriented transported 10/6/2016 to safety concerns during lidate that the following to secure their wheelchair has: all 4 floor retractors are chair, the seat belt is residents lap and secured to the shoulder strap is e shoulder and secured to art and oriented residents lap and secured to the shoulder strap is e shoulder and secured to art and oriented residents lap and secured to the shoulder strap is e shoulder and secured to art and oriented residents lap and secured to the shoulder strap is e shoulder and secured to art and oriented residents lap art	F 32	3	
	On 10/5/2016, 2 fac	s ility staff designated to aide in ns were checked off by the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345284	B. WING _				25/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 901 BETHESDA ROAD WINSTON SALEM, NC 27103		001	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 323	and Q' Straint manufacorporate van trainer directly from Q' Straint Seminar products in Scorporate van trainer received, Q' Straint maskills checklist to edskills validation is also member must demonappropriately. This also new team members of 911 for any accident transports. Training accorporate van trainer transportation aide contransports. A quality review will a transports are started review includes the addirector in their absert ransports weekly for and the chair are secured visualizing that all 4 fithe wheelchair, that the across the residents is restraints, shoulder significant and oriented resident and oriented resident and oriented residenting if their wheelchair.	utilizing the skills checklist acturer guidelines. The has received training of September 2016. The utilizes the training he hanufacturer guidelines, and ducate van transporters. A completed where the staff strate the skills so included educating the on the need to stop and call that occurs during was completed by the on 10/5/2016 prior to the ompleting any van Iso be implemented when back on 10/6/2017. The dministrator or maintenance nee will observe facility van 2 weeks to ensure residents ured to the vehicle by oor retractors are hooked to the seat belt is attached ap and secured to floor trap is positioned across the	F3				
	instructions. If errors will be suspended pe allegations. Any staff member determine transportation or any	are identified the employee nding an investigation of the signated to aide in facility in-house staff involved with tion, who did not receive					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			С	
NAME OF PE	ROVIDER OR SUPPLIER	343204	B. Wille _	STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	<u> </u>	/25/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	participate in facility to facility owned van und Validation of the credi included review of the safety and emergency the two current TA's to of the safety training, was CPR certified, recompleted by the corpvisualizing the van ke administrator's office. Immediate jeopardy v PM. 483.60(i)(1)-(3) FOOI STORE/PREPARE/SI (i)(1) - Procure food ficonsidered satisfacto authorities. (ii) This may include for from local producers, and local laws or regulations from using progradens, subject to consafe growing and food (iii) This provision does from consuming foods (ii)(2) - Store, prepare	not be allowed to work or cansportation using the cil training is completed. ble allegation of compliance extraining information on y procedures, interviews of coverify their understanding verification the van driver view of the van audits corate staff member and ys kept in the vas lifted on 5/25/17 at 7:00 D PROCURE, ERVE - SANITARY From sources approved or rry by federal, state or local cood items obtained directly subject to applicable State ulations. Is not prohibit or prevent roduce grown in facility compliance with applicable	F3			6/19/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 05/25/2017
NAME OF PE	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 371	foods brought to resvisitors to ensure sath andling, and consult this REQUIREMEN by: Based on observation facility failed to label clean 1 of 3 resident Nourishment Refriger Findings included: During an observation nourishment refriger medication room at a 4-unopened food ite ownership (1-containentree, 1-can soda a Dietary Manager (DI not purchased by the There were also large the refrigerator and a observed on the bott the bins in the refrigerator.	egarding use and storage of idents by family and other fe and sanitary storage, mption. T is not met as evidenced ons and staff interviews, the food items and properly s' nourishment refrigerators. erator #3. On on 5/24/17 at 10:04 a.m., ator #3 located in the nursing station #3 contained ms without names of the of ice cream, 1-frozen and 1-bottled soda). The My indicated these items were a facility's dietary services, we yellowed stains throughout a large red sticky, stain was soon shelf and inside one of the erator.	F 37	The statements made on this Plan Correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken of take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indice F 371 Food Procedure Corrective Action for Resident Affect An audit tool was put into place to a safe food storage practices and cleanliness of Nourishment areas of daily basis.	and do ne ate or will of be cated. cted monitor
	DM revealed that the responsible for keep refrigerators and the She also stated that were for the storage and for the residents During an interview Environmental Servi	nourishment areas clean. the nourishment refrigerators of food items belonging to		Corrective Action for Resident Pote Affected All residents have the potential to be affected by this alleged deficient properties. The audit tool began on June 5, 20 monitor safe food storage practices cleanliness of Nourishment Areas. Systemic Changes On 5/24/17 items that were not propagate in the properties of th	pee actice. 117 to s &

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRU G			LETED
		345284	B. WING _				C 25/2017
NAME OF P	ROVIDER OR SUPPLIER			901 BETHE	DRESS, CITY, STATE, ZIP CODE SDA ROAD I SALEM, NC 27103	1 037.	23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	each of these depart cleaning the nourish and when needed. T	made between ces and Dietary Services that ments would alternate ment refrigerators weekly he Supervisor revealed there dule or auditing report	F3	discar the retain and in- 2017, the Di were a includ areas in-hou receiv allower compl includ storag All more completing the we that the Starequirall Die by the that the Dietitia will me Qualit 5 days week! by Qui comm week! comm as app will be or Adri	rded, housekeeping was notified frigerator was cleaned. service was conducted on May 2 June 3, 2017 and June 5, 2017 retary Manager. Those who atternall dietary staff. The in-service to red maintenance of food storage in the nourishment rooms. Any use staff member who did not re in-service training was not be red to work until training was reted. Information presented red monitoring of nourishment for ge areas. Onitoring tools/audits will be reported retely/monthly QA meeting. Information has been integrated in red in-service refresher courses for each and and orientation training and in red in-service refresher courses for each reternal process to whe change has been sustained. The control on this issue using the "Dietary Assurance Process to whe change has been sustained." Assurance Audit" tool. This wis solve for four weeks and then by times two months or until resolution on the times that the process will be given to the process of the condition of the process will be given to the process of	by ded ppic od to nto nto nthe or ewed erify	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		345284	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	343204	B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD	•	05/25/2017
THE OAK				901 BETHESDA ROAD WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE
F 371	Continued From page	e 74	F 3	ongoing auditing program rev Weekly Quality of Life Meeting QA Committee meeting is atte Administrator, Director of Nurs Coordinator, Unit Manager, S Nurse, Therapy, Health Inform Manager, Dietary Manager, S Services, and Medical Director	g. Weekly ended by sing, MDS upport nation Social	6/19/17
SS=J	483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each rethis REQUIREMENT by: Based on record rev facility's administration manufacturer's recondaresident in the facility Resident #54 hitting It The facility administrations and follow when the wheelchair resident. After the refacility staff moved the wheelchair and drove without assessment for potential injury. This #54) of 1 sampled resusing the facility's variations.	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced iew and staff interview, the infailed to operationalize mendations for transporting ty van resulting in a fall with ner head on the van floor. The ation failed to enforce a ure the resident's wheelchair ing to manufacturer's we emergency procedures fell backwards with the sident fell in the van, the eresident back into the eresident back to the facility rom licensed staff for was evident in 1 (Resident sident who was transported		The statements made on this Correction are not an admissi not constitute an agreement valleged deficiencies. To remai compliance with all Federal at Regulations the facility has ta take the actions set forth in the Correction. The Plan of Correctionstitutes the facility's allegated compliance such that all allegate deficiencies cited have been corrected by the date or dates F490 EFFECTIVE ADMINIS /RESIDENT WELL-BEING Corrective Action: Resident #54 Discharged from facility.	ion to and do with the in in nd State ken or will his Plan of ection ation of jed or will be s indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _		l .	_
		345284	B. WING				C / 25/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	20/2011
				90	01 BETHESDA ROAD		
THE OAK	5			W	/INSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 490	Continued From page	e 75	 F	490			
		ortation Aide #1 failed to			Identification of other residents who ma	201	
		ir to the facility van floor			be involved with this practice:	ау	
		cturer's recommendation.			All residents have the potential to be		
	_	wheelchair tipped backwards			affected by the alleged practice.		
		nding on her back and hitting			On 9/30/2016, the facility van was take	n	
		floor. Transportation Aide#1			out of operation through 10/5/2016. On		
		d Resident #54 if she was			10/5/2017, the corporate van trainer		
	alright, and checked				completed the Vehicle Inspection: Safe	etv	
		1 proceeded to lift Resident			Inspection check list for the one facility	-	
		ack into the wheelchair and			owned van. No concerns were identifie		
	,	facility. Immediate jeopardy			On 05/24/2017 the Clinical RN consulta	ant	
	·	5/17 when the facility's			met with the administrator to determine)	
		allegation of compliance was			who the facility utilized as facility van		
	-	will remain out of compliance			drivers and that the designated drivers		
	at a scope and sever	ity level D (no actual harm			met the following criteria: Resident		
	with potential for mor	e than minimal harm that is			transportation should be completed by		
	not immediate jeopar	dy) to allow the facility time			employees who have been trained to d	0	
	to monitor and fully ir	mplement the new			so. Transportation aides must be curre	ent	
	procedures for securi	ing wheelchairs in the facility			Nursing Assistants or Emergency		
	van for resident trans	sport.			Medication Technicians. They must als	30	
					have valid CPR training. All van driver	S	
	Findings included:				must hold a valid North Carolina driver		
		Based on record review and			license, have had a drivers license DM		
		acility Transportation Aide			check, and have had documented train	ing	
		ure the wheelchair to the floor			on van usage prior to transportation of		
	-	ording to manufacturer's			residents. In addition to this, the		
		ansporting one of one			administrator was educated on ensurin	•	
		van transportation, Resident			that staff designated to transport reside	ents	
	#54. During transpor				on the facility van understand the		
		kwards with the resident			importance and expectation of the		
		and hitting her head on the			administrator for following Q' Straint		
		#54 complained of right			manufacturer guidelines when		
	shoulder pain after th	ie incident.			transporting residents. There will be no)	
	2 Cross rafor: E200	Based on record review and			tolerance of transportation staff not	\r	
					following the manufacturer guidelines of		
		cility TA#1 failed to secure ding to manufacturer's			having an attitude of non-compliance.1 Employee was designated as facility va		
		Resident #54, to the floor of			drivers meeting the above criteria. On	21 I	
		e transport. During transport			05/24/2017 the Clinical RN Consultant		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _		l ,	С
		345284	B. WING				25/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	_			90	01 BETHESDA ROAD		
THE OAK	5			W	VINSTON SALEM, NC 27103		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 490	Continued From page	e 76	F	490			
	the wheelchair with F	Resident #54 fell backwards			reviewed the skills check list for the		
	with the resident land	ding on her back and hitting			designated van driver to ensure that th	е	
		floor. The TA#1 failed to call			skills check list were completed by the		
	911 and the facility at	fter the incident and moved			corporate van trainer on 10/5/2016 or		
		a sitting position in the			sooner. On 9/30/2016, the one facility		
		ncident. Resident #54			owned van was removed from operation	n	
	complained of right s	houlder pain after the			and outside transportation company wa		
		or one of one residents			used to scheduled necessary transport		
	transported in the fac	cility van Resident #54.			for the facility from 10/1/2016 to 10/5/2016.		
	On 5/24/17 at 3:45 P	M, the Administrator was			Systemic Changes:		
		ediate jeopardy. The facility			On 05/24/2017, the Clinical RN Nurse		
		ole credible allegation of			Consultant educated all current FT, PT	-	
		17 at 2:22 PM. The credible			and PRN employees who operate the		
	allegation included:				facility owned van were educated on th		
					following Resident Transportation Police		
	Credible Allegation for	or F490			and Procedure.	,	
	Corrective Action for				Transportation Policy:		
	The facility immediate	ely began investigating the			Resident transportation should be		
	-	ident #54 occurring on			completed by employees who have be	en	
	9/30/2016 in which re				trained to do so. Transportation aides		
		he facility after a medical			must be current Nursing Assistants or		
		e to the facility resident #54			Emergency Medication Technicians. T	hev	
		nsportation aide that her			must also have valid CPR training.	,	
	wheelchair had faller				2. PRIOR to operating a facility		
	transportation aide th	nen looked into the rearview			transportation vehicle, the TSP-101 DA	AILY	
		ne patient's foot was upright.			VAN CHECKLIST will be completed. A	All .	
		on aide then proceeded to			residents will be properly secured with		
	drive until she was al	ble to find a safe and secure			appropriate strapping of wheelchairs		
	place to park, while to	alking to the patient to make			and/or seatbelt placement. Under no		
		d conscious. The van			circumstances will the van be operated		
	transportation aide w	as about two blocks from the			without adequate seatbelts for every		
	facility when she stop	pped the van. The van			resident being transported. If there is a	an	
	transportation aide th	nen asked resident if she was			issue identified on the daily checklist, it		
	alright and or hurt. Th	ne patient per the van			must be reviewed and corrected prior t	0	
	transportation aide ha	ad no apparent injuries so			the van being used if it is a patient safe	ety	
	she proceeded to see	cure the seatbelt strap to			issue.		
	release and move pa	tient so she could secure the			3. The van will also be inspected by th	е	
	wheelchair upright. C	once the wheelchair was			maintenance director or designee on a		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES			OIVID IN	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
						С
		345284	B. WING			/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			و ا	01 BETHESDA ROAD		
THE OAK	S			VINSTON SALEM, NC 27103		
24.0.1=	CUMMA DV CT	TATEMENT OF DEFICIENCIES		, T	CTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 490	Continued From page	e 77	F 490			
		with all four straps in place,		weekly basis. Results of the ins	nection	
	1	n aide lifted the patient		will be documented on form TSF	•	
	placing her into the w	· · · · · · · · · · · · · · · · · · ·		WEEKLY CHECKLIST.	102	
	1 .	en checked to make sure		4. All van drivers must hold a va	alid North	
	· ·	ve any open wounds and or		Carolina drivers license, have ha		
		sportation aide then secured		drivers license DMV check, and		
	I .	and proceeded back to the		documented training on van usa		
	1 -	ng to talk to patient. Upon		transportation of residents.	J -	
		the van transportation aide		5. In the event of an emergency	, call 911.	
		t and brought her into the		Provide basic first aid. Impleme	nt CPR if	
	facility dining room. T	he van transportation aide		it in indicated such as no heartbe	eat or	
	informed Administrate	or of the incident. The		breathing. Do not move patient	if injury is	
	administrator then no	tified the nurse on the hall		suspected or unless life is threat	ened.	
	that resident was on t	the facility van coming from		6. All wheelchairs used for trans	•	
	a doctor's appointme	nt when the van		of residents must be approved for		
	· ·	aid she looked in her rear		transport use. If a personally-ow		
		resident's legs up in the air.		wheelchair (not a wheelchair pro		
		ntinued to inform the nurse		arranged by the facility) is to be		
	1	tation aide then stopped the		transportation, it must be approv	•	
		nt lying on her back in her		Liberty Risk Management to dete	ermine if it	
	wheelchair on the floo			is safe for transport use.		
		tifying the nurse, the resident		7. Power wheelchairs must be f		
	_	m. When the administrator		transportation appropriate straps		
		nurse of the incident, the		correct tie down procedures in o		
	nurse went into the d	0		ready for use in the transportation		
	_	ner dinner independently and		they do not have manufacturer in safety strap attachment points or		
	resident that she nee	r residents. Nurse informed		be fitted with attachment devices		
		ne incident that happened in		manufacturer, they cannot be co		
		en told the nurse that she		safe for transport.	Halueleu	
		er and asked if the nurse		8. All transportation Aids must h	ave	
	could wait until she w			completed annual transportation		
		w any signs of distress, no		training.	23.00	
	I .	signs of injury were noted.		9. Training must include the safe	е	
		mpleted her dinner, the		procedures for loading and unload		
	I .	o take resident back to the		residents, the safe and proper us		
	T	her to the bed. The nurse		approved safety restraint system		
		assessment. The nurse		by the manufacturer of the trans		
	1	ead with a flash light and		van and emergency measures to	•	

OE: TE: T	OT OIL MEDIO, ILLE O	WEDIO/ ND OLIVIOLO				<u> </u>	7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345284	B. WING			l	25/2017
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THE OAK	•			W	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 490	of motion was done to	e 78 or discolorations. Full range o her extremities. Nurse oved all extremities well but	F	490	residents from the safety restraint system 10. Immediately notify the Administrate when an incident occurs during a van		
	did complain about he when she raised her initiated and were all	er right shoulder hurting arm up. Neurochecks were within normal limit. Vital and were Temperature 98.7,			transport regardless of how minor the incident is. This includes resident and non-resident incidents. Incidents include but are not limited to: fall from	le	
	P-87, and R -20 B/P Daughter and Physici and informed of the ir	125 /72. Resident #54 ans Elder Care were called acident. Order obtained for a			wheelchair, equipment malfunction, refusal of resident to utilize safety belts and injury of any nature. Administrator	;,	
	right shoulder x ray P X -Ray to right should 9/30/2016. Impressio of acute fracture or di	ler was completed on n: No radiographic evidence			phone number 336-830-1356 The following amendment to the policy to insure safety of residents during load and application of the safety restraint		
	compatible with chror				system; Item #1: All wheelchairs used in transportation		
	operation through 10/ was completed on 9/3	cility van was taken out of 5/2016. A 24 hour report 30/2016 and a 5 day report			must have foot rests in place (attached the chair) during loading, transport and unloading of residents. It has been		
	necessary transports	ny was used to schedule for the facility. The involved			determined that the resident's feet mus be on the wheelchair foot rests to preve feet and toes being caught or pinched	ent in	
	subsequently termina	spended on 9/30/2016 and ted on 10/7/2016. On ate van trainer investigated			the lift bridge plate during lift operations resulting in injury. Foot rests can help keep feet in a position that will not allow	to	
		rmined the root cause of this ortation aide failed to secure			toes to slide under the bridge plate. If chair being used for transportation doe not have foot rests attached at the time	s	
	wheelchair according guidelines.	to Q' Straint manufacturer			transport, appropriate foot rests are to located and attached to the chair prope	be	
	from 9/30/2016 through 2 facility staff designation				or another chair with foot rests is to be used. It is recommended the transportation aids set aside a wheelch	nair	
	van trainer utilizing th	checked off by the corporate e skills checklist and Q' guidelines. The corporate			for transportation use ahead of time to void the necessity of locating and fitting another wheelchair.	9	
		ed training directly from Q'			Item #2: All wheelchairs used in transportation		

CENTER	S FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345284	B. WING _			05/	25/2017
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
	_			90	01 BETHESDA ROAD		
THE OAK	S			W	/INSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 490	Continued From page	e 79	F4	90			
	_	er 2016. The corporate van			must be of the types that have remova	hle	
	-	ining he received, Q' Straint			arm rest. Access to the unrestricted by		
		nes, and a skills checklist to			of the wheelchair seat is required to		
	_	ters. A skills validation is			secure the lap safety belt in place over	the	
		e the staff member must			resident's lap. Placing the lap belt		
	· ·	s appropriately. This also			through the underside of the arm rest		
		ne new team members on			does not allow the belt to restrain the		
	the need to stop and	call 911 for any accident that			resident at the hip. The safety lap belt		
	occurs during transpo	orts. Training was			must cross over the lap from hip to hip	to	
	completed by the cor	porate van trainer on			keep the resident from slipping out of t	he	
	10/5/2016 prior to the	transportation aide			seat.		
	completing any van ti	ransports. The facility owned			Item #3:		
	·	in service from 10/6/2016			Wheelchair Floor restraints are never t		
		On 10/26/2016 facility owned			be attached to the cross (X) bars of the		
		by sister facility through			wheelchair. The cross bars are not pa		
		y has not utilized the facility			the frame of the chair and will collapse		
		26/2016 and the facility			the chair is forced on its side as in a ha		
		with the Administrator and no			turn. All floor straps are to be attached	סז נס	
		e keys. The facility owned vice until new facility staff are			the frame at or above the point where welded joints connect the frame. This	ie	
		ed by the corporate van			typically found where the wheels or wh		
	trainer.	ed by the corporate van			casters are attached. Item #4	CCI	
	Resident #54 was no	ot able to reenact the			Geriatric Chairs can never be used for		
		able to recall how the straps			transport. Gerri Chairs have no way	O	
	were placed on her w	•			lock the reclining feature of the chair a		
		yee reenacted the incident to			may fall into a reclining position during		
		stated "I loaded the patient			transport. IN the event of a chair reclir	ing	
	into the van, securing				during transport the safety harness	Ü	
	patient's wheelchair	with safety straps. I also			system will not protect the resident and	t	
	placed the seatbelt st	trap around patient's waist			may result in a serious or fatal event.		
	and through the right	side of patient's armrest,			Item #5		
	securing both straps	in place."			Power Wheelchairs must be approved	for	
		incident is employee #1 did			transportation before they can be used	for	
		nanufacturer guidelines and			transport of a resident. If they are not		
	facility policy in secur				considered safe for transport, the facili-	-	
		empleting the transport.			must provide a facility approved chair f	or	
	Corrective Action for	Potentially Affected			the resident transportation needs.		
	Residents				Item #6		
	On 9/30/2016, the fac	cility van was taken out of			Unoccupied wheelchairs will no longer	be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	' '	SURVEY PLETED
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		345284	B. WING				/25/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2017
					01 BETHESDA ROAD		
THE OAK	8				VINSTON SALEM, NC 27103		
24.0.15	CUMMADVCT	TATEMENT OF DEFICIENCIES			· 		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 80	F.	490			
		/5/2016. On 10/5/2017, the			transported on the facility van.		
		completed the Vehicle			This information has been integrated in	ito	
	T	spection check list for the			the standard orientation training and in		
	one facility owned va				required in-service refresher courses for		
	identified.				all employees who operate the facility		
	On 05/24/2017 the C	linical RN consultant met			and will be reviewed by the Quality		
	with the administrator	r to determine who the			Assurance process to verify that the		
	_	lity van drivers and that the			change has been sustained.		
	_	et the following criteria:			A quality review will also be implement		
	·	on should be completed by			when transports are started back once		
		been trained to do so.			start using facility owned van. The revi		
	•	must be current Nursing			includes the administrator or maintena	nce	
		ency Medication Technicians.			director in their absence will observe	4-	
		valid CPR training. All van alid North Carolina drivers'			facility van transports daily for 2 weeks ensure residents and the chair are	ιο	
		Irivers' license DMV check,			secured to the vehicle by visualizing th	at	
	i i	ented training on van usage			all 4 floor retractors are hooked to the	aı	
		of residents. In addition to			wheelchair, that the seat belt is attached	hd	
	-	r was educated on ensuring			across the residents lap and secured to		
		to transport residents on the			floor restraints, shoulder strap is		
	facility van understan				positioned across the shoulder and		
	_	ministrator for following Q'			secured to the lap belt. The administra	itor	
	Straint manufacturer	guidelines when transporting			will be responsible for ensuring safe		
	residents. There will I	be no tolerance of			transportation of residents. In addition	to	
	transportation staff no	ot following the manufacturer			this, alert and oriented residents will be	:	
	guidelines or having a	an attitude of			interviewed asking if the transporter		
	non-compliance.				secured both front and back safety		
		ignated as facility van drivers			harnesses as well as the wheelchair to	the	
		iteria. On 05/24/2017 the			van floor. If errors are identified the	_	
		nt reviewed the skills check			employee will be suspended pending a	n	
	the skills check list we	I van driver to ensure that			investigation of the allegations. The administrator and director of nursing the street of the stree	na	
		on 10/5/2016 or sooner.			attended the van training on 10/5/2016	-	
		e facility owned van was			provided by the corporate van trainer to		
	removed from operat	•			ensure proper knowledge of the safety		
	•	iny was used to scheduled			harness system in order to verify that it		
	necessary transports				completed correctly.	-	
	10/1/2016 to 10/5/20	•			Any staff member designated to aide in	1	
		n was taken out of operation			facility transportation or any in-house		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ² A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345284	B. WING				0
NAME OF D		343204	D. WING		27DEET ADDDESS SITV STATE 7/D SODE	05/	25/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	S				001 BETHESDA ROAD		
				,	WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 490	2 facility staff designa	gh 10/5/2016. On 10/5/2016,	F	490	staff involved with the facility transportation, who did not receive in-service training will not be allowed to)	
	van trainer utilizing th Straint manufacturer van trainer has receiv Straint/Surelock Natio products in Septembe	e skills checklist and Q' guidelines. The corporate red training directly from Q' onal Training Seminar er 2016. The corporate van ining he received, Q' Straint			work or participate in facility transporta using the facility owned van until training is completed. This in service was completed by May 25th, 2017. Monitoring:	tion	
	educate van transpor also completed where demonstrate the skills	nes, and a skills checklist to ters. A skills validation is the staff member must s appropriately. This also e new team members on			To ensure compliance, Director of Nurson designee will monitor this issue usin the QA survey tool. A quality review wi implemented when transports are start back once we start using the facility	g II be	
		call 911 for any accident that orts. Training was porate van trainer on			owned van. The director of nursing will also review incident reports during dail clinical meeting for accidents that may involve the van. If an event is identifie	у	
	completing any van tr van was placed back through 10/25/2016.	ransports. The facility owned in service from 10/6/2016 On 10/26/2016 facility owned by sister facility through			the chart will be checked by the Direct of Nursing to ensure that the patient w assessed promptly by the nurse. Char evidence will also be validated by	or as	
	5/23/2017. The facility owned van since 10/2 owned van keys are v	y has not utilized the facility 26/2016 and the facility with the Administrator and no			interviewing the patient and the nurse ensure that assessments were conduct promptly. If errors are the Quality		
	van will be out of serv	facility transportation have			Assurance Committee will review the event for appropriate corrective actions. This will be done for 4 weeks, and ther monthly for three months. The Director	1	
	Systematic Changes	rate van trainer educated 2			Nursing will review all incidents reports daily during daily clinical quality of life meeting (Monday through Friday).		
	facility staff designate transportations; they				Reports will be presented to the weekl QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate	e	
		: tation should be completed ave been trained to do so.			concerns will be brought to the Directo Nursing or Administrator for appropriat action. Compliance will be monitored a	е	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		245294	B. WING			С
NAME OF D	DOV/IDED OD OLIDDLIED	345284	D. WING _	OTDEET ADDRESS SITV STATE 71D SS		5/25/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
THE OAK	S			901 BETHESDA ROAD		
•,	-			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 490	Continued From pag	e 82	F 49	90		
F 490	Transportation aides Assistants or Emerge They must also have 2. PRIOR to operative vehicle, the TSP-101 will be completed. A secured with appropriand/or seatbelt place circumstances will the adequate seatbelts for transported. If there daily checklist, it must prior to the van being issue. 3. The van will also maintenance director basis. Results of the documented on form CHECKLIST. 4. All van drivers must Carolina drivers licer license DMV check, training on van usage residents. 5. In the event of an 911. Provide basic fin indicated such as Do not move patient unless life is threater 6. All wheelchairs us residents must be ap a personally-owned oprovided or arranged for transportation, it row Risk Management to transport use. 7. Power wheelchairs.	must be current Nursing ency Medication Technicians. It valid CPR training. Ing a facility transportation DAILY VAN CHECKLIST Ill residents will be properly riate strapping of wheelchairs ement. Under no it is an issue identified on the state reviewed and corrected grused if it is a patient safety in the inspected by the inspected by the inspection will be TSP-102 WEEKLY is thold a valid North isse, have had a drivers and have had documented it is prior to transportation of in the emergency, STOP and call rest aid. Implement CPR if it into heartbeat or breathing. If injury is suspected or ined. In the inspection of indexistence in the inspection in t	F 49	ongoing auditing program re Weekly Quality of Life Meeti QA Committee meeting is at Administrator, Director of Nu Coordinator, Unit Manager, Nurse, Therapy, HIM, Dietar Social Services.	ing. Weekly ttended by ursing, MDS Support	
TAG	Continued From pag Transportation aides Assistants or Emerge They must also have 2. PRIOR to operative vehicle, the TSP-101 will be completed. A secured with appropriand/or seatbelt place circumstances will the adequate seatbelts for transported. If there daily checklist, it must prior to the van being issue. 3. The van will also maintenance director basis. Results of the documented on form CHECKLIST. 4. All van drivers must Carolina drivers licer license DMV check, training on van usage residents. 5. In the event of an 911. Provide basic fiin indicated such as Do not move patient unless life is threater 6. All wheelchairs us residents must be ap a personally-owned or provided or arranged for transportation, it rouses it in the electric residents must. 7. Power wheelchair transportation appropriation ap	must be current Nursing ency Medication Technicians. It valid CPR training. Ing a facility transportation DAILY VAN CHECKLIST Ill residents will be properly riate strapping of wheelchairs ement. Under no evan be operated without or every resident being is an issue identified on the st be reviewed and corrected gused if it is a patient safety the inspection will be TSP-102 WEEKLY ast hold a valid North inse, have had a drivers and have had documented a prior to transportation of the emergency, STOP and call arst aid. Implement CPR if it into heartbeat or breathing. If injury is suspected or ined. Seed for transportation of the proved for transport use. If wheelchair (not a wheelchair I by the facility) is to be used must be approved by Liberty determine if it is safe for	TAG	ongoing auditing program re Weekly Quality of Life Meeti QA Committee meeting is at Administrator, Director of Nu Coordinator, Unit Manager, Nurse, Therapy, HIM, Dietar	eviewed at the ing. Weekly ttended by ursing, MDS Support	

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C 05/25/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	03/23/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 490	manufacturer installed points or cannot be if from the manufacturer considered safe for the safe safe for the safe safe safe safe safe safe safe saf	n. If they do not have and safety strap attachment litted with attachment devices er, they cannot be ransport. Aids must have completed an safety training. In ude the safe procedures for go fresidents, the safe and proved safety restraint the manufacturer of the end emergency measures to measure to me the safety restraint. If y the Administrator when an go a van transport regardless dent is. This includes ident incidents. Incidents mitted to: fall from ent malfunction, refusal of ety belts, and injury of any phone number the ment to the policy is to the ents during loading and	F 49		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		345284	B. WING			C 05/25/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		3372372017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 490	with foot rests is to be the transportation aid transportation use all necessity of locating wheelchair. Item #2: All wheelchairs used the types that have reto the unrestricted be required to secure the the resident's lap. Per the underside of the belt to restrain the relap belt must cross of keep the resident from Item #3: Wheelchair Floor resistanched to the cross that and will collapse side as in a hard turn attached to the frame welded joints connectioned where the wheattached. Item #4 Geriatric Chairs can Gerri Chairs have not feature of the chair aposition during trans reclining during trans reclining during trans system will not prote result in a serious or Item #5 Power Wheelchairs transportation before transport of a reside.	reproperly or another chair be used. It is recommended do set aside a wheelchair for head of time to void the and fitting another I in transportation must be of removable arm rest. Access ack of the wheelchair seat is he lap safety belt in place over lacing the lap belt through arm rest does not allow the resident at the hip. The safety over the lap from hip to hip to him slipping out of the seat. Straints are never to be as (X) bars of the wheelchair, not part of the frame of the se if the chair is forced on its heat or above the point where eat or above the point where be the frame. This is typically sels or wheel casters are never be used for transport. In way to lock the reclining and may fall into a reclining port. IN the event of a chair sport the safety harness of the resident and may fatal event. must be approved for the they can be used for not. If they are not considered the facility must provide a	F 49				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		345284	B. WING			C 05/25/2017	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		05/25/2017		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 490	transported on the factorial transported on the factorial transported the factorial transports are started facility owned vanual material to the seat belt is attacted and secured to the vehical floor retractors are started to the vehical floor retractors are started to the vehical floor retractors are secured to the vehical floor retractors are secured to floor positioned across the seat belt is attacted and secured to floor positioned across the seat belt. The action of the seat belt is attacted to the seat belt is attacted and secured to floor positioned across the seat belt. The action of the seat belt is attacted to the seat belt is attacted to the seat belt. The action of the seat belt is attacted to the seat belt is attacted to the seat belt in the seat belt is attacted to floor positioned across the seat belt is attacted t	chairs will no longer be facility van. Is been integrated into the intraining and in the required courses for all employees cility van and will be reviewed rance process to verify that en sustained. In also be implemented when eed back once we start using The review includes the intenance director in their refacility van transports daily reresidents and the chair are cole by visualizing that all 4 mooked to the wheelchair, that ched across the residents lap in restraints, shoulder strap is the shoulder and secured to diministrator will be responsible ensportation of residents. In that and oriented residents will not intend or intended as well as the van floor. If errors are even will be suspended ation of the allegations.	F 49	<u> </u>			
	by the corporate va knowledge of the sa to verify that it is co Any staff member d transportation or an the facility transport in-service training w	aining on 10/5/2016 provided in trainer to ensure proper afety harness system in order impleted correctly. esignated to aide in facility y in-house staff involved with ation, who did not receive vill not be allowed to work or transportation using the					

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _	B. WING		C 05/25/2017	
NAME OF PROVIDER OR SUPPLIER THE OAKS				901	REET ADDRESS, CITY, STATE, ZIP CODE 1 BETHESDA ROAD NSTON SALEM, NC 27103	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Validation of the credit was conducted on 5/2 interviewed regarding 5/25/17 and safety prodrivers confirmed trait were able to explain power and how to responsituation. Review of the had been observed to resident's wheelchair residents were select had been transported incidents had occurred revealed the TA's were current CPR certificated Director of Nursing results of Nur	ible allegation of compliance 25/17. TA's #2 and #3 were the training provided on occedures to follow. Both ning had been provided and procedures for securing the and in an emergency the audits confirmed both occrrectly secure a in the van. Sampled ed for record review that in the facility van and no d. Facility record review re nursing assistants with ion. The Administrator and ceived training on 5/25/17 at exampled en accepted professional these, the facility must ords on each resident that		514			6/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284		IDENTIFICATION NUMBED:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		B. WING				
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	05/25/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 514	Continued From page	e 87	F 514	4		
	(5) The medical recor	d must contain-				
	(i) Sufficient informati	on to identify the resident;				
	(ii) A record of the res	ident's assessments;				
	(iii) The comprehensing provided;	ve plan of care and services				
	(iv) The results of any and resident review e determinations condu					
	(v) Physician's, nurse's, and other licensed professional's progress notes; and					
	services reports as re	ogy and other diagnostic quired under §483.50. is not met as evidenced				
	Based on record revifacility failed to accurate medications were addreviewed (Resident # medications via a gas inserted into the stom	ews and staff interviews, the ately document the time ninistered for 1 of 1 resident 102) who received strostomy tube (a tube ach through an opening in r the administration of fluids		The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or w take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility □s allegation of	ill	
	The findings included	:		compliance such that all alleged deficiencies cited have been or will be		
		dmitted to the facility on		corrected by the date or dates indicate	ed.	
	6/20/16 with a cumula	ative diagnosis which difficulty swallowing) with		F514 RES		
	placement of a gastro	·		RECORDS-COMPLETE/ACCURATE /ACCESSIBLE		
		#102's May 2017 medication cations were scheduled to		Corrective Action: Resident #102. Physician notified. No	new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		345284	B. WING _			05/	25/2017
NAME OF PR	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK				90	01 BETHESDA ROAD		
THE OAKS	•			V	/INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	Continued From page	e 88	F 5	514			
F 514	be administered each AM, 8:00 AM, and 9:0 scheduled for 9:00 AM 30 milligrams (mg) lait that inhibits gastric ac dispersible (easily dis (under the tongue); 10 levetiracetam (an antigiven as 2.5 ml via gametoprolol tartrate (an medication) given as tube; and, 2 grams che medication used to de blood) given via gastria. An interview was con AM with Nurse #2. Nourse assigned to car the interview, inquiry time the 9:00 AM medications were given along with medications. The numedications were given AM. She reported the and administering medication to experience of the second was necessary to experience of the second was necessary to experience of the second administering medications was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to experience of the second administering medication was necessary to exp	morning at 6:00 AM, 6:30 00 AM. The medications of administration included: insoprazole (a medication cid secretion) given as 1 solved) tablet sublingually 00 mg / milliliter (ml) iconvulsant medication) astrostomy tube; 50 mg in antihypertensive 1 tablet via gastrostomy inclestyramine powder (a acrease lipids or fats in the iostomy tube. ducted on 5/24/17 at 7:55 urse #2 was the 1st shift are for Resident #102. During was made regarding what dications were going to be dent #102. Nurse #2 medications had already in the resident's 8:00 AM arse estimated the en at approximately 7:45 are hall had a heavy workload adications together (even eduled at different times) bedite the med pass. Nurse	F	514	orders. Medications administered as perphysician orders and documentation of medication administration times was accurate, timely and in accordance with the physician orders. Identification of other residents who make involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done by the Director of Nursing by 6/15/2017 checking the Medication Administration records ensuring that all medication were administered as prescribed. Random Medication Observations of Several Staff over different shifts and units (RN□s and LPN□s, Full time, Part time and PRN) were completed by the Director of Nursiand Pharmacist to ensure that medicat was administered as per physician orders and documentation of medication administration times was accurate, time and in accordance with the physician orders by 6/19/2017. The Random Medication Observations were of multiproutes of administration (oral, enteral, intravenous, subcutaneous, topical, optical etc.) and a minimum (not maximum) of 25 medication opportunitial the resident□s medication for each observed medication administration we observed and documented. Systemic Changes:	sing ion ers ely ble	
	Administration Record Nurse #2 at 7:58 AM. indicated Resident #1 were not documented	#102's electronic Medication d (MAR) was conducted with The electronic MAR 02's 9:00 AM medications I as given. Upon inquiry, e medications scheduled for			Director of Nursing and /or Designee in serviced all staff (full time, part time, ar PRN) to inform that the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245204	D. WWW.			С	
		345284	B. WING			05/	25/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	9			90	01 BETHESDA ROAD		
THE OAK	3			W	/INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	9:00 AM could not be MAR as given because The nurse stated she AM medications were MAR allowed her to do An interview was comparted by the facility's I interview, the discreparted Resident #102 's medication administered. The phyproviders were always there was a problem of medication administration also indicated that he documentation of medication stated she was a problem of medication of medication of medication of medication of medication stated she was a problem of medication of medication of medication of medication administration a	recorded in the electronic se it was too early to do so. would document the 9:00 e given when the electronic to so. ducted on 5/24/17 at 12:18 Medical Director. During the ancy between when dications were scheduled en they were administered used, along with the nurse 's the medications electrons electrons electrons electrons electrons electrons electrons electrons electrons electron electrons electron el	F	514	systematically organized. The medical record must contain sufficient informatic to identify the resident, a record of the residents assessments; The comprehensive plan of care and service provided; The results of any preadmiss screening and resident review evaluation and determinations conducted by the State; Physician sprogress notes and Laboratory, radiology and other diagnostic services reports. All Nurses (RNs, LPNs, full time, part time, and Pf were also educated on the fact that it is the nurse sresponsibility to notify physician, follow and initiate Physician orders. Medication should be administered as per physician orders a documentation of medication administration times should be accurate timely and in accordance with the physician orders. This in service was completed by June 16th, 2017. Any Nurse (RNs, LPNs, fu time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed to the standard orientation training and in 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. Monitoring: To ensure compliance, Director of Nursor designee will monitor this issue using the QA survey tool. The facility will mor compliance by completing 5 Random Medication Observations of Staff over	es ion ons r s; RN) s and e, ll ted. to the or the other sing g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	345264	B. WING _	STREET ADDRESS, CITY, STATE, ZIF		05/25/2017	
NAIVIE OF F	ROVIDER OR SUFFLIER			901 BETHESDA ROAD	CODE		
THE OAK	S			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE			CTION SHOULD BE O THE APPROPRIAT			
F 514	Continued From page	e 90	F 5	different shifts and units is weekends (RN□s and LF Part time and PRN) weel Medication Observations multiple routes of adminisenteral, intravenous, sub topical, optical etc.) and a maximum) of 25 medicat All the resident□s medication adribe observed and docume done on weekly basis for monthly for 3 months by Nurse, Unit Manager, or Reports will be presented QA Committee by the Addesignee to assure correinitiated as appropriate. A concerns will be brought Nursing or Administrator action. Compliance will be ongoing auditing program Weekly Quality of Life Medical QA Committee meeting is Administrator, Director of Coordinator, Unit Manage Nurse, Therapy, HIM, Die Wound Nurse.	PN s, Full time kly. The Rando will be of stration (oral, cutaneous, a minimum (not ion opportunitie ation for each ministration will ented. This will at 4 weeks then the Support designee. It to the weekly ministrator or ective action Any immediate to the Director for appropriate we monitored and reviewed at the eting. Weekly attended by f Nursing, MDS er, Support	t es. be of end he	