	-	D HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				<u>OMB NC</u>	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				LETED
		345284	B. WING			C 10/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	_			9	01 BETHESDA ROAD		
THE OAKS	5			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	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242 SS=D	SELF-DETERMINATI CHOICES CFR(s): 483.10(f)(1)-4 (f)(1) The resident has schedules (including s health care and provid consistent with his or and plan of care and o of this part. (f)(2) The resident has about aspects of his c are significant to the r (f)(3) The resident has members of the comr community activities b facility. This REQUIREMENT by: Based on record revi interview, family inter- facility failed to get a two weeks resulting ir and failed to provide a (Resident #5) for 2 of choices. Findings included: 1. The resident was a Resident #1 ' s quarter	ON - RIGHT TO MAKE (3) s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions s a right to make choices or her life in the facility that resident. s a right to interact with nunity and participate in both inside and outside the is not met as evidenced ew, observation, resident view, and staff interviews the resident out of her bed for n isolation (Resident #1) a preferred shower 3 residents reviewed for		242		do	11/10/17
	transfers and all activ diagnoses were apha	he resident required and total dependence for ities of daily living. The sia, hemiplegia, anxiety, iritis and contracture of the			F242 SELF-DETERMINATION-RIG TO MAKE CHOICES. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency		
	right arm.				cited;		
		SUPPLIER REPRESENTATIVE'S SIGNATURE	:		TITI F		(X6) DATE

Electronically Signed

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.

11/10/2017

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С	
		345284	B. WING	B. WING			19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	6				BETHESDA ROAD NSTON SALEM, NC 27103		
				VVII			
(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) COMPLETIC DATE
F 242	Continued From page	e 1	F 24	42			
					The facility failed to get a resident out	of	
	Resident #1 ' s care r	blan dated 10/11/17 revealed			her bed for two weeks resulting in		
	-	ns for at risk for falls which			isolation (Resident #1) and failed to		
	•	or all transfers, at risk for			provide a preferred shower (Resident #	# 5)	
	pressure ulcer use of	a gel cushion when up in			for 2 of 3 residents reviewed for choice	es.	
	the chair, communica	tion deficit secondary to			Resident #1. Care plan meeting was h	eld	
	stroke and aphasia, r	ight hemiparesis, and shift			on 11/7/2017 with the family present, a		
On dor	weight when up to the	e chair.			interdisciplinary team (in attendance w Nurse practitioner, Minimum Data Set	ere:	
	On 10/18/17 at 10:45	am an observation was			Coordinators, Social Worker, Dietary		
	done of Resident #1.	The resident was in her			Manager. Medical Doctor aware of		
	bed resting with eyes	closed, easily aroused by			meeting and gave recommendations the	nat	
	voice.				were presented by the Nurse Practition This recommendations were to have	ner.	
	On 10/18/17 at 2:10 p	om Resident #1 was			resident up and out of bed for 2 hours		
	observed to be in her				daily on first shift). Resident will be up	and	
	On 10/18/17 at 4:20 p	om Resident #1 was			out of bed for 2 hours daily on first shif	t to	
	observed to be in her				interact with other residents and		
	On 10/18/17 at 5:30 p				participate in activities as tolerated.		
	observed to be in her	bed.			Resident #5. Resident prefers showers		
	On 10/18/17 at 10:45	am an intonviow was			her scheduled shower days and prefer		
		ng Assistant (NA) #1. NA #1			bed baths on the other days. Resident received showers as scheduled every		
		#1 usually remained in bed			Friday on day shift, and every Tuesday	/ on	
		ization (readmitted 10/3/17).			day shift. Resident has received show		
		get out of bed to the chair			on 10/20/2017,10/27/17, 10/31/2017,	510	
		before the hospitalization.			11/3/2017 and 11/7/2017, 11/10/2017.		
					Resident is alert and oriented x3 and w	vas	
	On 10/18/17 at 10:50	am an interview was			able to validate that she received show		
	conducted with Nurse	e #2. Nurse #2 stated she			on her scheduled, preferred days.		
	was assigned to Resi	dent #1. Nurse #2 stated			Resident has a choice to receive a		
		s not get out of bed because			shower at any time when she requests		
	-	hair to sit up and the State			The procedure for implementing the		
	-	nat a Geri-chair was a			acceptable plan of correction for the		
		tated that the resident had			specific deficiency cited;		
		ince her readmission from			On 10/30/17, the Nurse Consultant		
		s ago because she was			reviewed each resident's Kardex (Care	9	
		vheel chair. Nurse #2 stated			plan interventions are reflected in the	to	
	there had not been a	n attempt to get the resident			Kardex) in the electronic health record	to	

Facility ID: 923497

If continuation sheet Page 2 of 44

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345284 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD THE OAKS WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 242 Continued From page 2 F 242 ensure that each resident had a Kardex in out of bed. the electronic health record. It was found On 10/19/17 at 9:00 am Resident #1 was that 100% of the residents had a Kardex. observed to be in her bed. On 10/30/2017 to 11/8/2017 all Kardex's On 10/19/17 at 11:05 am Resident #1 was (Care plan interventions are reflected in observed to be in her bed. the Kardex) were reviewed to ensure that On 10/19/17 at 1:55 pm Resident #1 was they had a shower schedule for each observed to be in her bed. resident per their preference and appropriate by Minimum Data Set On 10/19/17 at 8:45 am an interview was Coordinators, Nurse, Nurse aides, Quality conducted with the Resident #1 's family Assurance Nurse Consultant and Director member. The family member stated that he of nursing. Kardex are accurate and asked Nurse #2 on several occasions to get the appropriate. On 11/1/2017, The Nurse Consultant with resident out of bed every day. Nurse #2 did not provide the family member a reason why the the Minimum Data Set Nurse Consultants resident could not get out of bed. The family reviewed residents who are bedfast all or member stated he always found the resident in most of the time (e.g., in bed or geriatric bed when he came to visit. chair/recliner) includes bedfast with bathroom privileges to ensure that they On 10/19/17 at 12:30 pm an interview was were up and out of bed so as to interact conducted with the Physician's Assistant who with other residents and participate in stated there was no reason the resident could not activities. No other residents were get out of bed with the mechanical lift. identified as bedfast. On 11/1/17 to 11/8/2017, the Director of On 10/19/17 at 2:38 pm an interview was nursing, Regional Staff Development conducted with the Director of Nursing (DON). Nurse and Quality Assurance Nurse The DON stated that she was not aware that Consultant began in servicing all nurses Resident #1 had not been out of bed for weeks. and nursing assistants: The resident 's last hospitalization was a setback You are required to review the Kardex for the resident. The DON stated that physical (Care plan interventions are reflected in therapy would need to evaluate the resident 's the Kardex) of all residents assigned to chair safety. The DON would follow up with the your care prior to the beginning of each family. shift to identify care needs of the resident. If you do not see a Kardex then consult with your nurse for further care 2. The resident was admitted to the facility on instructions. 6/19/17. The quarterly Minimum Data Set dated You should always follow the plan of 7/24/17 revealed Resident #5 had an intact care for the residents as outlined on the cognition and no behaviors. The resident Kardex. If the resident's condition has

FORM CMS-2567(02-99) Previous Versions Obsolete

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY			
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,		COMPLETED			
				С				
		345284	B. WING		10/19/2017			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
THE OAK	S			901 BETHESDA ROAD WINSTON SALEM, NC 27103				
				PROVIDER'S PLAN OF CORRECTIO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC			
F 242	Continued From page	e 3	F 24	2				
		physical assistance for		changed, you feel that the plan is un	safe.			
		g. The resident's diagnoses		or the resident refuses to follow the p				
	-	ular disease, urinary tract		then you should notify the nurse for				
		osteoporosis, and deep vein		additional guidance regarding care.				
	thrombosis.			To access the Kardex you can c				
				on the resident's name in the electro				
		#5 's care plan dated		health record and click on the Karde	×			
		Is and interventions for and self-care deficit. The		brick.				
		ed to have a shower twice a		On 11/1/2017 to 11/8/2017, The Qua	lity			
	week.			Assurance Nurse Consultant and				
				Regional Staff Development Nurse ir	ו n			
	A review of Resident	#5 's shower log for August,		serviced all Nurses and Nurse Aides	(full			
		ber of 2017 revealed the		time, part time and PRN/as needed)				
		ed or a shower twice a week		inform them that, each resident has a	a			
	•	ay and missed on average		right to choose activities, schedules				
	one scheduled showe	er each week.		(including sleeping and waking times health care and providers of health c				
	On 10/18/17 at 1:45 p	om an interview was		services consistent with his or her				
		lent #5. Resident #5 stated		interests, assessments, and plan of o	care			
	sometimes the staff to	ook a while to answer the		and other applicable provisions of thi				
	call light and she had	to wait. The resident stated		part. Each resident has a right to ma	ke			
		er and had a shower mostly		choices about aspects of his or her li	fe in			
		sident washed herself in the		the facility that are significant to the				
		ot receive a shower. The		resident. Each resident has a right to				
		ays ready for a shower early hen she was not ready she		interact with members of the commu	-			
		ower later in the day. The		and participate in community activitie both inside and outside the facility. E				
		ould have liked a shower.		resident has a choice of how many ti				
				a week they can take a shower or ba				
	An interview was con	ducted with NA #1 on		Each resident has a right to receive a				
		NA #1 stated she worked at		shower or a bath per plan of care.				
		20 years. NA #1 indicated		As of 11/9/17 no employee (Register				
	-	on the first shift (7:00 am to		Nurse, Licensed Practical Nurse, and	d			
		ted her assignment normally		Certified Nursing Assistants) will be	h			
		ents per day. She indicated		allowed to work until the training has	been			
		cult" to get all her scheduled luring her normal shift. NA		completed. Effective 11/9/2017, this training is				
	#1 stated if the facility			incorporated into the new employee				

Facility ID: 923497

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 11/22/20 APPROVE . 0938-039
STATEMENT OF DEFICIEN	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY _ETED
		345284	B. WING		C 10/19/2017	
NAME OF PROVIDER OR	SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				901 BETHESDA ROAD		
THE OAKS			,	WINSTON SALEM, NC 27103		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
resident it helped Some sh Resident shower of a schedu reason for refusal, r documer documer not reme she had to compl schedule Director improved A phone 10/19/17 at the fac normally 11:00 pm filled in of were req the elect if a show required 10/19/17 with Nurs it was he missing of shower. or may h at anothe #3 stated shift and	her to comp owers were #5 sometim n the sched led shower or not giving esident unav- ted by the N tation syste ted as being mber if she reported cor ete her assig d showers) of Nursing in l. interview wa at 11:50 am cility for 2 ye worked on t b), but there n other shift uired to be of conic docum er was not g to be docum at 12:20 pm sing Assistar r fault the sh documentation Resident #5 ave been as er time. The l that if she h a resident w	e 4 vas not ready for their shower blete her assigned tasks. pushed off to the next day. hes did not receive her uled day. NA #1 indicated if was not completed, the the shower (ex: resident vailable) was required to be VA in the electronic m. If the shower was not g given NA #1 stated could gave one. NA #1 revealed herens about not being able gnment (which included to the Administrator and here past, but it had not as conducted with NA #2 on h. NA #2 stated she worked ars. NA #2 indicated she he second shift (3:00 pm to were occasions when she s. She reported showers documented by the NAs in entation system. She stated given the reason was hented by the NA. On h an interview was conducted ht (NA) #3. NA #3 stated that hower documentation log had on for Resident #5 ' s is may have gotten a bed bath sked if she wanted a shower nurse was not notified. NA had 14 residents on her day vas not ready for their there may not be enough	F 242		Ind in the ses for d by the dulatory of the ses change dulators the duled or notify efuses to e nurse e l notify efuses e l notify	

Facility ID: 923497

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		<u>0. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
						С
		345284	B. WING		10/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
INE OAN	5			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 242	Continued From page	5	F 24	2		
1 212		his or her shower for that	F 24	are receiving their showers as sc	hadulad	
		uld have to be pushed off to		or as requested. This will be done		
		er day. Not all residents		weekly basis for 4 weeks then mo		
	scheduled for a show			3 months.	· , ·-·	
		on that day. NA #3 stated		The Director of Nursing and/or Nu	urse	
	Resident #5 had beer	n offered a shower early in		Manager will observe 5 cognitive	у	
e c N d		ident was not always ready		impaired resident each week to m		
		early shower and staff		for showers as per preferred sche		
		a shower later in the day.		The Director of Nursing and /or N		
		ers were required to be		Manager will observe 5 residents		
	documented by the N			(Cognitively impaired residents) e		
	documentation system. She stated if a shower was not given the reason was required to be		week to ensure that they are gett daily as per their preferences.	ing up		
	documented by the N			Reports will be presented to the v	veeklv	
				Quality Assurance committee by		
	An interview was con	ducted with the Director of		Director of Nursing to ensure corr		
	Nursing (DON) on 10	/19/17 at 2:38 PM. The		action for trends or ongoing conc		
	DON indicated her ex	pectation was for residents		initiated as appropriate. The wee	kly	
	to receive showers tw	vice a week as scheduled.		Quality Assurance Meeting is atte		
		er was provided it was to be		the Director of Nursing, Wound N		
	documented by the N			Minimum Data Set Coordinator, L		
		m. She reported if a shower		Manager, Therapy, Health Inform		
	-	esident the refusal was		Management, Dietary Manager a	na tne	
	-	nented by the NA in the ition system, the nurse was		Administrator.		
		ly by the NA, and the nurse		The title of the person responsible	e for	
		t the refusal in a note. The		implementing the acceptable plan		
		not a surprise to her that		correction;		
		ovided as scheduled. She		Administrator and /or Director of I	Nursing.	
	stated the facility had	issues with showers being				
	-	d and staffing concerns				
	-	The DON indicated a root				
	-	as utilized at that time to find				
		with showers not being				
	-	. She reported staffing was				
		he nursing stations as well signments based on the				
		The DON stated she thought				
			1			1

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	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			COMPLETED	
		345284	B. WING		C 10/19/2017		
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK				90	1 BETHESDA ROAD		
				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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Continued From page	e 6	E E	242			
		ould warrant looking at					
F 282 SS=D	-	LIFIED PERSONS/PER	F	282			11/10/17
		e Care Plans d or arranged by the facility, mprehensive care plan,					
	care.	h resident's written plan of					
		is not met as evidenced					
	by: Based on observation	on, record review, resident			The statements made on this Plan of		
		iterview, the facility failed			Correction are not an admission to and	do	
		e interventions related to			not constitute an agreement with the		
		nts (Residents #6 and #8)			alleged deficiencies. To remain in		
		ts and the interventions			compliance with all Federal and State		
	related to aspiration presidents (Resident #	t1) reviewed with a tube			Regulations the facility has taken or will take the actions set forth in this Plan of		
	feeding. The findings				Correction. The Plan of Correction		
	5 5				constitutes the facility's allegation of		
		dmitted to the facility on			compliance such that all alleged		
		ently readmitted to the he diagnoses that included			deficiencies cited have been or will be corrected by the date or dates indicated	4	
	-	of one side of the body)			corrected by the date of dates indicated	J.	
	following a cerebral in				F282 SERVICES BY QUALIFIED		
		tracture of unspecified hand,			PERSONS/PER CAREPLAN.		
	and obesity.				The plan of correcting the specific	_	
	The quarterly Minimu	Im Data Set (MDS)			deficiency. The plan should address the processes that lead to the deficiency	9	
		7/17 indicated Resident #8 '			cited:		
		t. She was assessed with			The facility failed follow the plan of care	;	
	no behaviors and no	rejection of care. Resident			interventions related to falls for 2 of 3		
	#8 was coded as req	uiring the extensive			residents (Residents #6 and #8) review	ed	

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		345284	B. WING	С	
	ROVIDER OR SUPPLIER	545204		STREET ADDRESS, CITY, STATE, ZIF	10/19/2017
	ROVIDER OR SUFFLIER			CODE	
THE OAK	S			901 BETHESDA ROAD WINSTON 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 A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE
F 282	Continued From page	e 7	F 28	2	
		more staff with bed mobility	_	for accidents and the inte	erventions related
		ad impairment on one side		to aspiration precautions	
		er extremities and utilized a		1residents (Resident #1)	
	wheelchair.			tube feeding.	
				Resident#8 Care plan int	
		Resident #8 read, in part, "I		reflected in the Kardex in	
		ated to unsteady balance		health record was review	
	and nemiplegia. Tree	quire [Mechanical Lift #1]		by the Quality Assurance Consultant, Nurse, Nurse	
	-	ed Mechanical Lift #1 was		Data Set Consultant to e	
		ff assistance for transfers of		were accurate and appro	-
	Resident #8. This plan of care was initiated on 10/22/13 and the last revision was 10/18/17.			accurate and appropriate	-
				Resident #6 Care plan in	
				reflected in the Kardex in	
	An observation was o	conducted on 10/18/17 at		health record was review	red on 11/2/2017
		#8 in her room. Resident		by the Quality Assurance	
		be transferred from bed to		Consultant, Nurse, Nurse	
		g Assistant (NA) #1 utilizing		Data Set Consultant to e	
		There were no other staff		were accurate and appro	•
		Resident #8's room to assist operation of Mechanical Lift		accurate and appropriate Resident #1.Care plan in	
	#2.			reflected in the Kardex in	
	" - .			health record was review	
	An interview was con	ducted with the Staff		by the Quality Assurance	
	Development Coordir	nator (SDC) on 10/18/17 at		Consultant, Nurse, Nurse	
	2:45 PM. She stated	the facility utilized two types		Data Set Consultant to e	nsure that they
	of mechanical lifts, M			were accurate and appro	
		She indicated Mechanical Lift		Intervention in place indi	5
		utilized for residents who		resident is on aspiration	
		ring and Mechanical Lift #2		to tube feeding. Nurse to	
		lift utilized for residents who bearing. The SDC stated		to providing care. Head of lowered while tube feeding	
		as for two staff members to		Kardex is accurate and a	
	be present when ope			The procedure for impler	
		e reported this was for the		acceptable plan of correct	-
		s and staff members.		specific deficiency cited;	
				On 10/30/17, the Nurse (Consultant
		iducted with NA #1 on		reviewed each resident's	
	10/18/17 at 2:57 PM.	NA #1 confirmed she		plan interventions are ref	flected in the

Facility ID: 923497

					OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
			A. BUILDING	<u> </u>	с	
		345284	B. WING			
	ROVIDER OR SUPPLIER	343204		STREET ADDRESS, CITY, STATE,		9/2017
	ROVIDER OR SOFFLIER			901 BETHESDA ROAD		
THE OAK	S			WINSTON SALEM, NC 2710	3	
(VA) ID		ATEMENT OF DEFICIENCIES	ID		N OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X3) COMPLETIO DATE
F 282	Continued From page	e 8	F 28	32		
		ift #2 to transfer Resident #8		Kardex) in the electron	ic health record to	
	from bed to chair that	morning (10/18/17). She		ensure that each reside		
	revealed she utilized	Mechanical Lift #2 without		the electronic health re		
		present. She stated she		that 100% of the reside		
		acility's policy for the number		On 10/30/2017 to 11/8/		
		uired to be present during		(Care plan intervention		
		nanical Lift #2. NA #1		the Kardex) were revie		
		as not normally assigned to was unfamiliar with the		they were accurate and		
		operate Mechanical Lift #2.		Minimum Data Set Coo Nurse aides, Quality As		
				Consultant and Directo		
	An interview was con	ducted with Resident #8 on		Kardex are accurate ar	<u> </u>	
		Resident #8 indicated she		On 11/8/2017, The Nur		
	required the assistant	ce of staff as well as a		the Minimum Data Set		
	mechanical lift for trar	nsfers. She stated normally		reviewed residents who	o received tube	
		aff member present when		feeding to ensure that t		
	the mechanical lift wa	as utilized for her transfers.		interventions in place in	<u> </u>	
				resident is on aspiration		
		ducted with the Director of		to tube feeding. Nurse		
		/19/17 at 10:25 AM. She		to providing care. Head		
		xpectation that care plan wed. She additionally		lowered while tube feed	ang is musing.	
		ed the staff to follow the		On 11/1/17 to 11/8/201	7 the Director of	
		e two staff members present		nursing, Regional Staff		
		cal Lift #1 and Mechanical		Nurse and Quality Assu		
	Lift #2.			Consultant began in se		
				and nursing assistants	-	
		dmitted to the facility on			o review the kardex	
		es that included paraplegia		(Care plan intervention		
	and Multiple Sclerosis	s (MS).		the Kardex) of all resid	_	
	The admission Minim	um Data Sat (MDS)		your care prior to the b		
	The admission Minim	27/17 indicated Resident #6		 shift to identify care new If you do not see a 		
		. He was assessed with no		consult with your nurse		
		ection of care. Resident #6		instructions.		
	-	ng the extensive assistance		You should always	follow the plan of	
	of two or more staff w			care for the residents a	-	
		pairment on both sides of the		kardex. If the resident'		
	lower extremities and			changed, you feel that	the sector is the second sector	

Facility ID: 923497

If continuation sheet Page 9 of 44

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-03	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	IPLETED	
						С	
		345284	B. WING		10)/19/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
	e			901 BETHESDA ROAD			
	5			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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 282	Continued From page	e 9	F 28	82			
	The Care Area Asses	α		or the resident refuses to t			
		sment (CAA) related to falls sion MDS assessment		then you should notify the additional guidance regard			
		S was non-ambulatory. He		To access the kardex			
		d the extensive assistance		the resident's name in the			
		Resident #6 ' s risk factors		health record and click on			
	for falls included MS,	paraplegia, and muscle		brick.			
	spasms. He was indi						
		e damage that had the		On 11/1/2017 to 11/8/2017	7, The Quality		
	-	mobility and consequently		Assurance Nurse Consult			
	death.			Regional Staff developme			
				serviced all Nurses and N	•		
	-	Resident #6 indicated he was		time, part time and PRN/a			
	cause physical harm	bility to falling that may		inform them that the servic arranged by the facility, as			
		ry to non-weight bearing		comprehensive care plan			
	-	tatus due to MS. The		provided by qualified pers			
		d Resident #6 required		accordance with each resi			
	Mechanical Lift #1 for	r transfers. The plan of care		plan of care.			
	was initiated on 6/21/	17.		Nurse Aide Skill's sheeklis	t.w.oo		
	An interview was con	ducted with Resident #6 on		Nurse Aide Skill's checklis completed by Regional St			
		He indicated he required		Nurse and Quality Assurat			
		f as well as a mechanical lift		Consultant by 11/8/2017			
	for transfers. Resider			by completing an observa			
	transferred from his b	ed to his wheelchair by one		Mechanical lifts and provid			
		Mechanical Lift #2. He		resident receiving tube fee			
		Lift #1 was utilized when		part time and PRN/as nee	,		
		n. He indicated sometimes		that the followed the plan	of care as		
	there was one staff m	•		indicated.			
		Lift #1 and other times		Ap of 11/0/17 pa amaleur	o (Dogistorod		
	there were two staff n	nembers present.		As of 11/9/17 no employee Nurse, Licensed Practical			
	An interview was con	ducted with the Staff		Certified Nursing Assistan			
		nator (SDC) on 10/18/17 at		allowed to work until the tr			
		the facility utilized two types		completed.			
	of mechanical lifts, M			Effective 11/9/2017, this tr	aining is		
		She indicated Mechanical Lift		incorporated into the new			
	#1 was a full body lift	utilized for residents who		orientation program.			

Event ID: 0NC211

Facility ID: 923497

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345284 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD THE OAKS WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 10 F 282 were non-weight bearing and Mechanical Lift #2 This information has been integrated into was a stand-up style lift utilized for residents who the standard orientation training and in the were partially weight bearing. The SDC stated required in-service refresher courses for the facility 's policy was for two staff members to all employees and will be reviewed by the be present when operating both types of Quality Assurance Process to verify that mechanical lifts. She reported this was for the the change has been sustained. safety of the residents and staff members. The monitoring procedure to ensure that An interview was conducted with the Director of the plan of correction is effective and that Nursing (DON) on 10/19/17 at 10:25 AM. She specific deficiency cited remains corrected indicated it was her expectation that care plan and/or in compliance with the regulatory interventions be followed. She additionally requirements; indicated she expected the staff to follow the Starting evening shift of 11/1/2017 each facility 's policy to have two staff members nurse assigned to a unit will be required to present when using Mechanical Lift #1 and monitor change of shift activity to ensure Mechanical Lift #2. that Nurse Aides are reviewing the Kardex before they start their assignment. To 3. The resident was re-admitted to the facility on ensure compliance, the Director of 10/3/17 with multiple diagnoses that included Nursing will review the tools used by the aphasia, aphagia, hemiplegia, gastrostomy, and nurses in the unit to ensure that they are gastroesophageal reflux disease. monitoring the aide's change of shift on a weekly basis. The Director of Nursing and/or Nurse Resident #1 's quarterly Minimum Data Set dated 10/10/17 revealed the resident had a severely Manager will observe 5 nurse aides impaired cognition and no behaviors. The weekly to include weekends (all varies resident required extensive assistance and total shifts) to ensure that they are following the dependence for transfers and all activities of daily plan of care as indicated on the (Care living. The resident received her nutrition and plan interventions are reflected in the hydration by gastrostomy tube feeding. Kardex) while providing care (At least one of the observations will be done on a Resident #1 's care plan dated 10/11/17 revealed resident who receives tube feeding and goals and interventions for gastrostomy tube resident who require use of a mechanical feeding and potential for aspiration and to lift). This will be done on weekly basis for maintain nutrition by tube feeding. 4 weeks then monthly for 3 months. Reports will be presented to the weekly Physician 's order dated 10/3/17 revealed Quality Assurance committee by the Resident #1 was taking nothing by mouth. Director of Nursing to ensure corrective action for trends or ongoing concerns is Physician 's order dated 10/12/17 revealed initiated as appropriate. The weekly

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 0NC211

Facility ID: 923497

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TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 093 (X3) DATE SURV COMPLETED	/EY		
			A. BUILDING _	ILDING				
		345284	B. WING		10/19/2017			
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE				
THE OAK	6			901 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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CON	(X5) MPLETIO DATE		
F 282 F 312 SS=D	gastrostomy tube. On 10/18/17 at 11:30 done of Resident #1. bed with the head of the degrees and the tube milliliters per hour. N lowered the HOB to fil feeding was still infus coughing and her fact raised the HOB and r running. On 10/18/17 at 3:45 p conducted with NA #7 lowered Resident #1 the tube feeding was the resident had coug it was then that NA #7 was running. NA #1 to off. NA #1 stated she Nurse #2 to turn the the stated she usually ob turn off the tube feeding HOB. On 10/19/17 at 10:20 conducted with the D The DON stated that off the tube feeding b to keep the HOB elev the tube feeding was aspirations precaution ADL CARE PROVIDE	am an observation was The resident was in her the bed elevated (HOB) 45 feeding was infusing at 60 ursing Assistant (NA) #1 at for care and the tube ing. The resident started e turned flush red. NA #1 ealized the TF was still om an interview was 1. NA #1 stated that she had 's HOB and did not realize running. NA #1 stated that yhed and became flush and 1 realized the tube feeding thought the tube feeding was e raised the HOB and asked ube feeding off. NA #1 tained nursing assistance to ng before she lowered the am an interview was irector of Nursing (DON). staff was expected to turn efore lowering the HOB and ated 30 to 45 degrees when running as part of	F 282	Quality Assurance Meeting is atte the Director of Nursing, Wound N Minimum Data Set Coordinator, U Manager, Support Nurse, Therap Information Management, Dietary Manager and the Administrator The title of the person responsible implementing the acceptable plan correction; Administrator and /or Director of D	lurse, Jnit Jnit y, Health / e for n of Nursing.	0/17		

Facility ID: 923497

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 ATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CC	MPLETED	
		345284	B. WING			C	
	ROVIDER OR SUPPLIER	343204		STREET ADDRESS, CITY, STAT		10/19/2017	
	ROVIDER OR SUPPLIER			901 BETHESDA ROAD	E, ZIP CODE		
THE OAK	THE OAKS			WINSTON SALEM, NC 27	103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE	
F 312	Continued From page	a 12	F3	12			
1 512			F 3	12			
		is unable to carry out g receives the necessary					
	-	good nutrition, grooming, and					
	personal and oral hyg						
		is not met as evidenced					
	by:						
		iew, observation, and		The statements mad	le on this Plan of		
		erviews, the facility failed to			admission to and do		
		nowers for 2 of 4 residents		not constitute an agr			
		s of daily living (Residents #1		alleged deficiencies.			
		provide incontinence care		compliance with all F			
	as needed for 1 of 3 residents reviewed for incontinence care (Resident #1).		Regulations the facili take the actions set f	•			
	Incontinence care (Re	incontinence care (Resident #1).		Correction. The Plar			
	Findings included:			constitutes the facility	y's allegation of		
				compliance such that			
		admitted to the facility on		deficiencies cited have			
		's quarterly Minimum Data		corrected by the date	e or dates indicated.		
		evealed the resident had a			PROVIDED FOR		
		gnition and no behaviors. I extensive assistance and		F312 ADL CARE			
	-	ice dependent upon staff for		The plan of correctin			
		vities of daily living. The		deficiency. The plan			
		iplegia, osteoarthritis and		processes that lead t			
	contracture of the rig			cited;	2		
				The facility failed to p			
		an dated 10/11/17 revealed		showers for 2 of 4 re			
	0	ns for incontinence care of		activities of daily livin			
	-	otential for skin breakdown,		#7) and failed to prov			
		ssistant for all aspects of		care as needed for 1			
	activities of daily livin receive a shower twice	g. The resident was to		reviewed for incontin	ence care (Resident		
		LE A WEEK.		#1). Resident #1. Resider	nt representativo		
	A review of Resident	#1's shower log for August,			her scheduled shower		
		bber 2017 revealed the		days and prefers bec			
		her shower two to four		days. Resident recei			
	times during the mon				nday on day shift, and		
	-	ne resident received a bed		every Thursday on d	ay shift. Resident has		
	li i i i i i	hower days. The resident	1	received showers on		1	

Facility ID: 923497

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С	
		345284	B. WING		10/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE
THE OAKS				901 BETHESDA ROAD WINSTON SALEM, NC 27103	3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE HENCY)
F 312	Continued From page	<u>- 13</u>	E 31	12	
F 312	was scheduled to rec An interview was con 10/18/17 at 2:57 pm. the facility for about 2 she normally worked 3:00 pm). NA #1 stat included 13-14 reside it was "extremely diffi showers completed d #1 stated if the facility resident refused or w it helped her to comp Some showers were not completed. The r receive her shower ou indicated if a schedul completed, the reaso (ex: resident refusal, required to be docum electronic documentat was not documented not remember if she g she had reported con to complete her assig scheduled showers) f Director of Nursing in improved. A phone interview wat	eive a shower twice a week. ducted with NA #1 on NA #1 stated she worked at 0 years. NA #1 indicated on the first shift (7:00 am to ed her assignment normally ents per day. She indicated cult" to get all her scheduled uring her normal shift. NA v census was not full or if a as not ready for their shower lete her assigned tasks. pushed off to the next day or esident sometimes did not n the scheduled day. NA #1	F 31	10/26/2017, 11/12/2017 11/9/2017. Resident Inc provided as needed and care as indicated on the plan interventions are re Kardex) in the electroni Resident #7. Resident p her scheduled shower of bed baths on the other received showers as so Saturday evening shift a Wednesday evening shift a Wednesday evening shift a Wednesday evening shift a Wednesday evening shift a Resident #7. 10/28/17, 10/25/2017, 10/28/17, 11/4/2017 and 11/8/2017 The procedure for imple acceptable plan of corres specific deficiency cited On 10/30/17, the Nurse reviewed each resident plan interventions are re Kardex) in the electroni ensure that each resided the electronic health red that 100% of the reside On 10/30/2017 to 11/8/2 (Care plan interventions the Kardex) were review they had a shower sche resident and appropriat Data Set Coordinators,	continence care d as per plan of e Kardex (Care eflected on the ic health record. prefers showers on days and prefers days. Resident cheduled every and every hift. Resident has D/21/2017, 11/1/2017, 17. ementing the ection for the d; e Consultant c's kardex (Care eflected on the ic health record to ent had a kardex in cord. It was found onts had a Kardex. 2017 all Kardex's is are reflected on wed to ensure that edule for each te by Minimum
	normally worked on the filled in on other shifts	ars. NA #2 indicated she ne second shift (3:00 pm to were occasions when she s. She reported showers		aides, Quality Assurance Consultant and Director Kardex are accurate an	r of nursing. Id appropriate.
				On 11/1/17 to 11/8/2017 nursing, Regional Staff Nurse and Quality Assu Consultant began in se	Development urance Nurse

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` <i>'</i>	G	COMPLETED
					С
		345284	B. WING		10/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
THE OAK	3			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	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMPLE THE APPROPRIATE DATE
F 312	Continued From page	e 14	F 3 ⁻	12	
	An interview was com Nursing (DON) on 10 DON indicated her ex- to receive showers tw She stated if a showed documented by the N documentation system was refused by the re- expected to be document to be informed verball was also to document DON revealed it was showers were not pro- stated the facility had provided as schedule several months ago. cause analysis tool w a link between issues provided and staffing increased on one of t as rearranging NA as acuity of residents. T these concerns had to indicated this issue w again. 1b. Resident #1 's qu dated 10/10/17 revea facility on 6/20/17. T impaired cognition ar resident required exter totally dependent upo activities of daily livin hemiplegia, osteoarth right arm.	ducted with the Director of /19/17 at 2:38 PM. The spectation was for residents vice a week as scheduled. The was provided it was to be IA in the electronic m. She reported if a shower esident the refusal was mented by the NA in the ation system, the nurse was ly by the NA, and the nurse to a surprise to her that ovided as scheduled. She issues with showers being and staffing concerns The DON indicated a root ras utilized at that time to find with showers not being . She reported staffing was he nursing stations as well signments based on the The DON stated she thought been resolved. She rould warrant looking at		 and nursing assistants: You are required to r (Care plan interventions a the Kardex) of all residen your care prior to the beg shift to identify care need If you do not see a kard of the resident's of care for the residents as a kardex. If the resident's of changed, you feel that the or the resident refuses to then you should notify the additional guidance regar To access the kardee the resident's name in the health record and click or brick. On 11/1/2017 to 11/8/2017 Assurance Nurse Consult Regional Staff developme serviced all Nurses and N time, part time and PRN/a inform them that a reside to carry out activities of d receives the necessary semaintain good nutrition, g personal and oral hygiene Nurse Aide Skill's checklii completed by 11/8/2017 of (Full time, part time and F to ensure that they follow care in providing incontin indicated on the Kardex. 	are reflected on ts assigned to inning of each s of the resident. ardex then or further care ollow the plan of outlined on the condition has e plan is unsafe, follow the plan e nurse for ding care. c you can click on e electronic in the kardex 7, The Quality tant and ent Nurse in lurse Aides (full as needed) to int who is unable aily living ervices to rooming, and e. st was on Nurse Aides PRN/as needed) ed the plan of
	-	blan dated 10/11/17 revealed			

Facility ID: 923497

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		MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. (X3) DATE SU		
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLE		
			A. BOILDIN	0	с		
		345284	B. WING			/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				901 BETHESDA ROAD			
THE OAK	S			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 C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 312			F 3'				
		ns for incontinence care of		As of 11/9/17 no employe			
	-	otential for skin breakdown,		Nurse, Licensed Practica			
		or all aspects of activities of		Certified Nursing Assistar			
	daily living.			allowed to work until the	raining has been		
				completed.			
	On 10/18/17 at 10:45			Effective 11/9/2017, this t	•		
	conducted with NA #			incorporated into the new	employee		
		ived incontinence care at		orientation program.			
	-	. NA #1 stated that she had		This information has been			
		Ip for lunch in the dining		the standard orientation t	-		
		d before she could return for		required in-service refres			
		tinence care in about 45		all employees and will be	-		
		ated that they were short on		Quality Assurance Proces			
	another hall.	nd she was covering from		the change has been sus			
	On 10/18/17 at 10:50	am an interview was		The monitoring procedure the plan of correction is e			
		e #2 who was assigned to		specific deficiency cited r			
		#2 stated that incontinence		and/or in compliance with			
		as required to be performed		requirements;	i lite regulatory		
		#2 stated she was aware		Starting evening shift of 1	1/1/2017 each		
	-	ist incontinence care was at		nurse assigned to a unit			
	8:00 am this morning			monitor change of shift a			
	5			that Nurse Aides are revi	2		
	On 10/18/17 at 11:30	am observation of		before they start their ass	-		
		s done of Resident #1. The		ensure compliance, the D	-		
		ed. NA #1 prepared linen,		Nursing will review the to			
		bed bath and incontinence		nurses in the unit to ensu	-		
	· · ·	d stool incontinence care.		monitoring the aide's cha	-		
	Resident #1 was note	ed to have newly developed		weekly basis.			
	excoriated buttocks.			The nurse aide assigned			
				be required to document	in the residents		
	On 10/18/17 at 11:45			electronic medication rec	ord that the		
	conducted with Nurse	e #3. Nurse #3 stated she		resident received shower			
	was the wound care r			as requested. The Nurse	-		
		s required to be performed		the nurse assigned if a re			
	-	as needed when there was		have their scheduled sho			
		incontinence. Nurse #3		will talk with the resident			
	stated that Resident #	#1 ' a avaariated buttooka		resident still refuses, the	nurgo will notify		

Facility ID: 923497

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SI	0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLE	
					С	
		345284	B. WING		10/19	9/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
	s			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	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 312	Continued From page	e 16	F 31	12		
	1.0	need incontinence care		resident's responsible pa	arty and	
		urs, barrier cream (standing		document in the electror	-	
		ery two hours. Nurse #3		record.	-	
	stated that the reside			The Director of Nursing	and/or Nurse	
	interfered with peri-ar	nal care. Nurse #3 felt at		Manager will interview 5	alert and oriented	
	this time two staff me	mbers should provide		residents each week to	2	
	incontinence care.			are receiving their show		
				or as requested and that		
		ducted on 10/19/17 at 2:38		receiving incontinent car		
	-	of Nursing (DON). The DON		plan interventions. This		
		ware of an issue with timely sterday (10/18/17) from the		weekly basis for 4 week 3 months.	s then monthly for	
	-	esident #1. She indicated		The Director of Nursing	and/or Nurse	
		was unaware of any issues		Manager will observe 5		
	-	e as needed. She reported		impaired resident each		
	the facility began wor	-		for showers as per prefe		
		ated to incontinence care on				
	10/18/17 by looking a	at staffing for the resident		The Director of Nursing	and/or Nurse	
	acuity.			Manager will observe 5	nurse aides	
				weekly to ensure that th		
				the plan of care as indic		
		dmitted to the facility on		Kardex while providing i		
		d on 8/9/13 with multiple		to cognitively intact and		
		bstructive Pulmonary		impaired patients. This w		
	Disease (COPD) and	neart failure.		weekly basis for 4 week 3 months.	s then monthly for	
	The quarterly Minimu	Im Data Set (MDS)		Reports will be presente	d to the weekly	
		22/17 indicated Resident #7		Quality Assurance com	-	
		ct. He was assessed with no		Director of Nursing to er		
	-	sident #7 was coded as		action for trends or ongo		
		l assistance of one staff for		initiated as appropriate.	-	
		t steady on his feet, but was		Quality Assurance Meet	2	
	able to stabilize witho	out staff assistance.		the Director of Nursing,		
				Minimum Data Set Coor		
		Resident #7 indicated he had		Manager, Therapy, Hea		
	a self-care deficit rela			Management, Dietary M	anager and the	
	perform Activities of [Administrator.		
		to COPD and heart failure.			eneneible fer	
	i ne interventions ind	icated Resident #7 required		The title of the person re	esponsible for	

Facility ID: 923497

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							10. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		TE SURVEY MPLETED	
			-			С		
		345284	B. WING			1	0/19/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
THE OAK	S			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		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 312	Continued From page	e 17	F 3	12				
		ce with bathing.The plan of 12/2/13 and the last revised			implementing the acceptable plan of correction; Administrator and /or Director of Nur			
	The Nursing Assistant (NA) Kardex, a care guide, indicated Resident #7 required one staff assistance for bathing. His shower days were indicated as Wednesday and Saturday during the second shift (3:00 PM to 11:00 PM). A review of the shower/bathing documentation from 10/1/17 through 10/17/17 revealed Resident							
	(10/4/17). There was shower as scheduled 10/11, or 10/14. The a shower refusal or a for Resident #7 on 10 staff schedule for the received his schedule	4 scheduled showers s no documentation of a l for Resident #7 on 10/7, re was no documentation of an alternative form of bathing D/7, 10/11, or 10/14. The dates Resident #7 had not ed showers were reviewed. to Resident #7 on 10/7,						
	10/18/17 at 1:25 PM. required assistance f He reported his show Wednesday and Satu shift. He revealed he showers as schedule "[Staff] will tell you th give the shower". H	ducted with Resident #7 on Resident #7 stated he from staff to take a shower. vers were scheduled for urday during the second e did not always receive his ed. Resident #7 stated, ere aren ' t enough staff to e reported NA #2 was aware not receiving his scheduled e staffing.						
	10/18/17 at 2:57 PM. the facility for about 2	ducted with NA #1 on She stated she worked at 20 years. She indicated she he first shift (7:00 AM to 3:00						

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	10. 0938-039 TE SURVEY MPLETED	
		345284	A. BUILDING B. WING		С		
NAME OF P	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, ZIP CODE		0/19/2017	
THE OAK	S			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	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 312	PM). NA #1 stated he included 13-14 reside it was "extremely diffi scheduled showers of She stated if the facil resident refused their complete her assigne scheduled shower wa for not giving the shor resident unavailable) documented by the N documentation system reported concerns ab her daily tasks to the the past, but things he The interview with NA reported she was fam stated he required as reported she was una rejecting care from st A phone interview wa 10/19/17 at 11:50 AM the facility for 2 years normally worked on the 11:00 PM). She report to be documented by the N familiar with Resident assistance with show documentation from that indicated Reside scheduled showers w #2 stated if she had p shower she would ha	er assignment normally ents per day. She indicated cult" to get all of her completed during her shift. ity census was not full or if a shower it helped her to ed tasks. She indicated if a as not completed, the reason wer (ex: resident refusal, was required to be IA in the electronic m. NA #1 revealed she had yout being able to complete Administrator and DON in ad not improved. A #1 continued. She hiliar with Resident #7. She sistance with showers. She aware of Resident #7 aff. as conducted with NA #2 on 1. She stated she worked at 5. She indicated she he second shift (3:00 PM to orted showers were required the NAs in the electronic m. She stated if a shower ason was required to be IA. NA #2 indicated she was t #7. She stated he required	F 3	12			

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	-	D HUMAN SERVICES				FORM): 11/22/2017 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	LETED
		345284	B. WING			(10/ ⁻	C 19/2017
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			9	01 BETHESDA ROAD			
THE OAKS	8		v	VINSTON SALEM, NC	27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	shower she would hav indicated she was una no shower provided o #2 reported, "I don't k An interview was cond 10/19/17 at 12:05 PM worked on the first sh her assignment was a She indicated sometir complete all her assig normal shift. She rep required to be docume electronic documenta shower was not provid to be documented by days that she was rea resident if it was okay shower to the followin An interview was cond Nursing (DON) on 10/ indicated her expecta receive showers as so shower was provided the NA in the electron She reported if a show resident the refusal w documented by the N document to the DON revealed it was a showers were not pro stated the facility had provided as scheduler several months ago.	ve documented it. She able to recall why there was n 10/7, 10/11, 0r 10/14. NA now what happened". ducted with NA #3 on . She stated she normally ift (7:00 AM to 3:00 PM) and around 14 residents per day. mes it was difficult to uned tasks during her orted showers were ented by the NAs in the tion system. She stated if a ded the reason was required the NA. NA #3 revealed on ally busy she had asked a to "push" their scheduled g day. ducted with the Director of (19/17 at 2:38 PM. She tion was for residents to cheduled. She stated if a it was to be documented by ic documentation system. wer was refused by the as expected to be A in the electronic n, the nurse was to be he NA, and the nurse was he refusal in a note. The not a surprise to her that vided as scheduled. She issues with showers being d and staffing concerns She indicated a root cause	F 312		DEFICIENCY)		
	several months ago. analysis tool was utiliz	-					

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					OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	·	с
		345284	B. WING		10/19/2017
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/10/2011
	-			901 BETHESDA ROAD	
THE OAK	5			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 312	Continued From page	20	Г 2 1		
1 512			F 31	2	
	and staffing. She re	he nursing stations as well			
		A assignments based on the			
		The DON stated she thought			
	these concerns had b	been resolved. She			
	indicated this issue w	ould warrant looking at the			
	concern again.				
F 322	NG TREATMENT/SE	RVICES - RESTORE	F 32	2	11/10/17
SS=D	EATING SKILLS				
	CFR(s): 483.25(g)(4)	(5)			
	(g) Assisted nutrition	and hydration.			
		c and gastrostomy tubes,			
		ndoscopic gastrostomy and			
	-	copic jejunostomy, and			
	enteral fluids). Based	ssment, the facility must			
	ensure that a residen				
	(4) A resident who ha	s been able to eat enough			
		nce is not fed by enteral			
	methods unless the r	esident's clinical condition			
		teral feeding was clinically			
	indicated and consen	ted to by the resident; and			
	(5) A resident who is	fed by enteral means			
		ate treatment and services			
		, oral eating skills and to			
		s of enteral feeding including			
		ration pneumonia, diarrhea,			
		n, metabolic abnormalities,			
	and nasal-pharyngea	i uicers.			
	by:				
		iew, observations and staff		The statements made on this Plan o	f
		failed to maintain the head of		Correction are not an admission to a	
	the bed at 30 to 45 de	egrees during tube feeding		not constitute an agreement with the	
	for 1 of 1 residents re	viewed with tube feeding		alleged deficiencies. To remain in	

Event ID: 0NC211

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345284 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD THE OAKS WINSTON SALEM, NC 27103 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 21 F 322 F 322 (Resident #1). compliance with all Federal and State Regulations the facility has taken or will Findings included: take the actions set forth in this Plan of Correction. The Plan of Correction Resident #1 was admitted to the facility on constitutes the facility's allegation of 6/20/17 with multiple diagnoses that included compliance such that all alleged aphasia, hemiplegia, anxiety, depression, deficiencies cited have been or will be osteoarthritis and contracture of the right arm. corrected by the date or dates indicated. Resident #1 's quarterly Minimum Data Set dated F322 NG 10/10/17 revealed the resident had a severely TREATMENT/SERVICES-RESTORE impaired cognition and no behaviors. The EATING SKILLS. resident required extensive assistance and total The plan of correcting the specific dependence for transfers and all activities of daily deficiency. The plan should address the living. The resident received her nutrition and processes that lead to the deficiency hydration by gastrostomy tube feeding. cited: The facility failed to maintain the head of Resident #1 's care plan dated 10/11/17 revealed the bed at 30 to 45 degrees during tube goals and interventions for gastrostomy tube feeding for 1 of 1 residents reviewed with feeding and potential for aspiration and maintain tube feeding (Resident #1). nutrition by tube feeding (intervention: head of the Resident #1. Care plan interventions are bed (HOB) elevated 30-45 degrees during and reflected on the Kardex in the electronic thirty minutes after tube feeding). Total extensive health record was reviewed on 11/2/2017 assistant for all aspects of activities of daily living. by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Minimum Physician 's order dated 10/3/17 revealed Data Set Consultant to ensure that they Resident #1 was taking nothing by mouth. were accurate and appropriate. Intervention in place indicating that Physician 's order dated 10/12/17 revealed resident is on aspiration precautions due Glucerna 1.5 60 milliliters/hour continuous via to tube feeding. Nurse to be notified prior gastrostomy tube. to providing care. Head of bed not to be lowered while tube feeding is infusing. On 10/18/17 at 11:30 am an observation was Kardex is accurate and appropriate. done of Resident #1. The resident was in her The procedure for implementing the bed with the HOB elevated 45 degrees and the acceptable plan of correction for the tube feeding was infusing at 60 milliliters per specific deficiency cited; hour. Nursing Assistant (NA) #1 lowered the On 10/30/17, the Nurse Consultant HOB to flat for care and the tube feeding was still reviewed each resident's Care plan infusing. The resident started coughing and her interventions are reflected on the Kardex

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345284 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD THE OAKS WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 322 Continued From page 22 F 322 face turned flush red. NA #1 raised the HOB and in the electronic health record to ensure realized the TF was still running. The resident that each resident had a kardex in the recovered without further intervention. electronic health record. It was found that 100% of the residents had a Kardex. On On 10/18/17 at 3:45 pm an interview was 10/30/2017 to 11/8/2017 all Kardex's conducted with NA #1. NA #1 stated that she had (Care plan interventions are reflected on lowered Resident #1 's head of the bed and did the Kardex)were reviewed to ensure that not realize the tube feeding was running. NA#1 they were accurate and appropriate by stated that the resident had coughed and became Minimum Data Set Coordinators, Nurse, flush and it was then that NA #1 realized the tube Nurse aides, Quality Assurance Nurse Consultant and Director of nursing. feeding was running. She thought the tube feeding was off. NA #1 stated she raised the Kardex are accurate and appropriate. head of the bed and asked Nurse #2 to turn off On 11/8/2017, The Nurse Consultant with the tube feeding. NA #1 stated she usually the Minimum Data Set Nurse Consultants obtained nursing assistance to turn off the tube reviewed residents who received tube feeding before lowering the HOB. feeding to ensure that they have interventions in place indicating that: On 10/19/17 at 10:20 am an interview was resident is on aspiration precautions due conducted with the Director of Nursing (DON). to tube feeding. Nurse to be notified prior The DON stated that staff was expected to turn to providing care. Head of bed not to be off the tube feeding before the HOB was lowered lowered while tube feeding is infusing. and to keep the HOB elevated 30 to 45 degrees when the tube feeding was running as part of On 11/1/17 to 11/8/2017, the Director of nursing, Regional Staff Development aspirations precautions. Nurse and Quality Assurance Nurse Consultant began in servicing all nurses and nursing assistants: You are required to review the kardex (Care plan interventions are reflected on the Kardex) of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident. If you do not see a kardex then consult with your nurse for further care instructions. You should always follow the plan of care for the residents as outlined on the kardex. If the resident's condition has changed, you feel that the plan is unsafe,

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Event ID: 0NC211

Facility ID: 923497

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 11/22/2017 MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345284	B. WING		10	C / 19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
THE OAK	S			901 BETHESDA ROAD		
	-			WINSTON SALEM, NC 27103		1
(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 THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 322	Continued From page	23	F 32	 or the resident refuses to follow then you should notify the nur additional guidance regarding To access the kardex you the resident's name in the ele health record and click on the brick. On 11/1/2017 to 11/8/2017, The Assurance Nurse Consultant Regional Staff development Network and Nurses and Nurses time, part time and PRN/as network and hydration (includes naso-gastrostomy tubes, both percerendoscopic gastrostomy and percutaneous endoscopic jeju and enteral fluids). The facility ensure that a resident who has able to eat enough alone or wassistance is not fed by enternuless the resident's clinical of demonstrates that enteral fee clinically indicated and conset the resident. The facility must a resident who is fed by enterreceives the appropriate treat services to restore, if possible skills and to prevent complica enteral feeding including but raspiration pneumonia, diarrhed dehydration, metabolic abnorn nasal-pharyngeal ulcers. 	se for care.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPL	
345284 B. WING 10/1	; 19/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
901 BETHESDA ROAD	
THE OAKS WINSTON SALEM, NC 27103	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322 Continued From page 24 F 322 by completing on providing care to resident receiving tube feeding (Full time, part time and PRN/as needed) to ensure that the followed the plan of care as indicated. As of 11/9/17 no employee (Registered Nurse, Licensed Practical Nurse, and Certified Nursing, Jassitants) will be allowed to work until the training has been completed. Effective 11/9/2017, this training is incorporated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency tild remains corrected and/or in compliance with the regulatory requirements; Stating evening shift of 11/1/2017 each nurse assigned to a unit will be required to monitor of Nursing and/or in compliance, the Director of Nursing and/or in compliance, the Director of Nursing and/or Nurse Marager will observe 5 nurses in the unit to ensure that Nurse sist they are signed. To ensure compliance, the Director of Nursing and/or Nurse Marager will observe 5 nurse sides change of shift on a weekly basis. The Director of Nursing and/or Nurse Marager will observe 5 nurse aides weekly and including the weekends(varies shifts) to ensure that	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/22/2017 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/19/2017	
		345284	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	s			01 BETHESDA ROAD /INSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
	FREE OF ACCIDENT HAZARDS/SUPERVI CFR(s): 483.25(d)(1) (d) Accidents. The facility must ensu (1) The resident envin from accident hazard (2) Each resident rec and assistance devic (n) - Bed Rails. The fa appropriate alternativ bed rail. If a bed or s must ensure correct i	T SION/DEVICES (2)(n)(1)-(3) ure that - ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility	F 322	they are following the plan of ca indicated on the Kardex while p care to resident who are receiv feeding. This will be done on w for 4 weeks then monthly for 3 Reports will be presented to the Quality Assurance committee b Director of Nursing to ensure c action for trends or ongoing col- initiated as appropriate. The w Quality Assurance Meeting is a the Director of Nursing, Wound Minimum DataSet Coordinator, Manager, Therapy, Health Info Management, Dietary Manager Administrator. The title of the person responsi implementing the acceptable p correction; Administrator and /or Director of	providing ving tube veekly basis months. e weekly by the orrective ncerns is veekly attended by attended by attend	11/10/17

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345284 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD THE OAKS WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 26 F 323 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced hv. Based on observation, record review, resident The statements made on this Plan of interview, and staff interview, the facility failed to Correction are not an admission to and do consistently use the appropriate mechanical lift to not constitute an agreement with the transfer residents and failed to consistently utilize alleged deficiencies. To remain in 2 staff to operate the mechanical lifts for compliance with all Federal and State transfers, putting the residents at risk for injury for Regulations the facility has taken or will 2 of 3 residents reviewed for accidents (Resident take the actions set forth in this Plan of #6 and #8). The findings included: Correction. The Plan of Correction constitutes the facility's allegation of 1. Resident #8 was admitted to the facility on compliance such that all alleged 3/16/10 and most recently readmitted to the deficiencies cited have been or will be facility on 4/16/14 with diagnoses that included corrected by the date or dates indicated. hemiplegia (paralysis of one side of the body) F323 FREE OF ACCIDENT HAZARDS/ following a cerebral infarction affecting unspecified side, contracture of unspecified hand, SUPERVISION/DEVICES. and obesity. The plan of correcting the specific deficiency. The plan should address the The quarterly Minimum Data Set (MDS) processes that lead to the deficiency assessment dated 8/7/17 indicated Resident #8 ' cited: s cognition was intact. She was assessed with The facility failed to consistently use the no behaviors and no rejection of care. Resident appropriate mechanical lift to transfer #8 was coded as requiring the extensive residents and failed to consistently utilize assistance of two or more staff with bed mobility 2 staff to operate the mechanical lifts for and transfers. She had impairment on one side transfers, putting the residents at risk for of the upper and lower extremities and utilized a injury for 2 of 3 residents reviewed for wheelchair. accidents (Resident #6 and #8).

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIF	PLE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	IPLETED
				-		С
		345284	B. WING		10)/19/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
				901 BETHESDA ROAD		
THE OAKS	j			WINSTON SALEM, NC 2710)3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 323	Continued From page	27	F 32	23		
	Continued i form page		1 52	Resident#8 Care plan	intervention are	
	The plan of care for R	Resident #8 read, in part, "I		reflected in the Kardex		
		ated to unsteady balance		health record was revie		
		juire [Mechanical Lift #1]		by the Quality Assuran		
		transfers". This plan of		Consultant, Nurse, Nur		
	care was initiated on	10/22/13 and the last		Data Set Consultant to	ensure that they	
	revision was 10/18/17	7 .		were accurate and app		
				accurate and appropria		
		ask Listing Report was		Resident #6 Care plan		
		. This report indicated the		reflected in the Kardex		
		required for transferring #8 was noted as requiring a		health record was revie		
		d two staff assistance with		by the Quality Assuran Consultant, Nurse, Nur		
	transfers.			Data Set Consultant to were accurate and app	ensure that they	
	An observation was c	onducted on 10/18/17 at		accurate and appropria		
	9:25 AM of Resident	#8 in her room. Resident		The procedure for impl		
	#8 was observed to b	e transferred from bed to		acceptable plan of corr	-	
	wheelchair by Nursing	g Assistant (NA) #1 utilizing		specific deficiency cite	d;	
		here were no other staff		On 10/30/17, the Nurse		
		Resident #8 's room to		reviewed each residen	``	
	assist NA #1 with the	safe operation of		plan intervention are re		
	Mechanical Lift #2.			Kardex) in the electron		
	An interview was con	ducted with the Staff		ensure that each reside		
		nator (SDC) on 10/18/17 at		that 100% of the reside		
	•	the facility utilized two types		On 10/30/2017 to 11/8		
	of mechanical lifts, Me			(Care plan intervention		
		the indicated Mechanical Lift		Kardex) were reviewed		
		utilized for residents who		were accurate and app	•	
	•	ring and Mechanical Lift #2		Minimum Data Set Coo		
		lift utilized for residents who		Nurse aides, Quality A		
		bearing. The SDC stated		Consultant and Directo	•	
		as for two staff members to		Kardex are accurate a	nd appropriate.	
	be present when open					
		reported this was for the		On 11/1/17 to 11/8/20		
	safety of the residents	s and stall members.		Nursing, Regional Staf	-	
	An interview was con			Nurse and Quality Ass	urance Nurse ervicing all nurses	

Facility ID: 923497

If continuation sheet Page 28 of 44

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345284 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD THE OAKS WINSTON SALEM, NC 27103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 28 F 323 10/18/17 at 2:57 PM. NA #1 confirmed she and nursing assistants: utilized Mechanical Lift #2 to transfer Resident #8 You are required to review the kardex from bed to chair that morning (10/18/17). She of all residents assigned to your care prior revealed she utilized Mechanical Lift #2 without to the beginning of each shift to identify another staff member present. She stated she care needs of the resident. was unaware of the facility 's policy for the If you do not see a kardex then number of staff members required to be present consult with your nurse for further care during the operation of Mechanical Lift #2. NA #1 instructions. explained that she was not normally assigned to You should always follow the plan of Resident #8 and she was unfamiliar with the care for the residents as outlined on the proper procedure to operate Mechanical Lift #2. kardex. If the resident's condition has changed, you feel that the plan is unsafe, An interview was conducted with Resident #8 on or the resident refuses to follow the plan 10/19/17 at 9:00 AM. Resident #8 indicated she then you should notify the nurse for required the assistance of staff as well as a additional guidance regarding care. mechanical lift for transfers. She stated normally To access the kardex you can click on there was only one staff member present when the resident's name in the electronic the mechanical lift was utilized for her transfers. health record and click on the kardex brick An interview was conducted with NA #4 on 10/19/17 at 9:35 AM. NA #4 indicated her On 11/1/2017 to 11/8/2017, The Quality primary duty was as the facility scheduler, but she Assurance Nurse Consultant and was also an NA and worked on the floor if Regional Staff development Nurse in needed. She stated the facility utilized two types serviced all Nurses and Nurse Aides (full of mechanical lifts, Mechanical Lift #1 and time, part time and PRN/as needed) to Mechanical Lift #2. She indicated Mechanical Lift inform them that the facility must ensure #1 required two persons to operate it at all times. that the resident environment remains She reported Mechanical Lift #2 was sometimes free from accident hazards as is possible able to be used by one person depending on the and; each resident receives adequate resident 's ability to physically assist with the supervision and assistance devices to transfer as well as their size. NA #4 was asked prevent accidents. how staff knew what mechanical lift was to be utilized for the resident as well as the number of Nurse Aide Skill's checklist was staff that were required. She stated the NA completed by Regional Staff Development Kardex, a care guide for the NAs, indicated if a Nurse and Quality Assurance Nurse mechanical lift was required, the type of Consultant by 11/8/2017 on Nurse Aides mechanical lift, and the number of staff needed to by completing an observation of use of transfer the resident. Mechanical lifts (Full time, part time and PRN/as needed) to ensure that the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 0NC211

Facility ID: 923497

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	OF DEFICIENCIES	MEDICAID SERVICES			OMB NO. 0938-0 (X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	1 ° <i>î</i>		COMPLETED			
					С			
		345284	B. WING		10/19/2017			
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZI	P CODE			
	s			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	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE			
F 323	Continued From page	a 20	F 32	2				
1 020		esident #8 was reviewed on	F JZ	followed the plan of care	as indicated			
	10/19/17. This form i				as indicated.			
	required Mechanical			As of 11/9/17 no employ	ee (Registered			
	assistance for safety			Nurse, Licensed Practic				
				Certified Nursing Assista				
		ducted with the Director of		allowed to work until the	training has been			
	- · ·	/19/17 at 10:25 AM. She		completed.				
		xpectation that staff followed		Effective 11/9/2017, this				
		o have two staff members /lechanical Lift #1 and		incorporated into the new orientation program.	w employee			
	Mechanical Lift #2. S			This information has bee	en integrated into			
	expected the staff me			the standard orientation				
		echanical lift for the resident		required in-service refree				
		lan of care and the NA		all employees and will be				
	Kardex.			Quality Assurance Proce	ess to verify that			
				the change has been su	stained.			
				The monitoring procedu	re to ensure that			
				the plan of correction is				
		dmitted to the facility on		specific deficiency cited				
		es that included paraplegia		and/or in compliance wit	h the regulatory			
	and Multiple Sclerosis	s (MS).		requirements;				
	The edmission Minim	Num Data Sat (MDS)		Starting evening shift of				
	The admission Minim	27/17 indicated Resident #6		nurse assigned to a unit monitor change of shift a				
		He was assessed with no		that Nurse Aides are rev	-			
		ection of care. Resident #6		before they start their as				
		ng the extensive assistance		ensure compliance, the	•			
	of two or more staff w			Nursing will review the to				
	transfers. He had imp	pairment on both sides of the		nurses in the unit to ens	-			
	lower extremities and	l utilized a wheelchair.		monitoring the aide's cha	ange of shift on a			
				weekly basis.				
		sment (CAA) related to falls		The Director of Nursing				
		sion MDS assessment		Manager will observe 5				
		δ was non-ambulatory. He d the extensive assistance		weekly including the wee shifts) to ensure that the				
		Resident #6 ' s risk factors		plan of care as indicated				
		paraplegia, and muscle		while using mechanical				
	spasms. He was indi			done on weekly basis fo				

Facility ID: 923497

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED		
		345284	B. WING		C 10/19/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1		
THE OAK	6			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	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC		
F 323	23 Continued From page 30 fractures or soft tissue damage that had the potential to lead to immobility and consequently death.		F 32	monthly for 3 months. Reports will be presented to the Quality Assurance committee by Director of Nursing to ensure co	y the prrective		
	at increased suscepti cause physical harm gait/balance seconda bilateral extremities s	ry to non-weight bearing tatus due to MS. The d he required Mechanical		action for trends or ongoing cor initiated as appropriate. The we Quality Assurance Meeting is at the Director of Nursing, Wound Minimum Data Set Coordinator, Manager, Support Nurse, Thera Information Management, Dieta Manager and the Administrator.	eekly ttended by Nurse, , Unit apy, Health rry		
	reviewed on 10/18/17 specific interventions	Task Listing Report was 7. This report indicated the required for transferring #8 was noted as requiring transfers.		The title of the person responsil implementing the acceptable pla correction; Administrator and /or Director o	an of		
	10/18/17 at 1:30 pm. the assistance of staf for transfers. Residen transferred from his b staff member utilizing reported Mechanical staff had to weigh him there was one staff m	ed to his wheelchair by one Mechanical Lift #2. He Lift #1 was utilized when n. He indicated sometimes nember present when I Lift #1 and other times					
	2:45 PM. She stated of mechanical lifts, M Mechanical Lift #2. S #1 was a full body lift were non-weight beau	nator (SDC) on 10/18/17 at the facility utilized two types					

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		D HUMAN SERVICES				FORM	: 11/22/2017 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMPI	LETED
		345284	B. WING			(10/) 19/2017
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	E, ZIP CODE		
			90	1 BETHESDA ROAD			
THE OAKS	5		w	INSTON SALEM, NC 27	103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 323	the facility 's policy w be present when oper mechanical lifts. She safety of the residents An interview was com 10/19/17 at 9:35 AM. primary duty was as t was also an NA and w needed. She stated t of mechanical lifts, Me Mechanical Lift #2. S #1 required two perso She reported Mechan able to be used by on resident 's ability to p transfer as well as the how staff knew what r utilized for the resider staff that were require Kardex, a care guide mechanical lift, and th transfer the resident. The NA Kardex for Re 10/19/17. This form in required Mechanical Lift transfers. An interview was com Nursing (DON) on 10/ indicated it was her ex the facility 's policy to present when using M Mechanical Lift #2. St expected the staff me	bearing. The SDC stated as for two staff members to rating both types of reported this was for the s and staff members. ducted with NA #4 on NA #4 indicated her he facility scheduler, but she vorked on the floor if he facility utilized two types echanical Lift #1 and he indicated Mechanical Lift ons to operate it at all times. ical Lift #2 was sometimes e person depending on the hysically assist with the eir size. NA #4 was asked mechanical lift was to be ht as well as the number of ed. She stated the NA for the NAs, indicated if a quired, the type of he number of staff needed to esident #6 was reviewed on ndicated Resident #6 Lift #1 for safety and ducted with the Director of (19/17 at 10:25 AM. She expectation that staff followed o have two staff members lechanical Lift #1 and he also indicated she	F 323				

Facility ID: 923497

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
				С	
		345284		ET ADDRESS, CITY, STATE, ZIP CODE	10/19/2017
NAME OF P	ROVIDER OR SUPPLIER				
THE OAK	S			BETHESDA ROAD STON 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 COMPLET
F 323	Continued From page	e 32	F 323		
		lan of care and the NA			
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD,		F 441		11/10/17
33-0	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)			
	(a) Infection prevention	on and control program.			
		blish an infection prevention (IPCP) that must include, at ving elements:			
	investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according	der a contractual pon the facility assessment to §483.70(e) and following ndards (facility assessment			
		, policies, and procedures h must include, but are not			
	possible communicat	llance designed to identify ole diseases or infections ad to other persons in the			
		m possible incidents of se or infections should be			
		nsmission-based precautions rent spread of infections;			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345284	B. WING			C 10/19/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S				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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	 (iv) When and how ise resident; including but (A) The type and durat depending upon the in involved, and (B) A requirement that least restrictive possific circumstances. (v) The circumstances (vi) The circumstances (vi) The hand hygiene by staff involved in dir (4) A system for recorrunder the facility's IPO actions taken by the f (e) Linens. Personne process, and transports spread of infection. (f) Annual review. Thannual review of its IF program, as necessant This REQUIREMENT by: Based on observation facility failed to change 	blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable tin lesions from direct to or their food, if direct he disease; and e procedures to be followed rect resident contact. ding incidents identified CP and the corrective acility. I must handle, store, rt linens so as to prevent the e facility will conduct an PCP and update their ry. is not met as evidenced in and staff interviews, the e gloves and wash hands nence care and before	F	441	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 Regulations the facility has taken or w take the actions set forth in this Plan of	ill	

Facility ID: 923497

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 11/22/20 RM APPROVE IO. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY IPLETED
		345284	B. WING		1	C 0/19/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				901 BETHESDA ROAD		
THE OAKS	6			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) COMPLETIO DATE
F 441	Continued From page	e 34	F 441	Correction. The Plan of Correct	tion	
	The facility ' a infection	on control policy on hand				
	•	vealed it followed the Center		constitutes the facility's allegati compliance such that all allege		
		s guidelines. "Specific		deficiencies cited have been of		
		nd hygiene after contact with		corrected by the date or dates		
		lid or excretion and after				
	offering incontinence			F441 INFECTION CONTRO	DL,	
	-			PREVENT SPREAD, LINENS.		
) pm an observation of		The plan of correcting the spec		
		as done of Resident #1. The		deficiency. The plan should ad		
		ed and Nursing Assistant		processes that lead to the defic	ciency	
		a bed bath and incontinence		cited;		
	•	d stool incontinence care. e incontinence care gloves to		The facility failed to change glo wash hands after providing inc		
		drawer and retrieve a tube of		care and before providing furth		
	-	tinued using the same		1 of 3 residents (Resident #1).		
		e ointment over the resident '		Resident #1. Incontinence care	e provided	
	÷ .	es. At the completion of		as needed and as per plan of c	are as	
		A #1 was requested by the		indicated on the Kardex (this is	а	
		he resident ' s peri and labia		shortened version derived from		
		with peri-wipes which had		plan that identifies key care ne		
	-	#1 cleaned the additional		residents) in the electronic hea		
	hands.	loves and washed her		Nurse Aide Skill's checklist was completed from 11/1/2017 to 1		
	nanus.			Nurse Aides (Full time, part tim		
	On 10/18/17 at 3:45	pm an interview was		PRN/as needed) to ensure that		
		1 who stated that she		demonstrated hand hygiene pr	-	
		gloves after incontinence		after providing incontinence ca		
		on to other care, but had not		before providing further care. A		
		with Resident #1. NA #1		ensure that they demonstrated		
		emove her gloves and wash		hand sanitizer/hand washing p		
	her hands before beg	ginning other care.		how to don/remove/discard and	d utilize	
	On 10/10/17 -+ 0.40	nm on inton <i>iou</i> was		gloves per facility policy.	a tho	
	On 10/19/17 at 2:48	•		The procedure for implementin	•	
		virector of Nursing (DON). she expected all staff to		acceptable plan of correction for specific deficiency cited;		
		autions during all resident		On 11/1/2017 to 11/8/2017, Th	e Quality	
	-	illy to change gloves and		Assurance Nurse Consultant a	-	
	someor and opcomod	my to onlange gioreo ana				1

Facility ID: 923497

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 11/22/2017 RM APPROVED IO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345284	B. WING			1	C 0/19/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	5			90	01 BETHESDA ROAD		
	-			N	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	Continued From page	2 35	F	441	serviced all Nurses and Nurse Aid time, part time and PRN/as neede inform them that the facility has a established infection prevention a control program. Hand hygiene procedures must be followed by s involved in direct resident contact must handle linens, store, and pro- and transport them so as to preve- spread of infection. Nurse Aide Skill's checklist was completed by 11/8/2017 on Nurse (Full time, part time and PRN/as r to ensure that they demonstrated hygiene practices after providing incontinence care and before pro- further care. Also to ensure that th demonstrated use of hand sanitiz washing practice. Also to ensure and utilize gloves per facility polic As of 11/9/17 no employee (Regis Nurse, Licensed Practical Nurse, Certified Nursing Assistants) will the allowed to work until the training fr completed. Effective 11/9/2017, this training is incorporated into the new employ orientation program. This information has been integrat the standard orientation training a required in-service refresher cour all employees and will be reviewed Quality Assurance Process to ver the change has been sustained.	ed) to n staff Staff Decess ent the e Aides needed) hand viding ney er/hand that they e/discard y. stered and De nas been s ee tted into ind in the ses for ed by the ify that	
	7(02-99) Previous Versions Obs	olete Event ID:0NC2			The monitoring procedure to ensu		eet Page 36 of 44

Event ID: 0NC211

Facility ID: 923497

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TATEMENT O	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY PLETED
			A. BUILDIN	IG			С
		345284	B. WING			10/19/2017	
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS			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	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIC DATE
	QAA COMMITTEE-M QUARTERLY/PLANS CFR(s): 483.75(g)(1) (g) Quality assessme	1EMBERS/MEET S (i)-(iii)(2)(i)(ii)(h)(i)	F 4		the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulator requirements; The Director of Nursing and/or Nurse Manager will observe 5 nurse aides weekly including the weekend (varies shifts) to ensure that they demonstrate hand hygiene practices after providing further care. Also to ensure that they demonstrated use of hand sanitizer/han washing practice. Also to ensure that they demonstrated how to don/remove/disca and utilize gloves per facility policy. The will be done on weekly basis for 4 week then monthly for 3 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Management, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing	cted y nd ney ard is ks y e s by	11/10/17

Facility ID: 923497

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/22/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			_	C 10/19/2017	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE OAKS	3				1 BETHESDA ROAD	27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	37	F 5	520				
	(1) A facility must mai and assurance comm minimum of:	intain a quality assessment ittee consisting at a						
	(i) The director of nurs	sing services;						
	(ii) The Medical Direc	tor or his/her designee;						
	(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and							
	(g)(2) The quality ass committee must :	essment and assurance						
	coordinate and evaluate	respect to which quality						
		ement appropriate plans of tified quality deficiencies;						
	Secretary may not rec records of such comm such disclosure is rela	rmation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this						
	(i) Sanctions. Good fa committee to identify deficiencies will not be sanctions. This REQUIREMENT by:	and correct quality						

Facility ID: 923497

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/20 FORM APPROV OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 10/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	
THE OAK	S			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	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 520	record review, the fac and Assurance (QAA maintain implementer these interventions the place following the 5/ This was for three red areas of Care Provide Accordance with Care Nutrition/Hydration (F These deficiencies w current complaint inve 10/19/17. The contine during two federal su pattern of the facility of effective Quality Asse program. The finding This tag is cross refer 1. F282 - Care Provide Accordance with Care observation, record re and staff interview, the plan of care intervent residents (Residents accidents and the intervent residents (Residents accidents and the intervent resident #1) reviewed During the recertificar facility was cited F28. plan interventions for catheter. On the curr survey of 10/19/17 the to follow the care plan falls and aspiration pre-	In staff interviews, and cility 's Quality Assessment c) Committee failed to d procedures and monitor nat the committee put into 25/17 recertification survey. cited deficiencies in the ed by Qualified Persons in e Plan (F282), Assisted F322), and Accidents (F323). ere cited again on the estigation survey of nued failure of the facility rveys of record show a 's inability to sustain an essment and Assurance s included: renced to: ded by Qualified Persons in e Plan: Based on eview, resident interview, he facility failed follow the ions related to falls for 2 of 3 #6 and #8) reviewed for erventions related to s for 1 of 1 residents ed with a tube feeding. tion survey of 5/25/17 the 2 for failing to follow the care an indwelling urinary rent complaint investigation e facility was cited for failure n interventions related to	F 5	20 The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies. To rem compliance with all Federal Regulations the facility has take the actions set forth in Correction. The Plan of Con constitutes the facility's allege compliance such that all allede deficiencies cited have been corrected by the date or dat F520 QAA COMMITTEE-MEMBERS/M QUATERLY /PLANS. The plan of correcting the sp deficiency. The plan should processes that lead to the d cited; The facility ' s Quality Assess Assurance (QAA) Committee maintain implemented proces monitor these interventions committee put into place foll 5/25/17 recertification surver three recited deficiencies in Care Provided by Qualified Accordance with Care Plan Assisted Nutrition/Hydration Accidents (F323). These de were cited again on the curr investigation survey of10/19 continued failure of the facilit federal surveys of record sh of the facility ' s inability to s effective Quality Assessment Assurance program. This tag is cross referenced	Asion to and do twith the pain in and State taken or will this Plan of rrection gation of eged n or will be es indicated. IEET pecific address the eficiency assent and that the lowing the y. This was for the areas of Persons in (F282), r (F322), and ficiencies rent complaint 0/17. The ity during two row a pattern ustain an tt and

Facility ID: 923497

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY
			A. BUILDING	;		С
		345284	B. WING			
	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, ZIP CC		0/19/2017
	NOVIDER ON SOLT EIER			901 BETHESDA ROAD		
THE OAK	S			WINSTON SALEM, NC 27103		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLETIC DATE
F 520	Continued From page	e 39	F 52	0		
		vation, and staff interview,		Provided by Qualified Perso	ns in	
		aintain head of bed at 30-45		Accordance with Care plan.		
	•	eeding for 1 of 1 residents		The facility failed follow the	olan of care	
	reviewed for tube fee			interventions related to falls		
				residents (Residents #6 and		
		tion survey of 5/25/17 the		for accidents and the interve		
		3 for failing to provide tube		to aspiration precautions for		
		y the physician. On the		1residents (Resident #1) rev	viewed with a	
		estigation survey of 10/19/17		tube feeding.	ontiona ara	
	-	for failure to maintain head ses during tube feeding.		Resident#8 Care plan interv reflected in the Kardex in the		
		es during tube reeding.		health record was reviewed		
	2 E323 - Accidents: F	Based on observation,		by the Quality Assurance Nu		
		nt interview, and staff		Consultant, Nurse, Nurse ai		
		failed to consistently use the		Data Set Consultant to ensu		
	-	cal lift to transfer residents		were accurate and appropria	-	
	and failed to consiste	ntly utilize 2 staff to operate		accurate and appropriate		
		or transfers, putting the		Resident #6 Care plan interv		
		jury for 2 of 3 residents		reflected in the Kardex in the		
	reviewed for accident	s (Resident #6 and #8).		health record was reviewed		
	During the surgest first			by the Quality Assurance Nu		
	•	tion survey of 5/25/17 the		Consultant, Nurse, Nurse ai		
	-	3 for failing to secure the r of the facility van according		Data Set Consultant to ensu were accurate and appropria		
		tructions before transporting		accurate and appropriate.	ale. Natuex 15	
		the resident landing on her		Resident #1.Care plan interv	entions are	
		head on the van floor. On		reflected in the Kardex in the		
	-	investigation survey of		health record was reviewed		
	10/19/17 the facility w			by the Quality Assurance Nu	irse	
		aff to operate mechanical lifts		Consultant, Nurse, Nurse ai		
	for transfers.			Data Set Consultant to ensu	•	
				were accurate and appropria		
		ducted with the Director of		Intervention in place indicati		
	- · ·	dministrator on 10/19/17 at		resident is on aspiration pre-		
	-	ated they presently shared		to tube feeding. Nurse to be		
		erson for the facility ' s QAA plained the previous head of		to providing care. Head of be lowered while tube feeding i		
		had left the position several		Kardex is accurate and appr	-	
	months ago. They in			This tag is cross referenced		

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		345284		,	С	
	ROVIDER OR SUPPLIER	545204		STREET ADDRESS, CITY, STATE, ZIP CODE	10/19/2017	
				901 BETHESDA ROAD		
THE OAKS				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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
F 520	consisted of the Adm Data Set (MDS) Coor Coordinator #2, Wou Director, Dietary Man Therapy Manager, M Environmental Servic Consultant. The Con monthly with the exce Consultant and Medie minimum of quarterly DON indicated they w F323 were repeat cita recertification survey. Plans of Correction (f the exact deficiency t indicated as example was focused specifica	inistrator, DON, Minimum rdinator #1, MDS nd Nurse, Admissions lager, Social Worker, edical Director, tes Manager, and Pharmacy mittee reportedly met eption of the Pharmacy cal Director who attended a . The Administrator and were aware F282, F322, and ations from the 5/25/17 . They reported the previous POCs) were very focused on	F 52	Assisted Nutrition/Hydration The facility failed to maintain the he the bed at 30 to 45 degrees during feeding for 1 of 1 residents reviewed tube feeding (Resident #1). Resident #1. Care plan intervention reflected on the Kardex in the elecc health record was reviewed on 11/ by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Min Data Set Consultant to ensure that were accurate and appropriate. Intervention in place indicating that resident is on aspiration precaution to tube feeding. Nurse to be notified to providing care. Head of bed not lowered while tube feeding is infus Kardex is accurate and appropriate This tag is cross referenced to F32 Accidents: The facility failed to consistently us appropriate mechanical lift to trans residents and failed to consistently us appropriate mechanical lift to trans residents (Resident #6 and #8). Resident#8 Care plan intervention reflected in the Kardex in the elect health record was reviewed on 11/ by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Min Data Set Consultant to ensure that were accurate and appropriate. Ka accurate and appropriate. Resident #6 Care plan intervention reflected in the Kardex in the elect health record was reviewed on 11/ by the Quality Assurance Nurse Consultant, Nurse, Nurse aide, Min Data Set Consultant to ensure that were accurate and appropriate. Ka accurate and appropriate.	tube ed with ns are tronic 2/2017 himum t they t ts due d prior to be ing. e. 23 se the fer rutilize ffs for isk for for are ronic 2/2017 himum t they table d prior to be ing. e. 23	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/22/2017 FORM APPROVED OMB NO. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 10/19/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 901 BETHESDA ROAD WINSTON SALEM, NC 27103	ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	I OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 520	Continued From page	e 41	F 5	20 Consultant, Nurse, Nurse Data Set Consultant to were accurate and appropriat The procedure for imple acceptable plan of corres specific deficiency cited This tag is cross referent Provided by Qualified P Accordance with Care p This tag is cross referent Assisted Nutrition/Hydra This tag is cross referent Accidents On 11/3/2017, The Qua Nurse in serviced the Act reference to the Quality Assurance. A facility mu quality assessment and committee consisting at The director of nursing s Medical Director or his/f At least three other ment facility's staff, at least on the administrator, owne or other individual in a le and The quality assess assurance committee m least quarterly and as n coordinate and evaluate identifying issues with re quality assessment and activities are necessary and implement appropri to correct identified qua Disclosure of informatio Secretary may not requi the records of such cor	ensure that they opriate. Kardex is te. ementing the ection for the ; need to F282 Care ersons in blan. need to F322 ation need to F323 lity Assurance dministrator in Assessment and ust maintain a assurance ; a minimum of:(i) services;(ii) The her designee;(iii) mbers of the ne of who must be r, a board member eadership role; ment and hust :(i) Meet at eeded to e activities such as espect to which assurance ; and(ii) Develop iate plans of action lity deficiencies;(h) n. A State or the ire disclosure of

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DEPART CENTER	PRINTED: 11/22/2017 FORM APPROVED OMB NO. 0938-0391						
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 10/19/2017		
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	•			901 BETHESDA ROAD			
THE OAKS				w N	VINSTON 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 520	Continued From page	e 42	F	520	so far as such disclosure is related to compliance of such committee with the requirements of this section. (i) Sancti Good faith attempts by the committee identify and correct quality deficiencies not be used as a basis for sanctions. Effective 11/9/2017, this training is incorporated into the new employee orientation program. This information has been integrated i the standard orientation training and in required in-service refresher courses f all employees and will be reviewed by Quality Assurance Process to verify the the change has been sustained. The monitoring procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with the regulato requirements; This tag is cross referenced to F282 C Provided by Qualified Persons in Accordance with Care plan. This tag is cross referenced to F322 Assisted Nutrition/Hydration This tag is cross referenced to F323 Accidents To ensure compliance, Administrator of Director of Nursing will monitor this iss using the Quality Assurance survey to Facility will monitor compliance of Qua Assurance for F282, F322 and F323. will be done on weekly basis for 4 weat then monthly for 3 months by Administrator and reviewed monthly b the Quality Assurance Nurse Consulta to ensure compliance. Reports will be	e ons. to s will nto n the or the at hat cted ry care or sue ol. ality This eks y	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345284		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL A. BUILDING	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 10/19/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE OAK	8				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPL DEFICIENCY)		ULD BE COMPLETIC
F 520	Continued From pag	e 43	F 520	presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursin assure corrective action initiated a appropriate. Any immediate conce be brought to the Director of Nursi Administrator for appropriate actio Compliance will be monitored and ongoing auditing program reviewe Weekly Quality of Life Meeting. W Quality Assurance Committee mere attended by Administrator, Directo Nursing, MDS Coordinator, Unit M Support Nurse, Therapy, Health Information Management, Dietary Manager, Wound Nurse. The title of the person responsible implementing the acceptable plan correction; Administrator and /or Director of N	is erns will ing or in. d at the eekly eting is or of lanager, for of

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